Army Regulation 608–18

Personal Affairs

The Army Family Advocacy Program

Headquarters
Department of the Army
Washington, DC
30 October 2007

UNCLASSIFIED

SUMMARY of CHANGE

AR 608-18
The Army Family Advocacy Program

This rapid action revision, dated 30 October 2007--

- Provides new guidance concerning the completion of DA Form 7517 for all persons involved in incidents referred to the Family Advocacy Program (para 3-1f).

- Corrects typographical errors throughout the publication.

Headquarters
Department of the Army
Washington, DC
30 October 2007

*Army Regulation 608–18

Effective 30 November 2007

Personal Affairs

The Army Family Advocacy Program

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:

JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision. The portions affected by this rapid action revision are listed in the summary of change.

Summary. This regulation contains the policies for handling spouse and child abuse within the Army. This regulation implements Department of Defense Directive 6400.1, Department of Defense 6400. 1–M, and Department of Defense Instructions 6400.2, 6400.3, and 1402.5.

Applicability. This regulation applies to members of the Active Army; the Army National Guard of the United States, including periods when operating in an Army National Guard capacity; the United States Army Reserve on active duty training, special duty for training, or special active duty for training (duration of 30 days or more); other uniformed Services (and their Families) assigned to or residing on Army installations; and others entitled to care in medical treatment facilities. This regulation does not apply to members of the United States Army Reserve performing inactive duty training or to members of the Army National Guard of the United States performing duty in a State status under Title 32 of the United States Code. This regulation remains effective during mobilization unless otherwise stated.

Proponent and exception authority. The proponent of this regulation is the Assistant Chief of Staff for Installation Management. The Assistant Chief of Staff for Installation Management has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The Assistant Chief of Staff for Installation Management may delegate this approval authority, in writing, to a division chief within the proponent agency or a direct reporting unit or field operating agency of the proponent agency in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated (See appendix L).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP, 4700 King Street, Alexandria, VA 22302–4418.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.

Committee Continuance Approval. The Department of the Army Committee Management Officer concurs in the continuance of the Headquarters, Department of the Army and installation Family advocacy committees and case review committees.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army; D and E for the Army National Guard/Army National Guard of the United States; and C, D, and E for the United States Army Reserve.

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*This publication supersedes Army Regulation 608–18, dated 30 May 2006.

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Chapter 1
Introduction

Section I
General

1–1. Purpose
This regulation establishes Department of the Army (DA) policy on the prevention, identification, reporting, investigation, and treatment of spouse and child abuse. This regulation also assigns responsibility for the Family advocacy program (FAP) in accordance with Department of Defense Directives (DODDs) 6400.1 and 1030.1; DOD 6400.1–M; and DOD Instructions (DODIs) 6400.2, 6400.3, 1342.24, and 1402.5.

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities
Responsibilities are listed in section II of chapter 1.

1–5. Policy
a. DA policy is to prevent spouse and child abuse, to protect those who are victims of abuse, to treat those affected by abuse, and to ensure personnel are professionally trained to intervene in abuse cases. Since many incidents of abuse constitute violations of the law, DA policy also recognizes a commander's authority to take disciplinary or administrative action in appropriate cases.

b. The FAP will promote public awareness within the military community and coordinate professional intervention at all levels within the civilian and military communities, including law enforcement, social services, health services, and legal services.

c. The FAP is designed to break the cycle of abuse by identifying abuse as early as possible and providing treatment for affected Family members.

1–6. Objectives
The objectives of the FAP are to prevent spouse and child abuse, to encourage the reporting of all instances of such abuse, to ensure the prompt assessment and investigation of all abuse cases, to protect victims of abuse, and to treat all Family members affected by or involved in abuse. In carrying out these objectives, the FAP will—

a. Provide installation commanders with staff assistance in addressing the problems of spouse and child abuse.

b. Provide information and education designed to support strong, self-reliant Families and to enhance coping skills.

c. Provide services to at-risk Families who are vulnerable to the kinds of stresses that can lead to abuse.

d. Identify abuse as early as possible to prevent further trauma.

e. Provide treatment services to Soldiers and their Families who are involved in Family violence in order to strengthen the Family and prevent the recurrence of abuse.

f. Encourage voluntary self-referral through education and awareness programs.

g. Partner with installation and community organizations to promote community cohesion.

Section II
Responsibilities

1–7. Headquarters, Department of the Army and major Army command responsibilities
a. Assistant Chief of Staff for Installation Management. The Assistant Chief of Staff for Installation Management (ACSIM) has overall responsibility for policy guidance in implementing the FAP.

b. The Commander, U.S. Army Community and Family Support Center. The Commander, U.S. Army Community and Family Support Center (USACFSC)(CFSC–FP–A) will perform the following functions for the ACSIM:

(1) Designate an FAP manager (FAPM).

(2) Develop DA policy for ACSIM's approval of the FAP.

(3) Develop and implement a needs assessment and program evaluation system to determine and monitor the use of resources and to report on program efforts.

(4) Submit FAP resource requirements through budget channels.

(5) Ensure compliance with DOD 6400.1–M.

(6) Provide policy and guidance for operating and maintaining the Army Central Registry (ACR).

(7) Work with the U.S. Army Training and Doctrine Command (TRADOC), The Judge Advocate General (TJAG), and individual Army schools to ensure instruction is sufficient to prepare school attendees to perform their duties and responsibilities as defined in this regulation. Include instruction in medical, dental, law enforcement, legal, and social service programs of instruction.

(8) Fund and monitor the DA-sponsored Family advocacy staff training (FAST) and FAST-advanced (FAST–A) courses, which are taught several times a year, to include specialized training for law enforcement and legal personnel.

(9) Sponsor training workshops for Army Community Service (ACS) installation personnel.

(10) Visit, monitor, and provide technical assistance to specific Army Command (ACOM), Army Service Component Command (ASCC), and Direct Reporting Unit (DRU) (TRADOC (Accessions Command)), U.S. Army Intelligence and Security Command (INSCOM), U.S. Army Space and Missile Defense Command (SMDC), and U.S. Army Special Operations Command and Installation Management Activity (USASOC) (IMA) garrisons.

(11) Develop program materials.

(12) Establish and chair a multidisciplinary Headquarters, Department of the Army (HQDA) Family advocacy committee (FAC). Members include representatives from USACFSC; Office of the Deputy Chief of Staff, G–1 (DCS, G–1); Office of The Surgeon General (OTSG); U.S. Army Human Resources Command (USA HRC); Office of The Judge Advocate General; Chief of Chaplains; Security Force Protection and Law Enforcement Division, Office of the Deputy Chief of Staff, G–3 (DAMO–ODL) (DCS, G–3); U.S. Army Criminal Investigation Command (USACIDC); U.S. Army Center for Substance Abuse (USACSA); and Child and Youth Services (CYS)(Community and Family Support Center (CFSC)). A representative from the DOD dependent school system (DODDS) also will be invited to participate. The committee's purpose is to provide advice on FAP policy and promote related training.

(13) Establish and chair the Family advocacy research subcommittee (FARS), a subcommittee of the HQDA FAC. The FARS will review, coordinate, and recommend approval and dissemination of all Family advocacy research, evaluation projects, and research publications within the DA. The FARS will prepare a standing operating procedure (SOP) that details its procedures for review of proposals, protocols, and manuscripts and will furnish the SOP upon request to all interested parties. The FARS, jointly with the HQDA FAPM, will establish Family advocacy research needs and monitor the implementation of strategic research initiatives. The FARS meets quarterly or as determined by the HQDA FAPM. The Chair of the FARS is the HQDA FAPM. Core members include a representative from the Walter Reed Army Institute of Research; Army Research Institute; USACFSC, Strategic Planning and Policy (Research); OTSG Social Work Consultant; Chief, Behavioral Science Division, U.S. Army Medical Command (MEDCOM), as a nonvoting member; and an installation or IMA FAPM with research experience.

(14) Designate nominees to represent Army on the DOD Family Advocacy Command Assistance Team (FACAT) and ensure personnel are trained and are released from normal duty assignment while deployed with the team.

(15) Ensure individuals selected to serve on the DA Family Advocacy Regional Rapid Response Team are properly trained and are released from normal duty assignment while deployed.

(16) Establish and chair a multidisciplinary HQDA fatality review committee to review installation domestic violence and child abuse fatalities and forward a HQDA annual report through channels to the Office of the Deputy Under Secretary of Defense for Military Community and Family Policy. The Chair of the team is the HQDA FAPM. Members include representatives from USACFSC (FAP, CYS, CJA); OTSG; Office of The Judge Advocate General; Chief of Chaplains; DAMO-ODL (DCS, G-3); USACIDC; USACSA; MEDCOM (Medical Examiner/Pathologist, Pediatrician/Family Practitioner, Behavioral Health); IMA; and other consultants, as necessary.

c. Director, Installation Management Agency. The IMA Director will—

(1) Implement FAP policies and ensure program compliance with this regulation, AR 608–1, and DOD 6400.1–M.

(2) In overseas commands, establish procedures for authorized civilians involved in spouse or child abuse to participate in treatment under the FAP and protect victims from further trauma.

(3) Submit installation resource requirements to include medical treatment facility (MTF) and ACS FAP requirements through program and budget channels to the Assistant Chief of Staff for Installations Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.

(4) Distribute Office of the Secretary of Defense (OSD) FAP funds to installations for ACS and MTF in accordance with CFSC Funding Guidance and monitor program execution rates.

(5) Disseminate semiannual ACR statistical data to the regions and installations.

(6) Provide a representative to the HQDA fatality review committee.

d. The Deputy Chief of Staff, G–1. The DCS, G–1 is responsible for—

(1) Providing or designating a representative to the HQDA FAC.

(2) Providing staff assistance in the formulation of FAP policy.

e. U.S. Army Medical Command. The U.S. Army Medical Command (MEDCOM) is responsible for—

(1) Providing medical resources and medical policies related to the FAP and ensuring medical, dental, intervention/treatment, manpower, and funding resources are programmed with Army Medical Department (AMEDD) mission requirements.

(2) Supporting the FAP personnel funded by the OSD with additional MTF assets to include military and defense health program (DHP) personnel.

(3) Providing a representative to the HQDA FAC and the HQDA fatality review committee.

(4) Ensuring that continuing and graduate medical education/training programs and positions exist to train necessary military physicians and medical service providers on how to staff the FAP to include health care professionals serving on the Case Review Committee (CRC).

(5) Coordinating all FAP-related pilot and research projects through the Clinical Investigative Regulatory Office and FARS. Participating in or conducting clinical outcome studies and accomplishing clinical research.

(6) Developing and implementing an AMEDD FAP quality improvement program consistent with this regulation and DOD 6400.1–M.

(7) Providing a representative to participate in continental United States (CONUS) and outside continental United States (OCONUS) technical assistance visits with USACFSC upon request.

(8) Providing nominees to USACFSC to represent the Army on the DA Family Advocacy Regional Rapid Response Team and the DOD FACAT. Ensuring personnel are released from normal duty assignment while deployed.

(9) Establishing and maintaining a central registry system (in other words, the ACR) for collecting and analyzing data on spouse and child abuse and for quality assurance purposes. The function of the ACR is to track spouse and child abuse cases and to maintain a confidential database for Army-wide statistical information by compiling data on caseloads, demographics, and trends for management and planning purposes. In this regard, ACR will—

(a) Record all reported spouse and child abuse cases and have this information available as required by law and according to regulation.

(b) Respond promptly while complying with Freedom of Information Act and Privacy Act requirements to authorized CRC representative's requests for information on specific individuals or previously reported incidents of abuse.

(c) Forward a copy of the DA Form 7517 (DA Child/Spouse Abuse Incident Report) to the child and spouse abuse reporting component of the appropriate Service in all cases involving members of other military Services and their Families. DA Form 7517 is used to transmit case information to the ACR.

(d) Maintain information in the ACR according to AR 25–400–2, file no. 608–18 (CRC team files).

(e) Eliminate all identifying information pertaining to individuals within the ACR if an installation CRC determines that an alleged spouse and child abuse case is unsubstantiated.

(f) Provide technical and training guidance to MTFs in support of the management of Army-wide abuse reporting and its components. Ensure reported accountability and compliance with this regulation.

(g) Compile reports as requested by the Commander, USACFSC IMA and forward reports to USACFSC and specific points of contact (POCs).

(h) Provide quarterly updates to the Defense Manpower Data Center (DMDC) for DOD-driven research and analysis; provide consultation to DMDC in the formulation of abuse data, reporting requirements, and standardization.

(i) Provide quarterly updates of the ACR database to FARS for research and analysis of the Army FAP.

(j) Support the DA-sponsored FAST course.

(k) Respond to queries from congressional and executive-branch offices and consult with DOD FAP and Joint Service central registries and designees concerning standardized formats, procedures, and doctrine.

(l) Provide background checks on both staff and volunteers in ACS FAPs as well as on applicants, employees, and volunteers in DOD-operated or -sanctioned activities. Background checks for staff and volunteers for DODDS and Department of Defense dependent elementary and secondary schools (DODESS) will be conducted pursuant to local support agreements.

(m) Provide ACR checks of drill sergeants, recruiters, Department of the Army NCO, and Soldier of the Year Candidates, and enlisted aides.

(n) Provide ACR checks for CRC members. Individuals recorded as offenders in the ACR will no longer serve on the CRC or have access to the ACR (see para 8–5*e*).

(10) Designate an FAPM to supervise the overall operation of MTFs and ensure compliance with this regulation and DOD directives and instructions.

(11) Provide technical and professional guidance to MTF commanders and designees regarding medical aspects of FAP to include establishing procedures, protocols, standards, and doctrine concerning the medical and dental aspects of identification, case management, treatment, documentation, and rehabilitation.

(12) Review and resolve any issues related to noncompliance with the appropriate standards of clinical care (in accordance with DOD 6400.1–M, DA Pam 608–17, Child Abuse Manual (CHAM), Spouse Abuse Manual (SPAM), and app B) to include maintenance of the MEDCOM CRC case review process and advise CFSC of issues and trends. (See para 2–6.)

(13) Participate in accreditation visits to ensure care is consistent with program goals, mission, and published policies.

(14) Maintain policy on standard record content and maintenance.

f. The Judge Advocate General. TJAG will—

(1) Advise on legal issues involved in the FAP.

(2) Train and educate installation judge advocate officers in the legal issues involved in spouse and child abuse cases.

(3) Provide staff assistance in the formulation of FAP policy.

(4) Provide or designate a representative to the HQDA FAC and the HQDA fatality review committee.

(5) Provide assistance to IMA specific ACOMs, ASCCs, and DRUs and installations on the development of MOAs between Army installations and civilian social service agencies, law enforcement agencies, and the courts.

(6) Ensure the participation of judge advocate personnel at all levels of the FAP.

(7) When authorized, ensure there is a POC for-and serve as approval authority for-requests for Soldiers, Family members, civilian employees, and others to appear at government expense as witnesses in State or local proceedings relating to domestic violence.

(8) Provide nominees to USACFSC to represent the Army on the DOD FACAT and ensure personnel are released from normal duty assignment while deployed with the FACAT.

g. Chief, Security Force Protection and Law Enforcement Division, Deputy Chief of Staff, G–3. The Chief, DAMO–ODL, DCS, G–3 will—

(1) Provide law enforcement policy and guidance for the investigation of spouse and child abuse, to include developing MOAs with civilian law enforcement agencies consistent with both U.S. State and Federal law and host-nation laws and agreements.

(2) Provide a representative to the HQDA FAC and the HQDA fatality review committee.

(3) Provide a copy of the serious incident report (SIR) relating to child abuse in DOD-operated or -sanctioned activities to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.

(4) Establish a system to record and track all military no-contact orders. Records that pertain to military no-contact orders will be maintained in accordance with recordkeeping requirements outlined in AR 25–400–2. (See para 6–10.)

h. Commander, U.S. Total Army Personnel Command. The Commander, AHRC will—

(1) Coordinate with CFSC the reassignment, deletion, and deferment of Soldiers in appropriate FAP cases either when a child or spouse is at risk of death or serious physical injury or to stabilize FAP treatment.

(2) Provide a representative to the HQDA FAC.

(3) Provide CFSC with designated personnel to request and receive ACR background-screening results.

i. The Chief of Chaplains. The Chief of Chaplains will—

(1) Provide specialized training for chaplains in identifying, addressing, and reporting spouse and child abuse.

(2) Provide training, guidance, and policy to instruct unit ministry team members—particularly those chaplains participating on the CRC—on the issues of spouse and child abuse and the confidentiality of information obtained through privileged communications.

(3) Provide a representative to the HQDA FAC and the HQDA fatality review committee.

j. DA Inspector General. The DA Inspector General (DAIG) will conduct an investigative inquiry or an investigation in accordance with AR 20–1 upon receipt of an allegation of abuse involving general officers, promotable colonels, and senior executive service (SES) civilians. FAP is not relieved of its responsibilities to make an assessment and determination of each such allegation.

k. Other Headquarters, Department of the Army staff elements. Other involved HQDA staff elements (for example, CYS, USACSA, and Public Affairs) will review pertinent regulations and staff training efforts regarding information on spouse and child abuse and provide a representative upon request to the HQDA FAC. DODESS also will be asked to review their pertinent regulations and staff training efforts regarding information on spouse and child abuse and will be invited to provide a representative upon request to the HQDA FAC.

l. Commanders of specific major Army commands (TRADOC (Accessions Command)), INSCOM, SMDC, and USASOC. Specific ACOM, ASCC, and DRU commanders will—

(1) Implement FAP policies and ensure program compliance with this regular, AR 608–1, and DOD 6400.1–M.

(2) Submit installation resource requirements to include MTF an ACS FAP requirements through program and budget channels to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.

(3) Distribute OSD FAP funds to installations for ACS and MTF in accordance with CFSC Funding Guidance and monitor program execution rates.

(4) Disseminate semiannual ACR statistical data to subordinate commands.

m. Commander, U.S. Army Criminal Investigation Command. The Commander, USACIDC will—

(1) Train USACIDC agents to investigate cases of child sexual and physical abuse through attendance at the HQDA FAST course, advanced HQDA-sponsored training, and the Child Abuse Prevention and Investigation Techniques (CAPIT) course.

(2) Establish guidance and policy pertaining to the investigation of child sexual abuse.

(3) Ensure special agents specifically trained in interviewing victims of child sexual abuse are available and used by each installation.

(4) Investigate, through subordinate elements, cases of child physical and sexual abuse and spouse abuse, which fall within the investigative responsibility of USACIDC as established in AR 195–2.

(5) Provide a representative to the HQDA FAC and the HQDA fatality review committee.

(6) Provide nominees to USACFSC to represent Army on the DOD FACAT and to the HQDA Family Advocacy Regional Rapid Response Team. Ensure personnel are released from normal duty assignment while deployed.

(7) Provide a copy of the initial and follow-up reports on all child abuse cases occurring in DOD-operated or DOD-sanctioned activities (out-of-home care setting) within 24 hours of receipt to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.

1–8. Garrison staff responsibilities

a. Garrison commanders. Each Army garrison commander will—

(1) Establish a program for the prevention, reporting, investigation, and treatment of spouse and child abuse as outlined in this regulation.

(2) Appoint an installation FAPM on orders to coordinate and manage the FAP and to ensure compliance with this regulation.

(3) Review and approve appropriate FAP funding in accordance with published guidelines.

(a) Execute FAP funding within 1 percent of budget.

(b) Use the DOD FAP staffing formula as the basis for determining the allocation between treatment and prevention.

(c) Comply with DOD 6400.1–M, Army FAP standards (see app B), and the ACS accreditation program (see AR 608–1).

(4) Submit the consolidated MTF and ACS FAP budget requirements through the IMA for forwarding to CFSC.

(5) Designate a report point of contact (RPOC) and ensure a 24-hour emergency response system that is capable of providing immediate protection to victims of spouse and child abuse exists on the installation.

(6) Establish mandatory counseling and educational programs under the FAP for Soldiers involved in substantiated incidents of spouse or child abuse.

(7) Establish voluntary educational and counseling programs under the FAP and establish procedures to encourage participation in these programs by—

(a) Civilian Family members of Soldiers involved in spouse and child abuse.

(b) Other civilians in overseas commands involved in spouse or child abuse that are entitled to care in MTFs. Civilians in this category may but will not necessarily include: appropriated and nonappropriated fund DA employees, their Family members, and members of their households; retired Soldiers and their Family members; and employees of DA contractors and their Family members.

(8) Consider CRC recommendations when taking or recommending disciplinary and administrative actions with regard to Soldiers and civilians involved in spouse or child abuse. Many of the considerations listed in paragraph 4–4 apply when taking disciplinary and/or administrative actions with regard to civilians involved in spouse or child abuse.

(9) Direct the development of an MOA, whenever possible, with Child Protective Services (CPS) and other authorities in the civilian jurisdiction(s) adjoining the Army installation, to include the law enforcement agencies and courts involved in domestic violence. (See paras 2–12 through 2–15 and figs E–1 and E–2 for suggested contents and format of an MOA.) The MOA should delineate each required responsibility and which installation agency is responsible.

(10) Revise as follows: Appoint members of the CRC, FAC, and fatality review committee (FRC) by written order and by name to serve as members for a minimum period of 1 year, subject to reappointment. Appoint an FRC, if one does not exist in the local community. (See para 2-3*c*.) Installations which lack the required FRC composition and need to conduct a review should request guidance from their IMA regional FAPM.

(11) Review CRC, FAC minutes and FRC annual reports.

(12) Establish training to ensure that all subordinate commanders and senior enlisted advisers (E–7 through E–9) to commanding officers are briefed on the FAP within 45 days prior to or following assumption of command, as well as annually. This training will include a discussion of the material contained in the commander education program. (See para 3–2*b*.)

(13) Forward the FRC annual report through IMA channels to the Assistant Chief of Staff for Installation Management, CFSC-FP, ATTN: FAPM, 4700 King Street, Alexandria, VA 22302-4418, by 1 May of each fiscal year.)

(14) Establish training for the FRC to improve levels of expertise, maintain consistent application of review methods and activities through continuing education by professional organizations, conferences, and training events.

b. Unit/company commanders. Each unit/company commander will—

(1) Attend spouse and child abuse commander education programs designed for unit commanders within 45 days of assuming command.

(2) Schedule time for Soldiers to attend troop awareness briefings presented by FAP personnel.

(3) Be familiar with rehabilitative, administrative, and disciplinary procedures relating to spouse and child abuse.

(4) Report suspected spouse and child abuse to the designated RPOC on the installation and provide all relevant information to those investigating the report, including law enforcement agencies and CPS.

(5) Direct the Soldier to participate in assessment by FAP staff.

(6) Attend CRC case presentations pertaining to Soldiers in their command.

(7) Ensure that Soldiers involved in allegations of child and/or spouse abuse, after properly being advised of their Article 31(b), Uniform Code of Military Justice (UCMJ, Art. 31) rights with the use of DA Form 3881 (Rights Warning Procedure/Waiver Certificate) against self-incrimination, are encouraged to cooperate with FAP personnel to the maximum extent possible from initial report to case closure, to include participation in individual and Family interviews or examinations by appropriate social services, medical, and law enforcement personnel.

(8) Provide written military no-contact orders, as appropriate; counsel Soldiers; and take other actions, as appropriate, regarding compliance with civilian orders of protection for victims of spouse abuse. (See chap 3.)

(9) Support and comply with CRC treatment recommendations to the maximum extent possible. Provide nonconcurrence with CRC treatment recommendations in writing through the chain of command to the MTF commander.

(10) Consider CRC recommendations—

(a) Before requiring Soldiers to receive counseling and referral assistance in mandatory counseling programs established under the FAP. (See paras 3–24 and 4–4*b* on criteria for treatment.)

(b) When taking or recommending disciplinary and administrative actions in spouse and child abuse cases. However, such actions will not be delayed pending CRC recommendations.

(c) Before recommending deferment or deletion from reassignment of Soldiers who themselves or whose Family members are receiving professional counseling for spouse or child abuse. (See para 3–29.)

(d) Before recommending reassignment (or early termination of a duty assignment in a foreign country) when required treatment is unavailable and reassignment is the only available means of providing treatment to the abuser or protecting Family members from further abuse. A Soldier who is under investigation, is under restraint, has been charged with an offense, or is undergoing punishment (for example, resulting from a court-martial or nonjudicial punishment) must be flagged in accordance with AR 600–8–2 and therefore cannot normally be reassigned until the punishment is completed.

(e) Before initiating personnel actions to separate Soldiers for spouse or child abuse. Guidance for officer separations is found in AR 600–8–24, chapter 4; guidance for enlisted separations is in AR 635–200, chapter 14.

(11) Notify the CRC chairperson when reassigning Soldiers or moving Family members who are involved in treatment for spouse or child abuse; provide notification when reassignment notification is made to the command.

(12) Encourage the participation of civilian Family members in treatment programs.

(13) Provide a unit escort in accordance with the Joint Travel Regulations when a child is OCONUS, when the authorized transportation is to/from a medical facility for required medical attention that is not available locally, when the child cannot travel alone, and when a CRC representative is unavailable to perform this function.

(14) The Lautenberg Amendment addresses domestic violence and firearms. As such, this amendment may or may not apply to certain cases under this regulation. In appropriate cases, commanders and law enforcement authorities should consult AR 190–45, along with other DOD guidance and the servicing judge advocate or legal advisor.

c. Director, Community Activities. The Director, Community Activities (DCA) will—

(1) Ensure that programs have established SOPs for the identification, reporting, and evaluation of spouse and child abuse in accordance with this regulation and existing MOAs.

(2) Review and sign all SOPs for programs under his or her direct control.

(3) Support an effective, coordinated installation FAP.

(4) Ensure that the FAPM has access to the installation commander to conduct briefings in accordance with this regulation.

(5) Review and forward FAP consolidated budget (MTF and ACS) for approval by the installation commander.

d. Army Community Service director. The ACS director will—

(1) Ensure that a paid staff person who meets required professional standards is appointed on orders to serve as the FAPM. (See para 2–2.)

(2) Monitor and evaluate FAP services provided through ACS.

(3) Ensure management of OSD funding is handled in accordance with established guidelines.

(4) Ensure coordination with other ACS programs—to include the Exceptional Family Member Program (EFMP)—as appropriate.

(5) Ensure that ACS paid staff or volunteers do not provide FAP treatment services. Requests for exceptions must be forwarded through the IMA or specific ACOM, ASCC, and DRU to USAFWR (CFSC–FP–A). IMA or specific ACOM, ASCC, and DRU endorsements include coordination.

e. Installation Family advocacy program manager. As the overall program manager, the FAPM will—

(1) Coordinate the prevention, direct services, administration, evaluation and training efforts of the FAP on the installation to ensure compliance with this regulation.

(2) Ensure that any reports received by ACS are referred to the RPOC on the installation.

(3) Serve as the central POC for all FAP briefing or training requests related to the FAP or to Family violence.

(4) Supervise the ACS prevention staff. (See chap 3 for a discussion of prevention services.)

(5) Ensure compliance with DOD 6400.1–M and the ACS accreditation program. (See AR 608–1.)

(6) Provide liaison with civilian and military service providers and assume lead responsibility for developing and coordinating an installation MOA.

(7) Assess the special FAP needs of military Families residing on the installation and in the surrounding communities.

(8) In coordination with the Chief, Social Work Service (Chief, SWS), identify required prevention and treatment resources and submit the consolidated MTF and ACS budget requirements in accordance with published guidelines to the installation/garrison commander for review and approval.

(9) Coordinate the management of the installation FAP with other programs serving military Families to avoid duplication of effort.

(10) Provide quarterly verbal and/or written reports to the chain of command on the status of the FAP, emerging prevention and treatment issues, trends, and results of conducted prevention programs. The initial briefing to the installation commander should be conducted within 45 days of the commander's assignment.

(11) Consolidate and analyze statistical data on Family violence.

(12) Develop a post-wide community education program to—

(a) Inform all personnel about the seriousness of spouse and child abuse, including the causes, effects, and remedies.

(b) Publicize procedures for reporting incidents of spouse and child abuse and available services.

(c) Emphasize the importance of total community involvement in the installation FAP.

(d) Publicize information on the availability of specific installation and community resources (transitional compensation for abused dependents, National Domestic Violence Hotline (1–800–799–SAFE), and others) as appropriate.

(13) Implement ongoing training to ensure each unit commander and his or her senior enlisted adviser are briefed on the FAP within 45 days prior to or following assumption of command.

(14) Brief all staff members involved in FAP on the installation (in other words, DCA, SJA, provost marshal (PM), MTF commander, dental commander, alcohol and drug control officer (ADCO), CYS coordinator, chaplain, ACS director, and Chief, USACIDC) about the FAP when there is a change in staffing of any of these positions.

(15) Train CYS staff, volunteers, and other installation professionals with access to children on how to identify and report suspected child abuse. Training of DODDS or DODESS staff and volunteers will be conducted pursuant to local support agreements.

(16) Implement a child sexual abuse prevention program targeted at children, parents, teachers, and caretakers.

(17) Apply to attend the DA-sponsored FAST course within 6 months of appointment as FAPM.

(18) Complete 30 hours of continuing education annually regarding the prevention of spouse and child abuse.

(19) Set up a procedure for liaison with and referral to local military and civilian health and human service agencies that are capable of assisting victims and offenders of spouse or child abuse and maintain a list of existing services, key contact persons, emergency and regular referral procedures, and eligibility requirements.

(20) Serve as a member of the CRC, FAC, FRC, and the strategy team for out-of-home cases.

(21) Serve as a member of the installation suicide risk management team.

(22) Serve on the CYS evaluation team to participate in quality assurance programs, to include completing required checklist.

(23) Serve as a member of the victim/witness council, a forum to exchange information and consider victim and witness policies, where the installation has such a council.

f. The medical treatment facility commander. The MTF commander will—

(1) Supervise the multidisciplinary CRC.

(2) Ensure that the Chief, SWS or other medical professional with appropriate training and experience, as defined in DOD 6400.1–M, coordinates the MTF services to include spouse or child abuse assessment, intervention, and clinical treatment services. On small installations where there are limited resources and no MTF or SWS, the medical department activity (MEDDAC) commander or regional social work consultant will designate a senior social work officer with training and experience in accordance with DOD 6400.1–M to be responsible for direct services and clinical counseling.

(3) Implement CHAM and SPAM protocols to address child/spouse maltreatment.

(4) Ensure that all allegations of spouse and child abuse are reported to the military police or USACIDC as required.

(5) Establish an education program in coordination with the FAPM to train members of the CRC in the identification and management of spouse and child abuse.

(6) Ensure that needed medical care or assistance is both provided to the victims and offenders of spouse and child abuse and documented.

(7) Ensure that proper medical steps are taken in cases of sudden or unexplained deaths that may be related to abuse.

(8) Provide assistance as required when allegations of abuse involving Service members of the U.S. Air Force, U.S. Navy, U.S. Marine Corps, or U.S. Coast Guard occur on or near an Army installation.

(9) Provide advice and guidance on benefits of the Uniformed Services Health Benefits Program.

(10) Maintain confidentiality of information contained in medical records in accordance with law and regulation.

(11) Ensure that all direct services and supervisory staff in the MTF receive appropriate clinical training through in-service continuing education.

(12) Coordinate all phases of program development with the FAPM to assure that roles and responsibilities for training and counseling services are clearly defined.

(13) Provide oversight in the distribution of OSD FAP funding to ensure that OSD FAP-funded personnel are FAP dedicated. Ensure that the MTF provides DHP personnel, resources, space, equipment, and standard office supplies. DHP-funded personnel, space, equipment and standard office supplies will not be billed to the OSD FAP budget.

(14) Ensure adequate and appropriate medical staff and clinical and clerical support to provide crisis intervention, case management, medical or clinical evaluation, diagnostic assessment, counseling, treatment, follow-up, and reporting for all abuse cases. Manpower and funding requirements for this support will be identified and established through the MTF budget process. Ensure that personnel providing treatment/intervention services as defined by DOD 6400.1–M meet required educational and professional criteria.

(15) Ensure that the standardized intake and case-management procedures for spouse and child abuse are used.

(16) Provide local statistics and other pertinent information on the FAP to the FAPM for community and command information programs to identify trends and to prepare required reports (for example, the FAP annual report).

(17) Provide a quarterly report to the installation commander on CRC operations, issues, and other pertinent information. (See para 2–3.)

(18) Ensure that all FAP clients receive a copy of Family Advocacy Program (FAP), an information paper that includes the defined process for requesting a review of a CRC determination.

(19) Ensure that the standards of care outlined in appendix C are consistently applied and incorporated in existing quality improvement and medical protocols.

(20) Ensure the Chief, Department of Pediatrics designates a physician to serve as a member of the CRC and to be responsible for providing ongoing routine medical care to a child when child abuse is suspected or established. The Chief of Pediatrics will—

(a) Observe children to detect indicators of abuse.

(b) Support and encourage the Family caring for the child(ren).

(c) Conduct medical record evaluations for CRC and FRC upon request.

(d) Refer cases to the Chief, SWS when spouse abuse or child abuse and neglect are suspected.

(21) Ensure the Chief, Department of Psychiatry will—

(a) Provide diagnostic and treatment services on selected cases discussed and recommended at the CRC meeting.

(b) Serve as a consultant to the CRC upon request.

(c) Refer cases to the Chief, SWS when spouse abuse or child abuse and neglect are suspected.

(22) Ensure the community health nurse (CHN) will—

(a) Serve or provide a representative to serve as a member of the FAC and the FRC.

(b) Provide services directed toward the prevention of spouse and child abuse through health education to individuals, Families, and groups (for example, new-parent support, parenting, and child-development classes) and coordinate such efforts with the ACS FAP staff.

(c) Assist with identification of high-risk Families and provide direct services to selected Families.

(d) Serve as a nursing consultant to the MTF staff in the identification of suspected abuse cases.

(e) Refer cases to the installation RPOC when spouse abuse or child abuse and neglect are suspected.

(f) Serve as a consultant to the CRC upon request to provide nursing input into the assessment, intervention, and evaluation process of individual cases.

(g) Receive referrals from CRC for Family health counseling and provide this service in the clinic, CHN office, or Family home.

(23) Provide medical care, documentation of treatment needs, delivery of treatment services, CRC oversight and administration, reporting to the ACR, and credentialing and privileging of treatment providers.

g. Dental activity commander. The dental activity (DENTAC) commander will—

(1) Serve or provide a representative to serve on the CRC as a consultant upon request and as a regular member of the FAC and the FRC.

(2) Establish an education program in coordination with the FAPM to train dentists and supporting dental staff members in the identification and management of spouse and child abuse.

(3) Develop written protocols to address spouse and child abuse.

(4) Screen dental and medical records in order to identify and record all incidents of injury suggestive of spouse and child abuse.

(5) Refer cases to the Chief, SWS when spouse abuse or child abuse and neglect are suspected.

h. Chief of Dental Services. The Chief of Dental Services will—

(1) Identify and report child abuse as outlined in chapter 3 of this regulation.

(2) Participate in FAP prevention programs as required.

(3) Educate the members of the CRC on dental identification of abuse and neglect.

(4) Provide consultation to the CRC upon request.

(5) Refer cases to the Chief, SWS when spouse abuse or child abuse and neglect are suspected.

i. Officer-in-charge, personnel service battalion. The officer-in-charge, personnel service battalion (PSB) will—

(1) Give the CRC chairperson access to reassignment rosters to determine if active cases are being reassigned.

(2) Process application for deletion, deferment, or compassionate reassignment based on the Soldier's individual situation, the commander's request, and the CRC recommendation.

j. Provost marshal. The PM will—

(1) Serve or provide a senior representative to serve as a member of the CRC, FAC, and FRC.

(2) Conduct preliminary inquiries or investigation involving allegations of spouse or child abuse in accordance with AR 190–30.

(3) Coordinate the investigation of allegations of abuse that occur off the military installation, or when the assistance of civilian law enforcement is required to conclude an investigation with the host-nation law enforcement authorities and collaterally or jointly investigated by the appropriate Army or law enforcement authority.

(4) Notify the installation RPOC and SWS of all reports of spouse and child abuse.

(5) Provide a copy of the military police (MP) SIR (AR 190–40) filed in any spouse and child abuse case to the FAPM and, if appropriate, to the CYS coordinator. An SIR is always required for child abuse occurring in a DOD-operated or -sanctioned activity setting.

(6) Ensure crisis intervention training is provided for all MP personnel performing law enforcement duties within 90 days of being assigned duties that would typically require them to respond to domestic violence. Training will be conducted in coordination with the FAPM and will cover the physical and emotional trauma associated with spouse and child abuse and proper management procedures.

(7) Support the prevention and awareness efforts conducted by the FAPM.

(8) Conduct a local file check of law enforcement records upon request from the CRC to determine if alleged spouse and child abusers have had past incidents of behavior requiring MP intervention.

(9) Transport children suspected of having been abused to the MTF for medical assessments upon request by the CRC chairperson.

(10) Ensure that MP investigator personnel attend domestic violence intervention training, CAPIT courses, and other specialized training on child or spouse abuse.

k. The local U.S. Army Criminal Investigation Command. The local USACIDC investigative unit will—

(1) Notify the installation RPOC and SWS of all reports of child and spouse abuse in order to obtain support and services for the victims.

(2) Conduct investigations into allegations of assault, aggravated assault, and indecent acts or liberties with a child under the age of 16 years in accordance with AR 195–2 (see paras 3–15*a* and 3–15*b*).

(3) Provide a special agent to serve as a member of the CRC, FAC, and FRC.

(4) Ensure personnel attend the CAPIT course and other specialized training on child abuse and domestic violence.

l. Staff judge advocate. The SJA will—

(1) Serve or provide a representative to serve as a member of the CRC, FAC, and FRC.

(2) Advise commanders and the CRC on applicable laws and regulations affecting current spouse and child abuse cases and other FAP issues.

(3) Advise commanders on disciplinary and administrative actions against Soldiers in spouse and child abuse cases and on measures to protect victims from further abuse.

(4) Coordinate with Federal, State, local, or foreign authorities, as required, on the criminal prosecution of spouse and child abusers not subject to the UCMJ.

(5) Recommend alternative courses of action to the commander and the CRC when those actions under consideration are prohibited or otherwise limited by applicable law or regulation.

(6) Participate in the drafting of an installation MOA involving the handling of spouse and child abuse within the command.

(7) Participate in the negotiation and drafting of MOAs with CPS and other civil authorities in the jurisdiction(s) adjoining the Army installation.

(8) Advise the commander, CRC chairperson, FAPM, and MTF commander on all legal issues regarding the release

of information and records and the extent to which, if at all, the confidentiality of those making reports of spouse or child abuse is protected under applicable laws and regulations.

(9) Advise the commander, the CRC/FAC, and others as to the extent to which, if at all, State laws mandating the reporting of child abuse apply to those assigned to or residing on the installation.

(10) Advise the commander and CRC on the legal authority that may be exercised by State and foreign officials over Soldiers and Family members involved in spouse and child abuse cases residing on and off the installation.

(11) Make legal-assistance attorneys available to abused Family members and Soldiers to advise and counsel them on their legal rights regarding housing and financial support, divorce, legal separation and child custody, transitional compensation, civil actions, and remedies available to them to enforce their legal rights and to protect themselves from further abuse.

(12) Designate one or more persons to serve as a victim/witness liaison, through which abuse victims and witnesses may obtain information and assistance in securing available victim/witness services. (AR 27–10, chap 18, provides guidance.)

(13) When feasible and appropriate, appoint legal counsel to represent the abused child in sexual abuse and other cases in which civilian foster care or emergency placement care (EPC) is warranted. Such counsel should coordinate with the case manager to ensure that the interests of the child are fully protected. When local practice permits, this may include interface with local authorities, to include court appearances.

(14) Where appropriate, appoint a judge advocate to serve as a liaison with local civil authorities to ensure that courts conducting civil or criminal proceedings relating to child or spouse abuse involving Soldiers or their Family members are made aware of relevant information, to include the securing of witnesses, documents and other evidence. (See paras 3–30*h* and 7–9*a*(3)(d) for the required coordination on treatment referrals to civilian authorities.)

m. Installation chaplain. The installation chaplain will—

(1) Serve or provide a representative to serve as a member of the FAC, CRC, and the FRC.

(2) Be responsible for informing the CRC on Family compliance with treatment plans when the CRC refers a case to the chaplain program and the chaplain accepts the referral.

(3) Assure that pastoral care is available for Soldiers and Family members in abuse cases.

(4) Provide programs that promote Family wellness, effective parenting, Family enrichment, and Family spiritual life.

(5) Assure that chaplains providing treatment at Level Two as defined by DOD 6400.1–M meet the required education and experience.

(6) Ensure that chaplains, staff, and chapel program volunteers are trained in the identification and reporting of spouse and child abuse. This training should be coordinated with the FAPM.

n. Installation public affairs officer. The public affairs officer (PAO) will—

(1) Conduct media campaigns to increase community awareness of the problems of child or spouse abuse and the availability of resources (for example, medical, law enforcement, legal, and other assistance and counseling).

(2) Coordinate the release of all spouse and child abuse public-awareness materials with the FAPM.

(3) Release information to the media. Release of information regarding specific cases of spouse and child abuse that have aroused public concern are particularly sensitive and should be carefully coordinated with the SJA; FAPM; Chief, SWS; and appropriate law enforcement agencies.

(4) Advise the CRC on public affairs policies and procedures involving child and spouse abuse, including the provisions of AR 360–1, the Privacy Act, the Freedom of Information Act, and the public release of certain investigative reports.

(5) Obtain DA/IMA or specific ACOM, ASCC, and DRU public affairs guidance as required for specific situations with potential for adverse publicity for the DA.

Note. The DA/IMA or specific ACOM, ASCC, and DRU public affairs guidance is developed at HQDA on a case-by-case basis once the specific incident has been brought to the attention of higher headquarters. HQDA formulates the guidance and then distributes it through channels to the installation(s) for their use.

(6) Prepare public affairs assessments and annexes to planning documents.

(7) Serve or provide a representative to serve as a member of the FRC.

o. The clinical director, Army substance abuse program. The clinical director, Army substance abuse program (ASAP) will—

(1) Provide evaluation and counseling services to individuals whose alcohol or drug abuse may play a part in spouse or child abuse. (AR 600–85 contains ASAP policy.)

(2) At intake, inquire about the existence of spouse and child abuse.

(3) Coordinate with the FAPM to provide training to drug and alcohol counselors in the identification, reporting, Family dynamics, and treatment of spouse and child abuse.

(4) Serve as a member of the CRC, FAC, and the FRC.

p. Child and youth services coordinator. The CYS coordinator will—

(1) Ensure child abuse and neglect identification and reporting criteria training is provided to all caregivers, childcare providers, and volunteers. Training will be conducted in coordination with the FAPM.

(2) Establish internal procedures to ensure that all suspected cases of child abuse are immediately reported to the RPOC.

(3) Screen all childcare providers (including Family child care (FCC) provider applicants) for prior involvement in reported incidents of spouse or child abuse under provisions of AR 608–10 and AR 215–3.

(4) Serve as a member of the FAC and the FRC.

(5) Attend the CRC upon request and participate with the CRC in the treatment plan when an abused child is placed in CYS care after abuse has occurred or when the allegation involves a CYS activity.

(6) Implement a child safety education program in CYS in accordance with this regulation, AR 608–10, and AR 215–3.

q. The principals of Department of Defense dependent elementary and secondary schools and Department of Defense dependent school system. The principals of DODESS and DODDS will—

(1) Ensure child abuse identification and reporting criteria training is provided to school staff. Training should be conducted in coordination with the FAPM. Training will cover physical and behavioral indicators of abuse, the school's corporal-punishment policy, reporting procedures, and allowable services.

(2) Designate a faculty member to attend CRC meetings when a case to be discussed has been referred from a school or when the treatment plan involves school participation.

(3) Immediately report all suspected cases of child abuse to the installation RPOC in accordance with internal procedures established within each school.

(4) Implement a safety education program for children in coordination with the FAPM. (See para 8–4 for further information.)

Chapter 2
Organization of the Family Advocacy Program

2–1. Family advocacy program overview

The ACS is the agency responsible for the overall management of the FAP. The MTF, legal advisors, law enforcement personnel, chaplains, other installation staff, and civilian agencies such as the local CPS work together to ensure Families receive needed services. The FAPM administers and directs the installation FAP. The FAPM develops community, command, and troop education and prevention programs; coordinates civilian and military resources; assesses the special needs of the community; publicizes how to report child and spouse maltreatment and available services; and works with the installation commander to implement programs and services. The FAPM is the installation commander's primary representative and subject matter expert on child and spouse abuse. In this capacity, the FAPM will have direct access to all commanders on the installation. The CRC—a multidisciplinary team composed of military staff—assesses, evaluates, and manages allegations of child and spouse abuse. Figure 2–1 shows the installation FAP functional organization.

2–2. Family advocacy program manager

The FAPM will be appointed by written order by the installation commander. In accordance with DOD FAP Standards, the FAPM will hold a master's degree (see app B); will possess a range of administrative, management, prevention, and direct service experience; and will be capable of handling the complex issues associated with spouse and child abuse.

2–3. The Family advocacy committee, the case review committee, and the fatality review committee

a. FAC composition.

(1) The FAC will be a multidisciplinary team appointed and on orders by the installation commander; will advise on the installation FAPs and procedures, training, program evaluation efforts; and will address administrative details.

(2) The FAC chairperson will be the installation garrison commander or designee. The FAC may operate as a subcommittee of the installation human resources council. The FAPM provides logistical support for the FAC.

(3) The FAC members normally serve for a minimum of 1 year, subject to reappointment at the end of that period. They should have supervisory or functional responsibility for prevention, identification, reporting, investigation, diagnosis, and treatment of spouse and child abuse. In addition to the chairperson, the membership of the FAC will include the following:

(a) FAPM.

(b) Chief, SWS/CRC chairperson.

(c) A pediatrician or MTF representative (medical doctor).

(d) CHN or representative.

(e) DENTAC commander or representative.
(f) PM or senior representative.
(g) A representative designated by the local USACIDC investigative unit.
(h) SJA or representatives (CRC representative and victim/witness coordinator).
(i) ASAP clinical director or senior representative.
(j) CYS coordinator.
(k) Installation chaplain or representative.
(l) Installation command sergeant major.
(m) PAO.
(n) Consultants (for example, school liaison officer, CPS, and local court representative (domestic violence)). Local court representation should be a court administrator or the administrative assistant to the court judges.

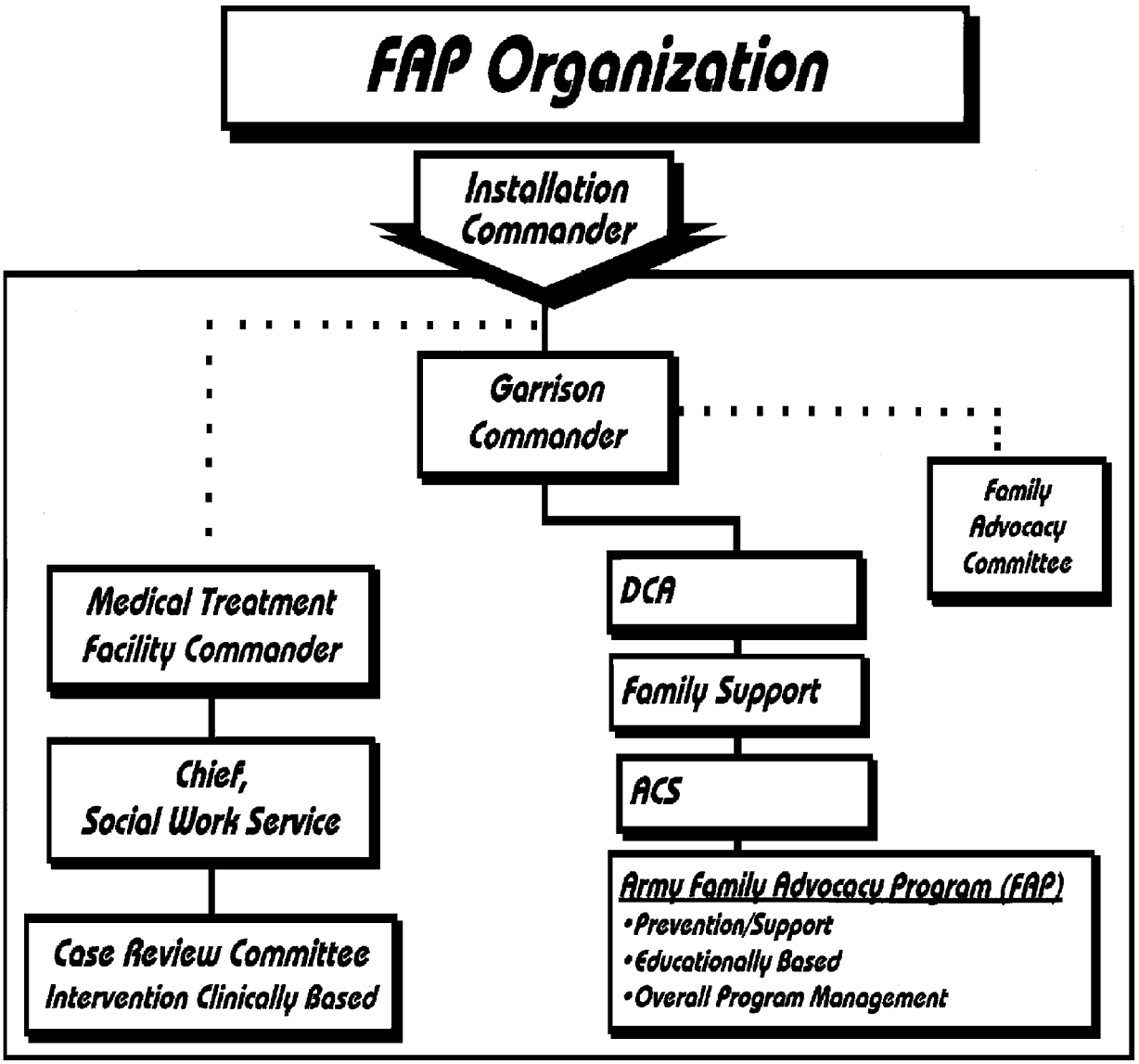

Figure 2–1. Family advocacy program organization

(4) The program aspects of FAP will be addressed through the FAC and meetings will be scheduled at least quarterly to—

(a) Provide recommendations for FAP programs and procedures.

(b) Facilitate an integrated community approach.

(c) Recommend new resources and programs needed.

(d) Identify long-range, intermediate, and immediate FAP needs and initiate action for their implementation to include addressing corrective action plans to comply with DOD 6400.1–M.

(5) The FAPM will report to the FAC on—

(a) Identified trends that may require a command or community response, the establishment of new programs, and plans for implementation.

(b) The results of the command training program, to include the number of new commanders assigned and the number trained.

(c) Special resource requirements.

(d) Results of quality assurance analyses, program evaluations, or special Inspector General (IG) reports.

(e) Results of primary and secondary prevention efforts, to include program schedules and number of attendees.

(f) Results of command attendance at CRC meetings by unit commanders.

(6) The CRC chairperson will report to the FAC on—

(a) Number and types of substantiated cases of spouse and child abuse, case transfers, closed cases, and any trends noted relative to command support of treatment recommendations and commanders' attendance at CRC meetings.

(b) Identified trends and special resource or program requirements for treatment.

(c) Identified quality improvement concerns that have community-wide impact.

(d) Results of medical quality improvement analyses or special IG reports pertaining to FAP.

(7) Each member will report on any identified trend related to the FAP that may require a command or community response as well as on the establishment of new programs, the status of existing programs, and the results of any needs assessments or surveys conducted.

b. Composition of the case review committee.

(1) The CRC is a multidisciplinary team appointed on orders by the installation commander and supervised by the MTF commander. The CRC's purpose is to coordinate medical, legal, law enforcement, and social work assessment, identification, command intervention, and investigation and treatment functions from the initial report of spouse or child abuse to case closure. A treatment team may handle both spouse and child abuse, or separate teams may be organized to handle each type of abuse.

(2) The CRC chairperson will ordinarily be the Chief, SWS. When this is not possible, the chairperson should be a paid professional credentialed by the MTF (a military officer or a GS–11 or above that meets requirements as defined by DOD 6400.1–M). Any exception to this policy must be submitted through the IMA or specific ACOM, ASCC, and DRU to the MEDCOM for consideration. When there is a separate team to address child abuse, this team may be chaired by the Chief of Pediatrics.

(3) Members and alternates normally serve for a minimum of 1 year, subject to reappointment at the end of that period. The installation commander will appoint by name and on written orders members and alternates. The CRC is not a public meeting, and membership is limited to those members identified in this regulation. Members must have supervisory or functional responsibility for prevention, identification, reporting, investigation, diagnosis, and treatment of spouse and child abuse. The membership of the CRC will include—

(a) The chairperson (see *b*(2), above).

(b) A physician. When the CRC is convened to review both child and spouse abuse, an additional medical doctor is not required; however, when the CRC is convened to review only child abuse, a pediatrician will be on the team.

(c) The installation chaplain.

(d) A representative designated by the local USACIDC investigative unit.

(e) The ASAP clinical director.

(f) The PM.

(g) The SJA.

(h) The FAPM.

(i) The case manager. (Case managers may vote only on their assigned cases.)

(4) The following persons and/or representatives from the following organizations may be requested to act as professional consultants to the CRC and may be invited to attend CRC meetings on an individual case basis. These persons/representatives will not vote on case determinations.

(a) DENTAC.

(b) Psychiatry/psychology or mental health activity.

(c) CHN.

(d) CYS coordinator.

(e) CYS program managers and school personnel may be invited to attend CRC meetings when the assessment and/or treatment plan warrants their participation.

(f) Victim advocate.

(g) School nurse.

(5) The unit commander exercising UCMJ authority over alleged abusers, or the civilian supervisory equivalent, will be invited to attend CRC meetings when cases involving his or her personnel are scheduled for presentation or review. In the absence of the commander or civilian supervisor, a senior enlisted adviser is authorized to attend.

(6) CPS or local court representatives may attend CRC meetings when their agency is involved in specific cases but may not vote on case determinations.

c. Composition of the fatality review committee.

(1) The chair will be the Garrison Commander or designee.

(2) Core members of the FRC represent the minimum number of members necessary to conduct a review and include:

(a) FAPM, serves as coordinator of the committee.

(b) Chief, Social Work Service (SWS)/Case Review Committee (CRC) Chairperson.

(c) Pediatrician or Family practitioner.

(d) Medical Examiner (ME)/pathologist from the medical treatment facility, if available.

(e) Provost Marshal (PM) or senior representative.

(f) A representative designated by the U.S. Army Criminal Investigations Command investigative unit.

(g) Staff Judge Advocate (SJA) or representative.

(h) Army Substance Abuse Program (ASAP) clinical director or senior representative.

(i) Installation Command Sergeant Major (CSM).

(3) Additional members that should attend the review include:

(a) Child and youth services (CYS) coordinator.

(b) Installation chaplain or representative.

(c) Public health nurse (PHN) or representative.

(d) Public affairs officer (PAO).

(e) Dental Activity commander (DENTAC) or representative.

(f) Consultants (for example, school counselor, Child Protective Services, and local court representative (domestic violence). Local court representation should be a court administrator or the administrative assistant to the court judges.

(4) The FRC will meet regularly to review all known or suspected domestic violence or child abuse related homicides and suicides to include all infant and child deaths in which the manner of death is undetermined at autopsy involving any of the following: a member of the Army on active duty; a current or former dependent of a member of the Army on active duty; a current or former intimate partner who has a child in common or has shared a common domicile with a member of the Army on active duty. The review should take place after related law enforcement investigations, autopsies, and court trials have ended. The review process is not a public meeting and the attendance is limited to the members of the FRC and consultants, as appropriate.

(5) Through multi lateral discussions, the FRC will provide a comprehensive assessment and review concluding with fairly developed and realistic resolutions. The review process incorporates the following tasks:

(a) Completing the domestic violence and child abuse fatality review data sheet(s) using the suggested format.

(b) Cases for review will come from multiple sources including: Family advocacy program records, Army Central Registry, reports from USACIDC, installation provost marshal, local law enforcement (if available), installation public affairs office, installation decedent affairs office, installation mortuary affairs/patient affairs office, local and state medical examiners/coroners office, and other community agencies.

(c) The FAPM, as the Garrison Commander's representative, will coordinate and conduct a review with all potential sources regarding death reports.

(d) Assure the data sheet(s) using the suggested format (Figure 1) are submitted in the annual report.

(e) Conduct reviews regarding the cause and circumstances surrounding deaths of spouse/intimate partners and children.

(f) Review and evaluate the involvement of each military, local/state agency that provided service to the Family (spouse/intimate partner and/or child) prior to his/her death.

(g) Document significant findings and make recommendations for systemic changes based on these identified deficiencies.

(h) Safeguard and maintain all records, data, training records and minutes in accordance with this regulation, AR 340-21, AR 25-55, AR 25-400-2, relevant state laws, and any other applicable regulations.

(6) The FRC will review death cases in closed session to formulate lessons learned, identify trends and patterns, contributing factors, results of prevention efforts, and recommendations for earlier and more effective intervention. A written annual report will be prepared for the Garrison Commander's review and approval. The annual report will be forwarded through IMA channels to reach CFSC by 1 May.

(7) The report will encompass domestic violence and child abuse fatalities that occurred 24 months following the end of the fiscal year in which fatalities have occurred, for example, fatalities occurring during fiscal year 2005 have a due date of 1 May 2007. This delay is intended to insure that installations have ample time to complete the reporting requirement.

(8) The report will, at a minimum, include:

(a) An executive summary on each fatality.

(b) Data setting forth victim demographics, injuries, autopsy findings, homicide or suicide methods, weapons, police information, offender demographics, household/Family information.

(c) Staff judge advocate verified military and/or civilian legal dispositions of cases involving homicides.

(d) System interventions and failures, if any, within the Army.

(e) A discussion of significant findings for each case.

(f) Recommendations for systemic changes, if any, at the installation and the Army level. For installation level, specify what actions are proposed to solve the problem/issue. For Army level, specify the rationale used to determine why this issue is an Army-wide issue.

(g) A signed annual report by the Garrison Commander or designee, to include negative reports.

(h) Failure to provide the minimum information listed above (a–g) needs to be fully explained in the report, that is, no autopsy report, police information, and so forth.

(i) See figure 2–2 for an sample of the Domestic Violence and Child Abuse Fatality Review Data Sheet.

DOMESTIC VIOLENCE AND CHILD ABUSE FATALITY REVIEW DATA SHEET

PART ONE: IDENTIFYING INFORMATION

A. Decedent's Demographics:

1. Age: _____
2. Sex: Male or Female (circle)
3. Military status: _____
4. Address: On post or Off post (circle):

_____

_____

_____

5. Date of injury: _____

6. Location of incident:
   Address: _____
   City: _____
   County: _____
   State: _____

7. Date of death: _____

8. Autopsy cause of death: _____

9. Autopsy manner of death (if stated): _____

10. Brief summary of final autopsy diagnosis: _____

_____

_____

_____

11. Brief summary of autopsy opinion, comment, or discussion paragraph (if stated):

_____

_____

_____

12. Toxicology result: _____

13. Office performing the autopsy: _____

14. Weapon use: yes or no (circle); if yes, type/description: _____

_____

Figure 2–2. Sample of Domestic Violence and Child Abuse Fatality Review Data Sheet

SAMPLE

15. Law Enforcement involvement: _____

_____

_____

B. Perpetrator's Demographics:

1. Age: _____
2. Sex: Male or Female (circle)
3. Military status: _____
4. Address: On post or Off post (circle): _____

_____

_____

5. Was the military member deployed, re-deployed (within the previous 6 months), or at home station, during the commission of the offense? _____

6. Family information: _____

_____

_____

7. Staff Judge Advocate verified legal disposition to include verdict and sentence, as applicable: _____

_____

_____

PART TWO: TODAY'S REVIEW

C. Agency or Position Represented	Check if member present	Indicate code*
1. Garrison Commander		
2. FAPM		
3. Chief, Social Work Service/ Case Review Committee Chairperson		
4. Pediatrician/ Family Practitioner		
5. Provost Marshal		
6. CID		
7. SJA		
8. ASAP Clinical Director		
9. CSM		
10. PHN		
11. Chaplain		
C. Agency or Position Represented	**Check if member present**	**Indicate code***

Figure 2–2. Sample of Domestic Violence and Child Abuse Fatality Review Data Sheet – continued

12. PAO		
13. Medical Examiner/ Pathologist		
14. CYS Coordinator		
15. DENTAC Commander		
16. Ad hoc consultant:_____		
17. Ad hoc consultant:_____		
18. Ad hoc consultant:_____		
19. Ad hoc consultant:_____		

- **Please ask each agency representative about their agency's records and use the following codes to record responses:**

0- Content of records shared at today's review
1- Not present at today's review
2- Not notified of review-did not check records
3- Notified of review-did not check records on decedent and/or family members
4- Cannot confirm or deny presence of records
5- Checked records-found none
6- Checked and found records but cannot share with team
7- Community representative (no agency records)
8- Agency records shared by another representative
9- Not indicated
10- Records not available (explain) _____
_____
_____

D. Fatality Sources:	**Please check all that apply**
1. Army Central Registry	
2. Family Advocacy Program records	
3. Installation Public Affairs Office	
4. Military Law Enforcement	
5. Civilian Law Enforcement	
6. Local or state Medical Examiners/Coroner's Office	
7. Installation Decedent Affairs	
8. Installation Mortuary Affairs/Patient Administration Office	
9. Other(s) (please list)	

PART THREE: OUTCOME

Figure 2–2. Sample of Domestic Violence and Child Abuse Fatality Review Data Sheet – continued

___System problem(s) identified ***(If checked, explain below)***

___No system problem identified

1 Identify **Systemic Issues.** Systemic issues include existing policies/ rules or gaps in services that contribute to domestic violence or child fatalities (like the death reviewed today). Please provide a detailed statement of each issue that your team identifies. **Be specific to help policy makers understand your team's significant findings and/or systemic issues.**

2 Provide a description of your team's **recommendations,** if implemented:

- Which agency(ies) would carry out this recommendation,
- Which population(s) will be targeted, and
- What resources will be required, if any

3 Record team members' **actions** (if any) resulting from the fatality review. Please be specific about which team member(s) took action; what they did, and if such action involved anyone outside your team membership.

4 Record issues (if any) resulting from the fatality review that needs to be addressed at the Department of the Army level and indicate the methodology used to arrive at that conclusion.

E. Significant Finding(s): (Indicate for each fatality)		
F. Installation Issue(s)	**Recommendation(s)**	**Action Taken**

Figure 2–2. Sample of Domestic Violence and Child Abuse Fatality Review Data Sheet – continued

G. Army Issue(s)*	Recommendation(s)

*** Indicate the methodology/rationale used to determine why this issue is an Army-wide problem/issue:** _____

Figure 2–2. Sample of Domestic Violence and Child Abuse Fatality Review Data Sheet – continued

2–4. Case management functions of the case review committee

The CRC, through SWS, will—

a. Ensure case management is assessment-based and management is in accordance with SPAM/CHAM guidance. Assess reports of spouse and child abuse to identify potential Family problems and intervene as necessary to prevent injury to the parties involved.

b. Obtain thorough medical and psychosocial evaluations of children, parents, spouses, or any other eligible beneficiaries involved in reported abuse incidents.

c. Complete and forward a DA Form 7517 to the ACR on all spouse and child abuse reports.

d. Complete and forward a DA Form 7517 to the ACR on child victims abused by youthful sex offenders who, at the time of the abuse, were over the age of 12 and in a caretaker role.

e. Open and close cases of reported abuse and determine, based on the preponderance of information presented, whether the case is substantiated or unsubstantiated.

f. Ensure the unit commander and MEDDAC commander (or CYS coordinator, if the report of abuse involves a CYS sponsored activity, employee, or provider) was notified in each case within 24 hours after the first report of spouse or child abuse was received.

g. Report all allegations of child abuse to the local CPS authorities pursuant to existing MOAs and State and Federal laws.

h. Determine initial disposition of each specific child abuse allegation discussed at CRC meetings and—

(1) Designate a case manager, if one has not already been designated.

(2) Request that the SJA designate legal counsel to represent an abused child in an appropriate case of sexual abuse or other case in which foster care is warranted.

(3) Conduct a thorough psychosocial assessment, develop a treatment plan, and identify and provide follow-up services in accordance with published guidance. (See app C.)

(4) Review cases at least quarterly to monitor progress in each case and to reassess the treatment plan.

(5) Maintain a case record.

(6) Initiate and maintain communication with CPS in accordance with local MOAs to ensure the case has been investigated and to ensure coordination of services.

(7) In accordance with local MOAs, make recommendations to the local CPS regarding civilian court and/or law enforcement intervention or removal of children from the home.

(8) Provide recommendations for further disposition of the case to the appropriate CPS or other civilian agency, including details of planned follow-up by the Army.

(9) Initiate and maintain communication with commanders, senior enlisted advisors, or equivalent civilian supervisors. (See para 4–4.)

(10) Initiate and maintain communication with local civilian prosecutors or court personnel to ensure coordination of services.

i. Coordinate service delivery in each case of spouse abuse and—

(1) Designate a case manager.

(2) Develop a treatment plan to identify necessary legal, medical, and social services.

(3) Review cases at least quarterly to monitor progress in each case and to reassess the treatment plan.

(4) Maintain case records of all case procedures.

(5) Initiate and maintain communication with commanders. (See para 4–4.)

(6) Initiate and maintain communication with local civilian prosecutors or court personnel to ensure coordination of services.

j. Refer a Family in treatment to the gaining installation or civilian community on reassignment, transfer, expiration of term of service (ETS), or retirement of the Soldier (see chap 7).

k. Recommend possible corrective measures to the unit commander of the Soldier involved when civilian Family members refuse to cooperate with CRC treatment plans or when further rehabilitation is not considered practical.

l. Ensure that the unit commander is advised of the continuing status of cases involving Soldiers and their Family members. Areas to be covered are expected length of time in treatment, attitude, cooperation, prognosis, and duty limitations. Ways in which the commander may cooperate to facilitate the treatment process also should be discussed.

m. Determine whether or not the medical record of Family members other than the victim/offender will be coded as a special category record. (See para 6–8 for a description of special category records.)

n. The substantiating CRC will submit a request to AHRC, with a copy forwarded to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418, for a Soldier to be deferred, deleted, and/or stabilized, or to change a programmed assignment to a location where adequate resources are available to continue the treatment process. (See para 3–29*c*.)

o. Recommend denial of reenlistment and processing of bar to reenlistment on Soldiers whose lack of progress in treatment does not warrant reenlistment.

p. Designate child abuse cases being transferred as *threat-to-life*, *protective placement* (other than threat-to-life), *stabilize treatment*, or *routine* cases in accordance with the criteria in paragraph 7–3*b*.

q. Identify those spouse abuse cases being transferred that require special precautions for the continued protection of the victim in accordance with paragraph 7–2.

r. Ensure that each case receives a case determination of substantiated, unsubstantiated–unresolved, or unsubstantiated–did not occur. Each case requires a vote by all voting members. The case determination will be recorded in the CRC minutes. A quorum (two-thirds) of the CRC members on orders must be present to vote on case determinations, and a majority of the members must vote to substantiate a case. The chairperson votes only to break a tie. The unit commander's absence will not prevent a case determination by the CRC members.

s. In instances of spouse abuse, ensure the primary aggressor has been identified in accordance with clinical practice protocols.

t. Initial presentation of a case to the CRC for determination must be within 30 working days of the receipt of the initial report to SWS. In the event the case is not ready for presentation, a brief summary will be presented, and the case record and CRC minutes will reflect the reason for the delay. The case will be updated at each CRC meeting until a determination is made.

2–5. Case review committee administration

a. The CRC should convene, at a minimum, monthly. Written notification of meeting dates will be provided to all members.

b. Minutes of the meetings must be written in the appropriate AMEDD format and kept on file. (AR 25–400–2 contains Army policy on maintenance of records.) Neither case names nor identification of referral sources will be included in the minutes. Cases will be identified in the minutes by CRC file numbers only.

c. The minutes will be presented to the MTF commander for approval and signature within 7 working days of the CRC meeting. The MTF commander will submit the signed copy of the CRC minutes to the installation commander within 14 working days. At a minimum, the minutes will include the following information:

(1) *Administrative.* Date of the meeting, members present, members absent, others present, and issues discussed (for example, quality improvement, local policy announcements, and so on).

(2) *Old cases.* Case number, brief summary of the initial presentation to CRC, determination, progress and status of treatment, scheduled review date or recommendation for transfer/closure, and CRC concurrence/nonconcurrence.

(3) *New cases.* Case number and type of abuse alleged, date commander notified, CPS notification/involvement, details of incident, determination (substantiated or unsubstantiated), identified problems, risk assessment, treatment plan, commander present, and scheduled review date.

d. The CRC will implement a quality improvement program and complete a quality improvement review once a year or as otherwise directed by the MTF commander. Though the CRC chairperson is primarily responsible for the quality assurance review, each member of the CRC and installation staff having responsibility for a particular function will monitor compliance of that function. The purpose is to review the installation program objectively, identify areas that need improvement and develop a plan to improve the program and request needed resources. The ACS accreditation program must be used as a supplement to any existing quality improvement measures. (See AR 608–1.)

2–6. Review of case review committee decisions

a. A Soldier, Family member, commander, or initiating CRC may request, in writing, CRC reconsideration based upon either of the following:

(1) The CRC did not have all relevant information when it made its finding. In such a case, the requestor will be afforded the opportunity to provide documentation that was not available at the time of the CRC determination or was not considered at such time. Information not available due to the requestor's failure to cooperate during intake and interviews is not a basis for a request for a reconsideration.

(2) A belief that the CRC did not follow published DA policy contained in this regulation.

b. During reconsideration, the CRC will follow the same published procedures for evaluation, presentation, and determination that are used during an initial CRC review. Accordingly, a case may be substantiated only if a preponderance of the available information indicates that the abuse occurred. The case reevaluation and determination will be documented in the record and in CRC minutes.

c. The request to the CRC must be made in writing through the MTF commander no more than 30 calendar days after the CRC decision. It must either state what relevant information was not available and why it was not available or state what published policy or procedure was not met. Only one reconsideration request will be considered for each incident. Treatment will not be suspended, interrupted, or postponed pending the outcome of the review.

(1) The MTF commander forwards the request to the Chief, SWS. The case is assigned to a new case manager, who reviews the case, interviews the individuals involved, and resubmits the case to the CRC with any new information obtained. The CRC reevaluates the case with the new information and reaches a case determination.

(2) A reconsideration will be conducted only by the CRC that made the initial determination on the case. If it is not possible for the initiating CRC to review the case (for example, if the installation has closed or downsized and there is no longer a CRC), the request will be submitted, with supporting information, directly to the Headquarters MEDCOM CRC.

d. In the event the requestor remains dissatisfied with the CRC process after reconsideration by the local CRC, the MTF commander may forward the case to The Commander, U.S. Army Medical Command, ATTN: MCHO–CL–H, 2050 Worth Road, Room 108, Ft. Sam Houston, TX 78234–6010, with a request for MEDCOM CRC reconsideration of both compliance with published policy and the appropriateness of case determination.

e. Initial determinations may be changed by the local CRC or by the MEDCOM CRC upon presentation of

additional information that does not support the initial determination or when the case, reworked and represented in accordance with published policies and procedures, does not support the original determination.

2–7. Chief, Social Work Service

The Chief, SWS (or the person appointed as the CRC chairperson when there is no such position at a particular installation) (para 2–3*b*(2)) will—

a. Serve as the CRC chairperson.

b. Coordinate the MTF treatment program to provide spouse and child abuse assessment, intervention and clinical treatment services, and logistical and administrative support.

c. Work with the FAPM and CRC members to develop an installation MOA that defines the responsibilities of the FAP and CRC.

d. Establish and implement a quality improvement program and CRC process to monitor and evaluate the MTF responsibilities of the FAP.

e. Ensure all of the individuals that are to be notified of a spouse or child abuse report are notified in a timely manner and are involved from initial investigation to case closure.

f. Ensure a case manager is assigned, an assessment is completed by a Level Two provider (to include a risk assessment), and a treatment plan is developed (to include a plan for protection) and reviewed quarterly.

g. Submit DA Form 7517 to the ACR within 10 working days following the CRC determination of case status and review by the CRC chairperson.

h. Ensure proper case-transfer procedures are followed and an up-to-date case record is maintained for each transferred case of abuse.

i. Serve as the primary POC to unit commanders on matters pertaining to treatment.

j. Ensure all FAP treatment services staff has access to a current list of existing services, key personnel, and emergency referral procedures.

k. Ensure all direct services and supervisory staff receives FAP annual training.

l. Apply to attend the HQDA-sponsored FAST and FAST–A training courses within 1 year of appointment as CRC chairperson.

m. Submit to the FAPM the names of all CRC team members and SWS staff for nomination to the HQDA FAST and FAST–A courses.

n. Communicate regularly with the FAPM to assure the roles and responsibilities for training and counseling are clearly defined.

o. In coordination with the FAPM, identify required resources and submit the MTF budget requirements to the MTF for approval prior to submission to the installation/garrison commander for final review and approval.

p. Ensure the availability of treatment services in accordance with this regulation and DOD 6400.1–M.

q. Serve as a member of the FRC.

r. Submit to ACR, through regional medical command and MEDCOM, a list of individuals to be authorized ACR access.

2–8. Funding and annual reports

a. FAP OSD funding for prevention and treatment are consolidated under the installation garrison commander. This gives the local commanders maximum flexibility in determining the right mix of prevention and treatment support to meet local demands.

b. All those responsible for the obligation of funds in the FAP will maintain strict accountability for any special congressional or DA appropriations for FAP to ensure appropriate use. FAPM completes the ACS portion and the Chief, SWS submits through channels the annual treatment report. Funding guidance for each fiscal year is issued during the fourth quarter of the preceding fiscal year.

c. The FAPM is responsible for completing and forwarding the automated FAP Annual Report and Budget Submit. Funding guidance for the next fiscal year is issued during the fourth quarter by CFSC.

2–9. Staffing

a. Commanders will provide professionally trained personnel of appropriate rank or grade based on the size and needs of the installation to ensure that quality FAP services are available. At a minimum, there will be an FAPM to operate and manage the program on each Army installation. (AR 570–4 and AR 570–5 provide guidance on general staffing procedures.)

b. DOD 6400.1–M sets minimum qualifications for FAP professional practitioners engaged in providing Level One and Level Two Interventions and Treatment Services. To ensure standard program quality and service delivery, installations and MTFs will comply with published DOD and Army staffing model concerning staffing of the FAP.

c. Case managers will be professionally trained individuals assigned to SWS. Any exception must be submitted to the MEDCOM for consideration.

2–10. Training

a. All FAP personnel and CRC members will receive training to enable them to execute their responsibilities.

b. IMA, specific ACOM, ASCC, and DRU and installation FAP staff will—

(1) Apply to attend the HQDA-sponsored FAST course within the first year of assignment.

(2) Apply to attend the HQDA-sponsored FAST–A courses.

(3) Attend FAP workshops sponsored by HQDA (CFSC–FP–A) and MEDCOM.

(4) Ensure a regular program of in-service technical training is provided for staff assigned to work with the FAP.

c. The FAPM and appropriate MTF staff will participate in continuing education regarding spouse and child abuse at least once every 12 months.

d. All installation staff officers and tenant organizations (for example, chaplains, SJA, PM, USACIDC, CRC members, MTF emergency room, nursing, SWS staff) involved in cases of spouse and child abuse will coordinate with the FAPM to obtain training at least annually for all of their personnel regarding proper procedures in identifying and responding to reports of spouse and child abuse and developing an understanding of the complexities and nuances of program definitions, participants, focus, available case-review procedures and timelines, and program impacts.

2–11. A cooperative approach

Regardless of the type of Federal legislative jurisdiction that exists on an Army installation, authorities on the installation should establish a cooperative relationship with local communities in identifying, reporting, and investigating child and spouse abuse cases; in protecting abused victims from further abuse in both emergency and nonemergency situations; and in providing services and treatment to Families in which child abuse has occurred.

2–12. Memorandum of Agreement

a. The use of an MOA in the United States between Army installations and adjoining local communities in addressing problems of spouse and child abuse within military Families is required. In cases where civilian State agencies refuse to enter such an agreement, the installation FAPM must notify the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418, through their IMA or specific ACOM, ASCC, and DRU. Information on the jurisdictional factors and Federal-State relationships that should be considered in drafting these MOAs is in appendix D. A suggested format for an MOA is in paragraph 2–14 and appendix E.

b. MOAs with local community agencies are necessary with regard to Army installations located outside the United States. In foreign countries, any agreement between commanders and host-nation authorities is regulated by Section 112b, Title 1, United States Code (1 USC 112b) (The Case-Zablocki Act). AR 550–51 addresses the authority and responsibility for negotiating, concluding, forwarding, and depositing international agreements.

c. The supporting SJA or equivalent legal advisor should review all MOAs and other agreements.

2–13. Key people and agencies

There are a number of key people and agencies on the installation and in the civilian community that should be involved in any cooperative approach to handling child and spouse abuse cases. All these need not sign an MOA between the Army installation and civilian community, but their roles should be addressed somewhere in the MOA when one is executed.

a. Military key people and agencies.

(1) Installation or Army community commander.

(2) DCA.

(3) ACS director.

(4) MTF commander.

(5) Chief, SWS.

(6) FAPM.

(7) CRC.

(8) RPOC.

(9) PM.

(10) USACIDC.

(11) SJA.

(12) Chaplain.

(13) FAC.

b. Civilian key people and agencies.

(1) Chief, CPS.

(2) County or district attorney.
(3) Presiding judge of Family or juvenile court.
(4) Other agencies as appropriate.

2–14. Contents of Memorandum of Agreement with local authorities

Where there is willingness between the installation and the local community to execute a formal MOA on the handling of child and spouse abuse cases, the MOA should address the following:

a. The legal authority of the installation commander over military discipline, law, and order on the installation.

b. The legal basis for the MOA and the exercise of jurisdiction by local authorities on the installation.

c. A description of the legal authority exercised by key people and agencies on and off the installation that are governed by the MOA.

d. The extent to which reports of child and spouse abuse and case information will be shared by the parties to the MOA with regard to both on- and off-post incidents of child and spouse abuse.

e. The agencies that have primary responsibility for assessing and investigating child and spouse abuse cases and the coordination required.

f. The agencies that are responsible for responding in emergency and nonemergency situations and the actions to be taken in such cases to protect children and spouses from further abuse, including the procedures to be followed in obtaining court authorization to remove abused children from their homes, place them in emergency placement, and take other actions necessary to protect them from further abuse (for example, military no-contact orders and child removal orders).

g. The agencies primarily responsible for providing services and treatment to Families in which child and spouse abuse has occurred.

h. MOAs may also be established with local shelters offering services to battered women and with other agencies to facilitate and define services to be offered.

2–15. Installation Memorandum of Agreement

The FAPM will coordinate MOAs between military and civilian agencies involved in the FAP to facilitate collaboration. Each MOA will delineate local policies, responsibilities, and functions according to this regulation. At a minimum, the following areas should be addressed in the MOA—

a. Prevention, education, and awareness.
b. Identification.
c. Reporting and notification procedures.
d. Crisis intervention.
e. Intake procedures.
f. Assessment/investigation.
g. Case management.
h. Treatment and support services.
i. Records management.
j. Out-of-home assessment/investigation procedures.
k. Quality assurance.
l. Program evaluation.
m. Notification and involvement of the commander.
n. Liaison with local courts and agencies.
o. Threat-to-life transfers.
p. Training.
q. Schematic flow chart for case handling.
r. Policy for responding to media inquiries.

2–16. Periodic review of a Memorandum of Agreement

a. The FAPM will identify installation procedures that do not comply with this regulation and bring them to the attention of the installation commander. Corrective actions with milestones will be written into the MOA.

b. The FAPM will conduct an annual review of all existing MOAs on the installation and with local authorities for compliance with this regulation, and will make recommendations to the installation commander to correct deficiencies.

c. The SJA will review new or modified MOAs for legal sufficiency and statutory compliance prior to implementation.

Chapter 3
Response to Spouse and Child Abuse

Section I
Prevention of Spouse and Child Abuse

3–1. Function of prevention programs

a. Army installations will provide services designed to prevent spouse and child abuse by improving Family functioning, easing the kinds of stress that can aggravate or trigger patterns of abusive behavior, and creating a community that is supportive of Families. The prevention program is designed to create community and command awareness of abuse, provide information of existing services, and provide specific educational programs. An important part of prevention is that it provides services to eligible Families on the installation and in the surrounding civilian communities who have special needs and stresses (for example, young and inexperienced Families, Families with closely spaced children, single parent Families, lower income Families, Families with parents who are soon to deploy, and Families with exceptional members). Child abuse prevention programs will address abuse in both Family and out-of-home settings (for example, quarters and facility-based CYS programs).

b. The FAP recognizes that—

(1) Prevention is a continuum that includes awareness, education, and intervention in high-risk situations.

(2) Prevention is a community responsibility; no single individual, agency, organization, or discipline can implement an effective and comprehensive program.

(3) A multidisciplinary team providing interdisciplinary support coordinated through Family advocacy is the best way to build strong and resourceful individuals, couples, and Families and to ensure safety for all members of the community.

c. A blend of prevention activities and programs (primary, secondary, and tertiary) offered in a variety of formats is the most effective way to address the prevention and reduction of Family violence.

(1) Primary prevention is community-based, promotes wellness for everyone, and commits resources to enhance healthy individual, couple, and Family functioning. Everyone can contribute to, and benefit from, primary prevention activities. Primary prevention creates a climate of awareness that encourages voluntary participation. Stress and anger management classes, new-parent support programs (NPSP), couples-communication groups, parent-child groups, marital enrichment programs, home visiting programs, childcare opportunities, parent education classes, and Family wellness programs are just a few of the delivery strategies for implementing effective primary prevention.

(2) Secondary prevention refers to those activities and services offered on a voluntary basis to individuals, couples, or Families considered to be "at risk" because of their current life situation. Secondary prevention programs and services address early symptoms of stress and crisis before they escalate into violent behavior, establish and reinforce safety limits, defuse crises and focus on changing precipitating behaviors and conditions before Family violence starts. Examples of secondary prevention strategies include support groups for teenage parents or single parents, programs for Families with exceptional Family members, outreach programs for isolated Families, intervention for Families experiencing marital and Family dysfunction, more-intensive home visitor or parent aide programs (depending on the needs of the Family), and anger control or alternative discipline classes or financial counseling.

(3) Tertiary prevention means assessment, intervention, and treatment services after an allegation has been made.

d. ACS FAP prevention staff offer primary and secondary prevention programs.

e. MTF staffs are responsible for tertiary prevention. MTF staff may also offer secondary prevention support services to at-risk Families. Services provided by SWS to at-risk Families must be properly documented according to published medical protocols.

f. A DA Form 7517 (DD-FM&P (W1738)) is required to be completed on all persons involved in incidents referred to the Family Advocacy Program.

3–2. Required prevention programs

All installation FAPMs are responsible for coordinating the required prevention programs discussed below; however, all FAP services do not need to be ACS/FAP-initiated programs. FAPMs should review available services to avoid duplication whenever possible. The services may be provided by installation staff, contracts, other military agencies, or a civilian agency when their services are available and accessible. An MOA or some other official written documentation describing responsibilities must be on file in ACS to ensure service is provided to Soldiers and their Families. Prevention programs (such as Family life education, parent education, new-parent support, and parent aide programs) should be conducted based on the results of community-wide needs assessments.

a. Community education program. This program informs the military community of the extent and nature of spouse and child abuse and focuses awareness of Family violence, including how to report it and what services are available. Community education involves making FAP services known, accessible, and attractive to those in the military community who can best use the services to improve their Family functioning. The purpose is to promote community support and encourage early referral. Minimum requirements for community education are monthly media contacts (for

example, installation home page, bulletins, newspapers, radio, and television); a monthly presentation to groups (for example, spouses' groups, parent–teacher associations, and church groups); participation in all appropriate special military community and unit events (for example, health fairs and organization days); and participation in special theme events (for example, Child Abuse Prevention Month, Month of the Military Child, and Domestic Violence Month).

b. Commander education program. This covers education regarding the FAP to ensure that commanders at all levels are aware of—

(1) The nature of spouse and child abuse and how to prevent it.

(2) FAP policies and procedures.

(3) Available FAP services and resources.

(4) Command responsibilities for identification, reporting, and coordination with the CRC.

(5) Information on FAP prevention services.

(6) Mandatory briefing requirements for unit commanders and senior enlisted advisers within 45 days after appointment to a command position.

c. Troop education program. This consists of annual troop education by FAP personnel for all Soldiers on the Family dynamics of spouse and child abuse, the availability of prevention and treatment services, and the Army's policies regarding Family violence.

d. Education for professionals program. This program provides semiannual education for personnel who work with children (for example, those working in CYS and schools) to ensure that they are aware of the seriousness of child abuse, the causes and effects of child abuse, the identification of child abuse, and the reporting responsibilities of child abuse.

e. Parent education and support. Parent education and support programs develop skills in physical care, protection, supervision and nurturing appropriate to a child's age and stage of development. The programs build or enhance strengths that the individual brings to the parenting role; enhance parent-child attachment; and provide role models and assistance in the form of home visitors and/or parent aides. They also foster skills development and information-sharing opportunities that enhance the parents' ability to interact more effectively with their children and to create and maintain a safe home environment in which self-esteem and learning are encouraged.

(1) *Parent education program.* This program involves education that is designed to enhance parenting and child management skills. Parent education and support groups may be combined to provide a forum for parents to exchange ideas, information, and resources and to practice new behaviors. The program also may reinforce or teach basic skills in physical care, protection, supervision, and psychological nurturing appropriate to a child's age and stage of development.

(2) *New-parent support program.* The DOD model for NPSPs is divided into two categories: primary prevention (NPSP–Standard) and secondary prevention (NPSP–Plus).

(a) Primary prevention (NPSP–Standard) targets all Families with children 3 years of age and younger. Priority will be given to first-time or single parents and dual military Families. Program entry may occur by self-referral or a referral by a health professional or the command. The program activities include screenings; information and referral; clinic and hospital visits; classes and childcare; support groups; respite support or other concrete services as needed; and play mornings. The duration of this phase of the program is 3 to 6 months.

(b) Secondary prevention (NPSP–Plus) targets parents at moderate to high risk. Program entry may occur by self-referral or a referral by FAP, a health professional, or the Command. Activities for this category includes: standardized risk assessment; periodic assessment during service delivery; intensive and comprehensive home visiting; provision of health and child development services; intensive role modeling and mentoring to change skills, respite support, and other concrete services as needed; and parent classes, play mornings, and groups. The duration of involvement in this phase of the program ranges from prenatal to three years of age.

(c) Specific guidance on NPSP is available in the Army's "Prevention Services for New Parents Implementation Guidelines." In accordance with Federal Acquisition Regulation guidance, personal services contracts for the NPSP–Plus must be approved by MEDCOM (MCHO–CL–H). (See app F for Army NPSP standards.)

(3) *Respite care.* Respite care may be used as a prevention/intervention measure for those Families at risk for abuse or neglect. Additionally, respite care may be used as part of an ongoing treatment program for child abuse/neglect, EFMP, or EPC. Respite care costs are normally the responsibility of the parent or guardian. Exceptions to policy can be made when the parent or guardian of the child(ren) is financially unable to pay. The local ACS financial readiness program staff will conduct a financial assessment to establish financial need. ACS has the flexibility to fund the cost of the respite care with operations and maintenance, Army, or OSD funding.

f. Safety education programs. There are two target groups for safety education. The first target group is composed of parents, teachers, caregivers, and all concerned adults in the community. This audience needs information about how to protect children and how to listen to and talk with children about child abuse prevention. Children need to have programs and activities geared to their ability to understand and act on safety and exploitation issues, including child abuse. Education programs should help children develop skills to protect themselves against abuse and may include

other community efforts such as fingerprinting and neighborhood safe-house programs. These programs will be made available to children enrolled in CYS activities (age 6 years and older), DODDS, and DODESS.

g. Spouse abuse prevention programs. Strengthening and stabilizing intimate relationships is one approach to preventing marital distress and spouse abuse. The goals of spouse abuse prevention programs are to enhance and sustain communication, decision-making, and conflict-resolution skills and to clarify perceptions within the relationship. Prevention strategies may include educational programs and interactive workshops on couples communication, conflict resolution, assertive training, stress management and marital enrichment classes, and programs for children who witness violence.

h. Victim advocacy services program. Provides comprehensive assistance and support to victims of spouse abuse, including crisis intervention, assistance in securing medical treatment for injuries, information on legal rights and proceedings, and referral to military and civilian shelters and other resources available to victims.

(1) Victim advocates, in coordination with installation SJA victim/witness liaisons, help victims of abuse prepare applications and obtain legal documentation necessary to receive monetary compensation and benefits available through such programs as transitional compensation and the State crime victim compensation funds.

(2) The victim advocate is a nonvoting member of the CRC representing the victim's interests during the committee's proceedings.

(3) The victim advocate provides support services to victims in accordance with the intervention plan developed by the case manager.

(4) Victims must be notified at the time of the first contact that the victim advocate can offer only limited confidentiality. If the victim requests full confidentiality and nondisclosure, the victim should be informed that confidential services are available through shelters and victim advocates in the civilian sector.

(5) In collaboration with the case manager, the victim advocate will review the victim safety plan and ensure that the plan is updated as necessary.

(6) Although victim advocate services include the provision of pretrial, trial, and post-trial information and support, the victim advocate does not have authority to represent or advocate for the victim in court.

i. Family life education. Family life education focuses on enrichment programs that provide knowledge, social relationship skills, and support throughout the Family life cycle. The goal is to improve life management and Family coping skills, enhance self-esteem, and improve communication skills and marital relationships.

Section II
Reporting of Spouse and Child Abuse Incidents

3–3. Report point of contact

a. Each installation will establish a telephone reporting system for handling all reports of spouse and child abuse to include abuse that occurs in a DOD-operated or -sanctioned activity for children (CYS, for example). Separate systems may be established for reporting spouse and child abuse. The system should be tailored to each installation's size, location, and other unique factors (for example, the presence of a military police station or "MP desk," the existence of an MOA with CPS, the presence of a spouse abuse shelter, the availability of an MTF emergency room). In most instances, the central location for receiving reports of abuse should be the MTF emergency room or MP desk, where available. Procedures for documentation of reports, initiation of prompt investigation, and notification of unit commander will be established by MOAs and medical protocols, as appropriate. As a matter of Army policy, the reporting procedures within these documents will comply with applicable State laws mandating the report of child abuse to the extent permitted by Federal laws; executive orders; regulations; and Military Rule of Evidence (M.R.E.) 502 and 503) on privileged communications.

b. At a minimum, the report system established will require a single RPOC for all reports of abuse. The installation commander will designate the RPOC. The RPOC will be accessible to the military community, both on and off the installation, on a 24-hour-a-day basis.

c. The local telephone number for reporting abuse will be given ongoing publicity.

d. Despite local efforts to publicize a central point of contact to receive reports of abuse, several activities on the installation can expect to receive initial reports. The person receiving the report should record the information with as much detail as the reporter is able or willing to provide. The person receiving the report should immediately inform the RPOC, who in turn will notify the CRC chairperson of every report received. (See para 3–12.) Any investigation that follows will be conducted according to applicable laws and regulations and existing MOAs.

3–4. Army reporting requirement in abuse cases

a. Every Soldier, employee, and member of the military community should be encouraged to report information about known or suspected cases of spouse and child abuse to the RPOC or the appropriate law enforcement agency as soon as the information is received. (See app G for information on privileged communications.)

b. All installation law enforcement personnel, physicians, nurses, social workers, school personnel, FAP and CYS

personnel, psychologists, and other medical personnel will report information about known or suspected cases of child and spouse abuse to the RPOC or appropriate military law enforcement agency as soon as the information is received.

c. Commanders will report allegations of abuse involving their Soldiers to the RPOC.

3–5. Promise of confidentiality

a. A confidential source is a person or organization that has furnished information to the Army under an express promise that his, her, or its identity would be withheld. A source that provides information to the Army without an express promise of confidentiality is not a confidential source. The content of a report made by a confidential source may be disclosed only in accordance with applicable laws and regulations. Not all criminal investigations or trials result in the identity of confidential sources being disclosed to alleged abusers. A promise of confidentiality does not necessarily confer any immunity from disciplinary action. Requests for immunity must be referred to the SJA for processing under the provisions of AR 27–10, paragraph 2–4. Only an appropriate General Court-Martial Convening Authority may grant immunity to a Soldier. The SJA must forward requests for immunity on behalf of a civilian to the Department of Justice (DOJ) for action.

b. In order to encourage Soldiers, Family members, and others living and working in the military community to report all incidents of spouse and child abuse, Army personnel, volunteers working in the FAP, and those performing law enforcement duties may accept and record anonymous reports. A promise of confidentiality ordinarily will not be given unless it is necessary to encourage the person to make a report of spouse or child abuse. All express promises of confidentiality must be reported to the CRC chairperson for documentation in the file. A promise of confidentiality may be appropriate in cases where the person making the report of abuse is a neighbor or relative of the abused spouse or child, or another interested party. A promise of confidentiality ordinarily is inappropriate when the person making the report has an independent duty, by virtue of his or her status, employment, or duty position, to discover, report, investigate, or treat abuse (for example, physicians, nurses, social workers, law enforcement personnel, school personnel, CYS personnel, and clinical psychologists). Any person making a promise of confidentiality must explain the limits of confidentiality as set out in *a*, above.

c. CRC records containing written statements or summarized written reports of oral statements taken from persons whose identity the Army has expressly promised to withhold will be marked "express promise of confidentiality given," together with the name of the person making the promise, the date upon which the promise was given, and the identity of the authorizing individual.

d. The identity of a confidential source, together with his or her statement, may be released to officers and employees of DOD, including those performing law enforcement duties, who have a need for this information in performing their duties or as otherwise authorized by law (for example, to the FBI, DOJ, or State and local authorities). The release of confidential information to third parties (for example, private citizens or DOD officials acting in an individual capacity) or those to whom the information pertains (for example, victims of abuse, abusers, or attorneys requesting such information on their behalf) will be in accordance with law and regulation. (See M.R.E. 507, AR 25–55, and AR 340–21 for restrictions and procedures regarding the disclosure of information pertaining to the identities of informants and confidential sources.)

e. The SJA will be consulted for legal advice on the extent to which the identity of those making reports of spouse or child abuse may be protected under applicable laws and regulations.

3–6. Reports to commanders

a. The CRC chairperson (or his or her SWS designee) will notify the unit commander within 24 hours after receiving any report of spouse or child abuse pertaining to the Family of one of his or her Soldiers. Date of notification will be recorded in the CRC file. The initial report will provide the commander with all available and relevant information, including, but not limited to, the type of abuse, the alleged abuser, the case manager, and the date and time of the next CRC meeting at which the case will be reviewed. The initial report to the commander should be regarded as a report of suspected abuse. The primary purpose of this initial report is to share information during the assessment. Subsequent updates are the responsibility of the designated case manager. These updates should include the expected length of time in treatment, attitude of the abuser, his or her degree of cooperation, programs of treatment, and duty limitations. Ways in which the commander may facilitate the treatment process or choose administrative actions also will be suggested. (See para 3–26 for command communication procedures.) Specifically, the *appropriate commander* is defined as the immediate commander of the alleged reported abuser and/or victim; reporting should be made to him or her in accordance with guidance in the installation MOA. The installation MOA will be established in accordance with the guidance in paragraphs 2–14 and 3–3 with the assistance of the installation SJA. All command contacts will be recorded in the case record.

b. In the event a Soldier, regardless of rank, is assigned to an organization not normally a command (in other words, an agency without UCMJ authority or assumption of command orders in accordance with AR 600–20) and is reported as a victim or offender in an FAP case, for the purposes of FAP, that Soldier will be attached to an organization that has UCMJ authority and can execute command responsibilities defined in paragraph 4–4.

3–7. Reports from States

a. The FAPM will request the appropriate officials of the State or States in which the military installation is located and in which Soldiers and their Families reside to provide full case information on all known and suspected instances of child abuse involving Soldiers and their Family members.

b. All instances in which any State refuses to provide such reports will be reported through IMA or specific ACOM, ASCC, and DRU to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418. HQDA will address these concerns with the Department of Health and Human Services and the DOJ.

Section III
Evaluating Allegations of Spouse and Child Abuse

3–8. Overview of the evaluation process

a. The process of evaluating allegations of child and spouse abuse is twofold: gathering investigative facts and conducting the psychosocial and Family assessments necessary to protect the victim of abuse and provide necessary support services. Information is gathered by interviewing available witnesses, discovering the identity of other witnesses and interviewing them, and collecting physical evidence. Physical evidence may include photographs of injuries inflicted in an assault, medical specimens taken from the victim of an alleged sexual assault, and weapons or other items used as weapons during the course of an alleged assault.

b. Social workers, medical personnel, and law enforcement personnel share a common interest in ensuring that all reports of spouse and child abuse are promptly and fully investigated and assessed. A prompt and full assessment and investigation is particularly important in a child abuse case because such cases often involve victims who are too young or too frightened to explain what happened to them or to report it. In child abuse cases, the prompt gathering of physical evidence before it disappears or is destroyed is essential.

c. Both social workers and law enforcement personnel have a responsibility to protect the victims of abuse from further physical and emotional harm. Emotional harm or trauma can be caused unintentionally by unnecessary and repeated questioning of victims by the various agencies involved in the assessment or investigation, as well as by the approach taken or attitude displayed by those doing the questioning. All personnel must be sensitive to the emotional needs of victims when conducting such questioning.

3–9. Objectives of assessment/investigation

The objectives of any assessment by SWS or investigation by CID/law enforcement and/or CPS of a reported spouse or child abuse case are as follows:

a. To gather all of the evidence by every lawful means available, including, when appropriate, the use of—

(1) Search authorizations (M.R.E. 315) or search warrants.

(2) Authorizations to apprehend (Rule for Courts-Martial (R.C.M.) 302) or warrants to arrest.

(3) Photographs.

(4) Scientific examinations and findings.

(5) Medical examinations and findings.

(6) Psychosocial and Family assessments by social workers.

b. To gather the evidence as quickly as possible to prevent its destruction.

c. To gather the evidence in a lawful manner by—

(1) Properly advising Soldiers suspected of criminal acts of abuse of their rights under UCMJ, Art. 31, before questioning them about suspected or known instances of abuse.

(2) Ensuring appropriate command and law enforcement involvement in any medical or social work inquiry of a child or spouse abuse case whenever there is probable cause to believe that a criminal act of abuse has occurred (for example, assault, battery, indecent assault, or indecent exposure).

d. To protect the victim of abuse from—

(1) Further physical harm by law enforcement making an immediate apprehension or by SWS or law enforcement requesting the appropriate commander take the necessary measures to restrain the suspected abuser or to isolate the victim from the abuser (for example, restriction, bar from the military installation, or medical protective custody).

(2) Emotional trauma by avoiding unnecessary and repeated questioning of the victim.

e. To make accurate and timely findings of fact that are supported by all the available evidence.

3–10. Cooperative effort

In order to accomplish the objectives set forth in paragraph 3–9, this regulation mandates a cooperative effort by law enforcement, medical, and social work personnel in responding to all spouse and child abuse reports, to include a sharing of information and records insofar as permitted by law and regulation. (See para 6–2 on the Army policy in sharing case-record information.)

3–11. Action on receiving initial reports

a. Assessment or investigation of a report of spouse or child abuse should never be undertaken as an individual effort by the source of the report. The RPOC or appropriate law enforcement agency should be notified immediately of any suspected or known abuse.

b. Military law enforcement personnel will immediately notify the RPOC when a report of spouse or child abuse is initially received. Although a law enforcement investigation will not be delayed to await participation by social workers, interviews of child victims ordinarily should be conducted with social workers present in order to avoid multiple interviews.

c. When doctors, nurses, social workers, or others involved with providing treatment in the FAP initially receive a report of spouse or child abuse, the person receiving the report will make an immediate report to the RPOC.

d. The RPOC will receive and manage referrals from community agencies and authorities in accordance with the local MOA.

e. In appropriate cases, the SJA may designate legal counsel to represent an abused child in order to fully protect the interests of the abused child in abuse cases and in cases in which civilian foster care or EPC is warranted. Legal counsel in these cases will be provided as soon as possible. Counsel will work closely with the case manager to ensure that the child is protected throughout the investigation and subsequent proceedings.

3–12. Mandatory notification of military police

a. If the RPOC is other than the MP, the RPOC will notify the MP of every report of child abuse as soon as the report is received. If the FAPM is the initial recipient of a child maltreatment report, it is imperative that he or she ensures that these reports are immediately referred to the designated RPOC on the installation.

(1) Child abuse in the form of an assault or an assault and battery is not a criminal offense under the UCMJ if it can be justified on the basis of administering reasonable parental discipline to a child. Any act of punishment exceeding reasonable parental discipline is unlawful and should be reported to the MP. Where applicable, State or foreign criminal law may provide a different standard on this issue.

(2) All child neglect involving violations of applicable child protection laws (for example, school attendance laws) or wanton disregard or malicious intent on the part of the parent will be reported to the MP.

(3) The MP will be immediately notified of any report of child abuse alleged to have occurred in a DOD-operated or -sanctioned activity or involving any childcare employee or volunteer, including babysitters, who are providing care on the installation.

b. All allegations of spouse abuse will be promptly reported to the MPs.

c. All agencies will immediately notify the MP whenever assistance is required to protect any victim from further abuse or harm.

3–13. Action by the report point of contact

When a report of abuse is received, the RPOC will immediately—

a. Notify the MP (if not previously notified).

b. Notify the Chief, SWS/CRC chairperson so a timely report can be made to the appropriate commander and a case manager assigned.

c. Notify the local IG's office in allegations involving general officers, promotable colonels, and SES civilians. The local IG's office will in turn make the report to the Investigations Division, DAIG in accordance with AR 20–1.

d. Notify the CYS coordinator when a report involves child abuse alleged to have occurred in a CYS quarters- or facility-based operation or involves a CYS employee or volunteer.

e. Notify the FAPM, who is responsible for notifying the chain of command, when a report involves an out-of-home incident. (See para 8–10.)

3–14. Interviewing the reporter of abuse

a. The person reporting the abuse should be fully questioned before others are questioned in the case.

(1) When the person making the report of abuse is a Soldier suspected of a criminal offense under the UCMJ, such questioning will be preceded by an advisement of rights under UCMJ, Art. 31 (para 3–18).

(2) When the person making the report of abuse is a child victim of abuse, such questioning should be conducted with the participation of law enforcement and social work personnel.

(3) When the person making the report is a civilian suspected of a criminal offense, such questioning should normally be preceded by an advisement of rights against self-incrimination when the questioning constitutes custodial police interrogation, although advisement may be given at any time in the discretion of the interrogator. (See para 3–18*e*.)

(4) The safety of the victim is the primary consideration.

b. Any person receiving an initial report of spouse or child abuse from an anonymous telephone caller should obtain as much information as possible about the abuse, including dates, times, places, and persons involved as well as the basis of knowledge that the caller has for concluding that abuse was actually inflicted (for example, personal

observation or personal conversation with the victim or a Family member). Anonymous callers should be encouraged to make their identity known. When authorized by competent authority to do so, Army personnel and volunteers working in the FAP and those performing law enforcement duties may promise to keep in confidence the identity of the person making the report. (See para 3–5 on promises of confidentiality.)

3–15. Interviewing the victim of abuse

a. Victim safety. The safety of the victim is the primary consideration.

b. Spouse abuse. Victims of spouse abuse should be protected from further trauma caused by unnecessary or repeated questioning by the various agencies involved. This regulation mandates coordinated joint interviews by law enforcement and medical and social work personnel whenever possible. Victims should be interviewed separately outside the presence of the offender. All initial allegations of spouse abuse will be reported to the RPOC regardless of who receives them. The various installation agencies should report pertinent information to the SWS case manager for purposes of completing the psychosocial/Family assessment and presentation of the case to the CRC.

c. Child abuse.

(1) This regulation mandates a coordinated effort by law enforcement, medical, and social work personnel in interviewing victims of child abuse. An MOA with the local jurisdictions should, whenever possible, describe the procedures that will be followed to prevent unnecessary and repeated questioning of child victims by the various agencies involved in the investigation.

(2) When victims of child abuse are able to provide information about the abuse incident, they should be interviewed before the alleged abuser is interviewed. Where one or both of the parents are suspected of inflicting the abuse or in concealing information about the abuse, the child victim should be interviewed outside the presence of the parent(s). Unless otherwise required by applicable law, parental consent is not required to interview children suspected of being abused by one or both of their parents. If parental consent is not obtained, the interview of a child victim will be conducted only with the participation or consent of the law enforcement or CPS agency having jurisdiction in the case.

(3) The place of the interview will depend on the circumstances of the case. Interviews will be conducted in a private setting with as little attention called to the event as possible. If a child's statement constitutes the initial report of abuse, any follow-up interview should involve all agencies that will be participating in the investigation of the case. Information should be obtained not only from interviewing the child victim but also, if appropriate, from a medical examination of the child as well. Alleged child abuse victims may be interviewed in a school setting without parental consent.

3–16. Medical examinations

a. The MTF commander will ensure that a physician or other health care professional (including, when appropriate, a dental officer) is made available to examine all victims of alleged spouse or child abuse as soon as possible after receiving the initial report of abuse. Depending on the circumstances of the particular case, the medical examination may occur before, during, or after the time the victim provides information about the abuse. With young child victims, the medical examination may constitute the only evidence of abuse. In child abuse cases, the medical examination may be required to corroborate information provided by the victim. In either instance, a prompt medical examination performed by a physician usually will be essential. When child sexual abuse cases are reported in a timely manner, the examination will include a colposcope examination by a qualified physician.

b. Unless otherwise required by applicable law, parental consent is not required for medical examination, treatment, or hospitalization of a victim of child abuse in the MTF when one or both of the parents are suspected of inflicting the abuse or in concealing information about the abuse. However, FAP personnel have no individual authority to remove a child from the home, school, or CYS facility for the purpose of hospitalization or medical examination or treatment unless a bona fide emergency exists. In the absence of these circumstances, obtain judicial authorization or the assistance of local civilian authorities in accordance with the MOA before attempting removal. When this is not possible or feasible, consult the supporting SJA. All legal efforts should be exhausted in order to avoid leaving a child alone with a parent suspected of having abused the child.

c. Photographs will be necessary in cases of child physical or sexual abuse and in some cases of child neglect to substantiate medical findings and to corroborate information, if any, provided by the victim. Law enforcement personnel have the primary responsibility for taking photographs in abuse cases. If photographs are not taken, MTF personnel will take such photographs during or following medical treatment.

d. The MTF will use the USACFSC protocols (CFSC–FP–A) that address the following:

(1) *Spouse abuse.*

(a) Initial treatment and follow-up. This includes inpatient and outpatient medical care for physical injuries sustained by victims of spouse abuse.

(b) Clinical evaluation. Clinical evaluation will be performed as soon as spouse abuse is suspected. A physician will screen medical records for indications of previous abuse, and the Chief, SWS will check ACR data to ascertain the existence of previous reports of abuse.

(c) Collection of forensic information and evidence. Evidence of spouse abuse will be documented. Photographs should be taken by medical or law enforcement personnel in order to document visible injuries.

(2) *Child abuse.*

(a) Initial treatment and follow-up. This includes inpatient and outpatient medical care for physical injuries sustained by victims of child abuse.

(b) Clinical evaluation. Clinical evaluation of children and their Families will be initiated as soon as child abuse is first suspected. A physician will screen medical records of all Family members for indications of previous abuse and request that the Chief, SWS contact the ACR to check for previous child abuse.

(c) Collection of forensic information and evidence. Evidence of child abuse will be collected through documentation. The attending physician will carefully record all observations, to include description of the child's general appearance and the location of bruises, contusions, fractures, or other injuries. The size, color, and location of injuries will be documented on a body chart or similar drawing. When appropriate, photographs will be taken as soon after the abuse as possible and again approximately 30 hours after the incident when full coloration appears. (See *c*, above, on the responsibility for photographs). Photographs will show the patient's name and the date taken. The signature of the physician and the photographer will be written on the back of the photograph. In cases of severe bruising, obtain coagulation studies. Obtain a detailed account of how injuries were reported to have occurred from the person who brought the child to the MTF. Record this information on appropriate medical forms and file in the CRC file. Other recorded information should include laboratory data, full radiographic survey, and consultation reports as indicated. At least one survey should be completed 2 weeks after the incident occurred. Coordinate evidence collection with law enforcement authorities. On occasion, it is necessary to examine the victim's home or the place where the alleged incident occurred to complete the forensic evidence and gain valuable information about the child's living environment. In most cases, law enforcement personnel conduct this visit to the crime scene. However, when it is necessary to visit the victim's home to obtain additional information about the child's living environment, the CRC chairperson may request a CHN to conduct the home visit.

(d) Child sexual abuse evaluation. Each MTF should have the capability to collect evidence in child sexual abuse cases. MTF staff and law enforcement agencies will determine the need for forensic examinations, cultures, or radiological surveys. Documentation of genital and anal injuries should be made on appropriate diagrams. All child sexual abuse evaluations must have the following types of assessment, if applicable, as part of the MTF clinical workup:

1. Psychological assessment of each parent to determine his or her mental status, personality, parenting capabilities, psychiatric problems, and potential for harming any child in the Family.

2. Psychological assessment of the suspected victim to determine the child's mental status, psychiatric problems, and potential to develop psychological problems.

3. Psychological assessment of siblings to prevent and identify any self-abuse, suicide or homicide potential.

e. Mental health personnel, social workers, CPS caseworkers, medical personnel, and law enforcement personnel should carefully coordinate the diagnostic interviews to avoid duplicating diagnostic efforts in identifying spouse or child abuse.

f. Clinical data on the psychological status of the parents and suspected victim will be integrated with medical data, legal data, and CPS agency data. In no case should a suspected child sexual abuser be cleared on the basis of polygraph data alone. Any discrepancies between what the parent says and what the victim says need to be carefully assessed and documented.

g. In all cases of suspected child sexual abuse where the child victims are 10 years of age or younger, the clinician doing the assessment will report both his or her tentative findings, if any, as to whether or not sexual abuse occurred and the clinical indicators for that conclusion. Such clinical reports should contain as many details, facts, and clinical observations as possible.

3–17. Search authorizations

a. Emergency searches to save life or for related purposes. In emergency circumstances to save life or for a related purpose, a search of persons and property may be conducted pursuant to M.R.E. 314(i) in a good faith effort to render immediate medical aid, to obtain information that will assist in the rendering of such aid, or to prevent immediate or ongoing personal injury.

b. Probable-cause searches. Under M.R.E. 315, some Army commanders, military judges, and part-time military magistrates have the authority to order the searches of Soldiers and their quarters on the military installation based on probable cause. In foreign countries such searches may be conducted off the installation when permissible under the governing Status of Forces Agreement (SOFA). The supporting SJA ordinarily should be consulted prior to requesting a commander, military judge, or part-time military magistrate to issue a search authorization.

3–18. Questioning Soldiers and civilians suspected of offenses involving spouse or child abuse

a. Under UCMJ, Art. 31, a person or civilian agent of a person subject to the UCMJ may not question a Soldier suspected of an offense without first informing the Soldier of the nature of the accusation and advising the Soldier that

he or she does not have to make any statement regarding the offense of which he or she is accused or suspected and that any statement made the Soldier may be used as evidence against him or her in a trial by court-martial. In addition, prior to questioning, a Soldier suspect must be advised of his or her right to counsel as set out in M.R.E. 305.

b. The requirement to advise Soldiers of their rights under UCMJ, Art. 31, prior to questioning does not apply to a situation in which the questioning is conducted by foreign authorities and is neither instigated by nor participated in by military personnel or their agents. However, other constitutional or statutory rights advisement requirements may apply. Consult the SJA for these and any applicable SOFA provisions.

c. The law enforcement agency with jurisdiction in the case has the primary responsibility for the formal or informal questioning of Soldiers and civilians suspected of spouse or child abuse. The USACIDC should perform the initial questioning if the suspected abuse occurred on an Army installation. In foreign countries, if the abuse occurred off the installation or involved civilians, existing agreements may require appropriate involvement of host-nation law enforcement agencies. In the United States, a CPS agency investigating child abuse on an Army installation pursuant to an MOA between the installation and a local jurisdiction may question Soldiers suspected of child abuse only with MP or USACIDC involvement.

d. Except when not required by law or when delay would likely result in an immediate threat to the life or safety of an abused child, Soldiers suspected of spouse or child abuse will be advised of their rights under UCMJ, Art. 31, using DA Form 3881, and of their right to counsel prior to being questioned about abuse offenses. Soldiers who are self-referrals also will be advised of their rights under UCMJ, Art. 31, and of their right to counsel prior to being questioned about abuse offenses. The Army policy on self-referrals should also be explained to them, but should not be used as an inducement to persuade Soldiers to waive their rights under UCMJ, Art. 31. (See para 3–25 for the Army policy regarding self-referrals.)

e. Military social workers and MTF personnel must immediately notify the MP or USACIDC when a child or witness discloses child abuse or when they suspect that a criminal offense may have occurred, whether or not it is substantiated. Social workers are not law enforcement officials gathering information for an investigation. Their primary concerns are protecting the victim from further harm, gathering information concerning the psychosocial and Family dynamics in order to develop effective treatment plans, and providing the necessary support services. Once a determination has been made that an active duty member is the alleged offender, the social worker or medical personnel should not attempt an interview without first contacting law enforcement personnel. When a Soldier walk-in or self-referral discloses to a social worker or medical personnel that he or she physically or sexually abused a Family member, the social worker should at this point stop the interview and contact the MP or USACIDC for advice pertaining to proper rights advisement. A civilian is not subject to UCMJ, Art. 31, and therefore does not have to be advised of his or her rights by a social worker or medical personnel (military or civilian). Generally, if the purpose of the interview is purely health care, there is no need for a health care professional to provide a civilian suspect a rights warning of any sort. However, this is not always the case. Health care professionals should coordinate with the SJA prior to interviewing civilian suspects to determine the current status of the law with regard to providing rights advisements. (See app H for further clarification.) In the case of joint interviews, the lead in the investigative process rests with the law enforcement agent. Law enforcement personnel should read any rights warnings because in joint interviews, the separation of function between the social worker or medical personnel activities and the criminal investigation is not always apparent.

3–19. Findings of fact

a. Every report of spouse or child abuse will be promptly and fully investigated. The CRC, after considering each report of abuse, will make and enter findings on DA Form 7517 that the abuse is either substantiated or unsubstantiated. If further information is required before such findings can be made, the CRC may reschedule the case to a later CRC meeting until sufficient information is available to make such a finding, but in no case should a determination be delayed more than 60 calendar days.

b. CRC findings are clinical decisions, not criminal determinations. The CRC is an advisory team that can make recommendations to commanders, supervisors, and courts regarding administrative and disciplinary actions for child/spouse abuse offenses. The purposes of the CRC are to identify whether someone has been the victim of abuse, determine if the victim is at immediate risk of further trauma, and coordinate the necessary support services to protect the victim and ameliorate the situation. A CRC finding identifying an alleged offender may cause a commander or supervisor to pursue administrative or disciplinary measures against that individual, who is then entitled to the full range of due process rights afforded in those proceedings. Because CRC findings are used within the FAP for the purpose of providing services and developing treatment plans for Families, there is no right for Soldiers or Family members to be present at CRC meetings while their cases are being discussed. CRC findings may not be used outside the FAP as the sole basis for denying a person an opportunity for employment or for taking adverse actions. However, the information upon which such findings are based, together with the information gathered from other sources (for example, MP reports or statements by the alleged abuser or witnesses), may provide the basis for taking such actions.

Section IV
Protection of Spouse and Child Abuse Victims

3–20. Medical protective custody of child victims

a. Circumstances requiring immediate measures to protect a child abuse victim may arise before the alleged abuser is apprehended or questioned. Unless otherwise prohibited by applicable law, a physician treating an abused child on a military installation may take the child into medical protective custody without parental consent if the circumstances or condition of the child are such that allowing the child to remain in the care or custody of the parent presents an imminent danger to the child's life or health. Although parental consent for medical protective custody should normally be obtained, *b* through *d*, below, establish the procedure to be followed when parental consent has not been obtained and the child has been properly delivered to the MTF for medical treatment (see para 3–16*b* for restrictions on moving a child to an MTF without parental consent). Law enforcement personnel should always be involved in any questioning of the parent or parents suspected of abuse or of concealing information about the abuse.

b. The treating physician will make the initial determination that medical protective custody is required. That determination is subject to approval by the MTF commander following consultation with the supporting SJA. The MTF commander will ensure that the CRC chairperson, the law enforcement or CPS agency having jurisdiction in the case, and the suspect's unit commander are notified immediately so that appropriate judicial or command action to protect the child following the period of medical protective custody can be implemented in a timely manner. (See fig 3–1 for a sample request for command action to ensure victim safety.)

(Office symbol) (ARIMS record number) (Date)

MEMORANDUM FOR Commander, (soldier's unit and unit address) (Personal and Confidential)

SUBJECT: Family Violence Case

1. (Alleged offender's grade/name and Social Security number).

2. As a result of an incident involving domestic violence, an assessment of the potential risk to the victim(s) indicates a need for command action.

a. *Facts of the case*. See attached reports/statements. (Summarize facts pertinent to the case—such as who, what, where, and why—that are not covered in attached documents, if any.)

b. *Assessment of risk*. Based on my personal knowledge of the facts, a review of available documents, and a review of the risk factors listed below, it is my professional assessment that the risk to the victim(s) from the alleged offender in this case is: critical/high/medium/low (circle one).

Risk factors:
Lethality of injury
History of injuries (progressive in severity and frequency)
Involvement of lethal weapons/objects
Occurrence during pregnancy
Significant substance abuse/binge drinking
Multiple involvements with law enforcement

3. Actions already taken to protect victim(s):

Family member(s) admitted to shelter (yes/no) (name of family member(s)).
Family member(s) admitted to hospital (yes/no) (name of family member(s)).
Child removal order signed by the installation commander (yes/no) (name of installation commander).
Family member(s) referred to victim advocate (yes/no) (name of family member(s)) (civilian/military).

4. Recommendation for command action (see AR 608–18):

Confinement of the suspect (yes/no).
Restriction of the suspect (yes/no).
Military no-contact order (see attached).
Child removal order (see attached).
Other (see attached).

FOR THE PROVOST MARSHAL:

Encls

(Signature block)
(Military police officer designated
to sign on behalf of the
provost marshal's office)

CF:
FAPM
MP/CID report

Figure 3–1. Sample request for command victim safety action

c. The standard to be applied in determining whether to take medical protective custody of a child is whether the child suffers from abuse or neglect by a parent to the extent that immediate removal from the home is necessary to avoid imminent danger to the child's life or health. If applicable law establishes a different standard, then the standard required by that law should be applied. The following are some examples of situations in which an MTF commander may approve medical protective custody for a child:

(1) The child's parent refuses to permit the child to receive immediate medical care for a condition that seriously endangers the child's life or health and there is a suspicion that the parent may flee with the child or refuse to comply with ongoing medical treatment.

(2) When, based on a mental health assessment, there is a finding that the child's parent is physically or psychologically impaired to the point that he or she is otherwise unable to care for the physical needs of the child or to adequately protect the child.

(3) The child would return to the care of a parent who absolutely refuses or is unwilling to supply the minimal necessities of food, clothing, or shelter.

(4) The child's parent plans to place the child in the company of a person or persons whom, in the CRC's judgment, are likely to physically injure or sexually abuse the child.

d. The Chief, SWS will inform the child's parents when the MTF commander retains a child in the hospital under medical protective custody.

e. Arrangements for admission to a civilian or other military hospital will be made if the MTF does not have inpatient capability to admit children requiring medical protective custody. Prior to transfer, the physician will notify the CRC chairperson unless urgency dictates otherwise.

f. The physician will consult the CRC chairperson before a child in medical protective custody is discharged from the MTF. If the parents want to remove the child from the MTF against medical advice, the attending physician will notify the MP, contact the CRC chairperson and obtain advice from the SJA. (See para 3–22*e* on EPC procedures.)

3–21. Protection of abused spouses and children

a. Responding law enforcement personnel will follow the provisions of applicable Army law enforcement regulations to include AR 190–30, AR 190–45, AR 195–1, and AR 195–2.

b. Regardless of whether or not an apprehension is made, the MP will interview the spouses separately so that each spouse can speak freely without being inhibited by the presence of the other. If either spouse chooses to leave the quarters, the MP should stand by to preserve the peace and remain in the home for a reasonable period of time to allow the departing spouse to remove personal and necessary belongings. In all cases, the victim will be informed about the FAP and about a shelter or other available victim assistance services. The MP also will arrange or provide transportation for the victim to a shelter, MTF, or other appropriate victim assistance agency.

c. The MP will notify the RPOC on a daily basis of all reports of spouse abuse received by the MP. The notification procedures, whenever possible, should be included in any MOAs with local jurisdictions regarding reports of spouse abuse occurring off the military installation.

d. The following policies and procedures apply to no-contact orders, including child removal orders (CROs) and military no-contact orders:

(1) The commander must be prepared to act decisively in cases involving alleged child and spouse abuse and has the inherent authority to take reasonable actions commensurate with that responsibility. This is especially true overseas and in other areas where civilian assistance for victims is not readily available, and the absence of recourse in the civilian community mitigates in favor of taking decisive affirmative action under this provision.

(2) Installation commanders are authorized to issue CROs. Commanders are referred to herein as issuing authorities. The format set forth herein (see fig 3–2) is suggested, not required, since similar actions could have taken place without specific authorization. CROs are only issued on installations where there is no existing MOA with a civilian CPS agency, usually installations located overseas. If a CRO is issued, the original is to be given to the individual who has been the custodian of the child(ren), with copies to others-such as the foster parents and SWS-who may have custodial interest in the child(ren). A copy of each CRO issued is to be forwarded immediately to the provost marshal's office (PMO), SWS, and FAPM.

(a) CROs may be *ex parte* (issued after hearing only one side of the story) if the issuing authority considers it an emergency situation where neither judicial authorization nor parental consent can be obtained, and removal from the home is necessary to avoid risk of imminent death, serious bodily harm, or serious mental or physical abuse. Ex parte CROs should have the shortest duration possible, normally not more than 10 days, because opponents have a right to be heard and respond to allegations. In cases not requiring ex parte determinations, opponents should be given the opportunity to respond and be heard before the CRO is issued. Formal hearings are not required; however, a legal review of all CROs is required.

(b) CROs are based upon a balancing of interests. The greater the crisis and the need to protect, the greater the need

to move quickly and to focus on the safety of the person(s) needing protection. As the crisis abates and long-term solutions are considered and put into effect, the need for a CRO diminishes.

(c) For the purpose of this regulation, CROs are written orders, but may be verbal, if necessary. Verbally issued orders should be put in writing as soon as possible. Issuing authorities may use the suggested format located in this chapter.

(Office symbol) (ARIMS record number) (Date)

MEMORANDUM FOR (Name of alleged offender's commanding officer, unit, unit address)

SUBJECT: Military Child Removal Order In The Case Of (Insert Name of Alleged Offender)

1. You are hereby directed to remove (name of child(ren)), son(s)/daughter(s) of (name of alleged offender and spouse), from the family home at (address). Unless otherwise directed by me or my designee, the above child(ren) will be returned to the home not later than (insert date).

2. I am directing this action because I have substantial reason to believe that an emergency situation exists and that the above child(ren) may be in imminent danger of serious mental, emotional, or physical harm.

3. You are directed to ensure that during the period of removal the above child(ren) (is/are) placed in the care of persons who are reliable and trustworthy and can provide a safe and secure environment throughout the removal period.

4. You are directed to: (Insert information about who will temporarily care for the child(ren).)

5. This order will remain in effect until (insert date) unless sooner canceled by me or by higher authority. **Violations of this order may result in administrative or disciplinary action, including trial by court-martial.**

AUTHORITY LINE:

(Signature block)
Garrison commander

CF:
PMO
FAPM
Chief, SWS
Custodial parent
Noncustodial parent

Figure 3–2. Sample child removal order

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(3) Commanders are specifically authorized to issue military no-contact orders to ensure the safety and security of persons within their commands or to protect other individuals from persons within the command. A copy of each military no-contact order issued is to be forwarded immediately to the PMO, SWS, and FAPM.

(a) Military no-contact orders may be directed to military members and may be broad in scope since Soldiers are subject to military orders. When a military no-contact order is issued to a military member, the commanding officer who issues the military no-contact order will provide a written copy within 24 hours of its issuance to the person with whom the member is ordered not to have contact. (See fig 3–3 for a sample military no-contact order.) For installation commanders, directives to civilians are limited to orders commensurate with the commander's authority to maintain security and control over the activities of employees, residents, and guests on the installation. These include barment orders, employer directives, and housing-areas directives. For a more detailed description, see paragraph 3–22.

(Office symbol) (ARIMS record number) (Date)

MEMORANDUM FOR (Name of alleged offender, unit, and unit address)

SUBJECT: Military No-Contact Order Concerning Allegations of Child/Spouse Abuse

1. You are directed to (circle all that apply):

Remain (200/500/1,000/(other) feet) from the person(s) listed in paragraph 3 at all times.

Remain (200/500/1,000/(other) feet) from your spouse's residence at (street address).

Remain 200 feet from the following vehicle(s): (year, make, and license plate number).

Remain (200/500/1,000/(other) feet) from your spouse's place of employment at:
(employer name and address).

Remain 200 feet from the school(s) of child(ren) listed in paragraph 3 (name(s) of the school(s)).

Make no contact through phone, mail, e-mail, or third party, other than through the command, with the person(s) listed in paragraph 3.

Report all contacts/attempts at contact initiated by the person(s) named in paragraph 3 unless sooner canceled by me or by higher authority.

Additional instructions: (List).

2. This order is an administrative action to ensure the safety and security of the person(s) listed below. It is also intended to protect you from further allegations concerning family abuse while the order is in effect.

3. This order is issued concerning your association and contact with the following person(s): (your spouse (insert name), your child(ren) (insert name(s)), other person(s) (insert name(s)).

4. This order remains in effect unless modified or rescinded by me. **Violations of this order may result in administrative or disciplinary action, including trial by court-martial.**

AUTHORITY LINE

(Signature block)
Unit commander

CF:
PMO
FAPM
Chief, SWS
Victim

Figure 3–3. Sample military no-contact order

(b) Military no-contact orders are similar to civilian temporary restraining orders. They may be ex parte if the issuing authority considers it necessary to ensure the safety and security of persons for whom the command is responsible. In cases not requiring ex parte determinations, opponents should be given the opportunity to respond and be heard before the military no-contact order is issued. (See fig 3–4 for a sample response to a military no-contact order.) Formal hearings are not required.

(Office symbol) (ARIMS record number) (Date)

MEMORANDUM FOR (Name of alleged offender's commanding officer, unit, and unit address)

SUBJECT: Military No-Contact Order

I have read the above military no-contact order and understand its content. I acknowledge that administrative or disciplinary action may be taken against me if I fail to follow this order.

I understand that failure to sign does not relieve me of the responsibility to comply with the terms of the military no-contact order, dated (insert date).

(Signature of alleged offender)
(Name of alleged offender)

(Signature of witness)
(Name of witness)

Figure 3–4. Sample response to military no-contact order

(c) Military no-contact orders are based upon a balancing of interests. The greater the crisis and the need to protect, the greater the need to move quickly and to focus on the safety of the person(s) needing protection. As the crisis abates and long-term solutions are considered and put into effect, the need for a military no-contact order diminishes.

(d) Military no-contact orders are administrative in nature, unlike most pretrial restraint and pretrial confinement, but they do constitute conditions on liberty and must be tailored appropriately after consulting with the servicing judge advocate or legal advisor.

(e) Military no-contact orders directed to military personnel may include, but are not limited to: direction to refrain from contacting, harassing, or touching certain named persons; direction to remain away from specific areas, such as the home, schools, and CYS facilities; or direction to do, or refrain from doing, certain acts or activities.

(f) The order will specify its duration, the factors permitting the lifting of the order, or the fact that it is in effect until further notice by the issuing authority or designee.

(g) Issuing authorities should seek the advice and assistance of SWS and the victim advocate program. Health care professionals, social workers, law enforcement personnel, and attorneys also will play a significant role. Early intervention and cooperation are essential to ensure maximum success.

(h) For the purpose of this regulation, military no-contact orders are written orders, but may be verbal if necessary. Verbally issued orders should be put in writing as soon as possible thereafter. Issuing authorities may use the suggested format located in this chapter. The actual military no-contact order should be given to the subject of the order with a copy provided to the Chief, SWS for the FAP case file.

3–22. Long-term protection of abuse victims

The installation commander is responsible for ensuring that procedures exist to protect victims of abuse following the report of abuse and for approving measures that will serve to protect abuse victims from further harm. Such actions should be taken only after consultation with the CRC and supporting SJA.

a. Pretrial restraint. Under R.C.M. 304, a Soldier suspected of spouse or child abuse may be ordered by his or her

commander to refrain from doing specified acts as a condition of remaining at liberty or to remain within specified limits. Such forms of pretrial restraint may be appropriate in both spouse and child abuse cases. For example, a commander may order a Soldier to stay away from his or her military or civilian Family quarters for a specified period of time, or the commander may order the Soldier to have no personal contact with an alleged abused victim for a specified period of time. If appropriate, the Soldier may be restricted to the specified limits as designated by his commander or may have pass privileges revoked. Pretrial restraint may be appropriate for a solider who has threatened further harm to abuse victims or when the commander has reasonable grounds to believe that the Soldier will intimidate the abuse victim or otherwise obstruct justice. Some form of pretrial restraint is usually appropriate in a child sexual abuse case where a Soldier parent has been removed from the home to protect the victim from further abuse or possible intimidation. Removing the suspected offender from the home, rather than the child victim, is the preferred means of protecting the child in such cases. It is important to note that the imposition of restraint may have significant legal consequences. The servicing judge advocate or legal advisor should always be consulted before taking any of these measures.

b. Pretrial confinement. Under R.C.M. 305, a commander may order a Soldier into pretrial confinement if the commander has reasonable grounds to believe that the Soldier committed an offense triable by a court-martial, that confinement is necessary to prevent the Soldier from committing further serious misconduct, and that less-severe forms of restraint are inadequate. The servicing judge advocate should always be consulted before ordering a Soldier to pretrial confinement.

c. Removal from government Family quarters. An installation commander has authority to remove entire Families, or members of Families, from government Family quarters on the installation (including government-leased quarters off the installation).

(1) Removing an entire Family from government quarters is not appropriate unless such a measure is the only means available to protect a child abuse victim from further abuse on an Army installation where a local jurisdiction refuses to exercise jurisdiction over the case. Otherwise, commanding officers should ensure that innocent civilian Family members are not removed from government Family quarters solely because they were victims of an abuse incident. Close supervision by the CRC of a Family on the installation is preferred in most instances.

(2) Removing individual civilian members of a Family from government quarters may be an appropriate means of protecting a military spouse or minor children from further abuse. In cases of spouse abuse where there are no minor children, removal of the civilian spouse abuser from government Family quarters will in effect terminate the assignment of the quarters to the abused Soldier.

d. Bar from installation. A commander of an installation in the United States has the inherent authority to permanently bar any civilian from entering the installation, regardless of whether or not the installation is generally open or closed to public access. A bar order can be imposed on a civilian spouse or parent whose continued presence on the installation represents a threat to the safety of any adult or child living on the installation. Violations of bar orders are crimes (18 USC 1382) which are separately punishable before a Federal magistrate or Federal district court judge.

e. Civilian foster care or emergency placement care. In order to place an abused child in civilian foster care or EPC, the consent of one of the parents is required, or, in the absence of consent, the appropriate State or foreign court having jurisdiction in the case must authorize EPC. In the United States, the local CPS or courts usually will assist in placing children in foster care when parental consent is not given. In foreign countries, access to courts may be more difficult. The installation MOA and the MOA (if any) with local authorities should describe the procedures to be followed to obtain court authorization to place children in EPC (see chap 9). In overseas locations without court authorization and/or CPS, the suggested CRO format can be used; however, when considering such actions, consult the local SJA.

(1) When the CRC determines that abuse is substantiated, a child is at risk of death or serious injury, and civilian foster care or EPC is required, placement will be accomplished whenever feasible through the judicial system of the State or host nation having jurisdiction over the child. In the United States, the CRC through the CPS will seek judicial authorization even in cases where the parents of the child have consented to foster care. In foreign countries, CRC will use the judicial system of the host-nation court having jurisdiction over the child in appropriate cases. (See chap 7 on the transfer of child abuse cases designated as threat-to-life and protective placement.)

(2) In situations where judicial authorization or parental consent for EPC cannot be obtained, or cannot be obtained in a timely manner, and medical protective custody is not appropriate, an installation commander may authorize EPC when abuse is substantiated and when neither judicial authorization nor parental consent can be obtained, and removal is necessary to avoid risk of imminent death, serious bodily harm, or serious mental or physical abuse. The suggested CRO format can be used in consultation with the local SJA. FAP personnel have no independent authority to remove a child from the home, school, or CYS facility (see para 3–16*b*). In foreign countries, FAPM will consult with the supporting SJA on the procedures to be followed in authorizing EPC, but such EPC should only be authorized on a temporary basis generally not to exceed 90 days pending judicial authorization from a court having jurisdiction over the case. EPC may be necessary not only in cases of physical abuse but also in cases where children have been abandoned or are at risk for sexual abuse. Cases requiring EPC not in excess of 90 days and not a part of a host-nation foster care order must be coordinated for return to an appropriate CONUS location.

f. Overseas command actions. In some cases, long-term protection of spouse and child abuse victims may not be

possible in overseas commands. In accordance with AR 608–75, paragraph 2–1*b*(1), Families will be screened for EFMP by contacting the nearest MTF EFMP case coordinator after the Soldier receives OCONUS assignment instructions. The following measures may be appropriate to protect child abuse victims when judicial authorization or parental consent cannot be obtained and in spouse abuse cases when necessary in the interests of the command or the parties concerned:

(1) The overseas commander or designee may issue a letter of warning to the abuser.

(2) When abuse is substantiated and the abuser is an employee of an appropriated fund instrumentality, nonappropriated fund instrumentality, private organization, or government contractor, the overseas commander may notify the abuser's supervisor, provided that the nature of the abuse reflects on employment qualifications.

(3) The overseas commander or designee may order the advanced return of civilian Family members of Soldiers and employees to the United States.

(a) If a Family member refuses to depart, his or her entitlement to logistical support (for example, post exchange and other privileges) may be terminated. Medical care at the MTF, access to the commissary, and entitlement to enrollment in DODDS may not be terminated. The sponsor's assignment to government Family quarters also may be terminated, and the Family member may be barred from entering specified Army installations.

(b) In appropriate cases, the appropriate commander or designee may request host-nation authorities to remove a civilian Family member (or employee or retiree) from their country if such person refuses to leave voluntarily and his or her continued presence will probably result in more criminal misconduct in the host country and lead to greater embarrassment to the United States.

(4) The overseas commander or designee may curtail the Soldier's military tour of duty in the foreign country and order his or her return to the United States. This will usually, but not necessarily, mean that the Family member involved in or victimized by the abuse will return with the Soldier to the United States, where courts that can address the abuse problem and protect the abuse victim are more readily available.

Section V
Treatment of Spouse and Child Abuse

3–23. Goals of treatment of spouse and child abuse

a. Treatment includes intervention and therapeutic services designed to prevent repetition of abuse and to restore the health of victims and innocent Family members who have suffered physical or psychological damage from abuse. Treatment also may include crisis intervention, educational programs, short-term counseling, marital and Family therapy, and support groups.

b. The primary goal of FAP treatment of spouse and child abuse cases is rehabilitation. However, certain cases of abuse, by nature of their repetitiveness and severity, are not amenable to treatment. Treatment does not preclude disciplinary and administrative actions against offenders in appropriate cases.

c. Army MTFs have the primary responsibility for treatment of victims and offenders. Other available and appropriate professional resources, both military and civilian, should be used to rehabilitate Families.

3–24. Rehabilitation of Soldiers

a. When an allegation of abuse against a Soldier is substantiated, the Chief, SWS or designated case manager will review the case material and make recommendations to the Soldier's command regarding the Soldier's participation in FAP treatment. In addition to the factors listed in R.C.M. 306(b), commanders will consider the following in disposing of offenses by abusers:

(1) The Soldier's service record and any demonstrated potential for further service.

(2) A treatment prognosis from the CRC.

(3) Recognition by the abuser that the behavior was wrongful, an acceptance of personal responsibility for that behavior, and the expression of a genuine desire for treatment.

b. Relocating Soldiers during treatment sometimes interferes with the successful completion of a treatment plan and may not in the best interest of the Soldier, the Family, or the Army. The move may exacerbate the Family's problems or place the victim at further risk without adequate support systems. This is particularly true when Soldiers are being assigned to overseas commands. CRCs must communicate with commanders on particularly sensitive cases, review personnel levy rosters, and follow the case transfer procedures outlined in chapter 7. The CRC and commanders must work cooperatively to stabilize open FAP cases. Multiproblem Families should not be sent overseas. (See paras 2–4*n* and 3–29*c*.)

c. Soldiers whose commanders do not recommend or concur with FAP treatment or Soldiers who fail to progress in treatment will be considered for separation under provisions of AR 635–200, chapter 14 (for enlisted Soldiers) or AR 600–8–24, chapter 4 (for officers) unless disposition of charges by court-martial is being considered or has been initiated.

3–25. Self-referrals

Abusers should be encouraged to seek assistance through self-referral. Soldiers who seek treatment or assistance for abuse problems may initiate the evaluation and intervention process by voluntarily disclosing the nature and extent of their problem to their unit commander or FAP counseling personnel.

a. Admission of abuse by the abuser is sufficient information for the notification of the Soldier's unit commander when disclosure is made to an individual other than the unit commander. (See para 3–6 on the requirement to notify unit commanders in all abuse cases.) Disciplinary or administrative action against a Soldier is not precluded by self-referral.

b. The fact that a Soldier not already under investigation/assessment for spouse or child abuse voluntarily disclosed such abuse may be considered when determining whether disciplinary or administrative action against the Soldier is appropriate. Voluntary disclosures of spouse or child abuse by a Soldier do not preclude the Army from taking adverse action or reporting the abuse to State authorities pursuant to an MOA, nor do they protect the Soldier against possible civilian judicial actions, criminal or civil. When a self-referral or self-disclosure is made to SWS, the Soldier must be advised of the limits of confidentiality and advised of UCMJ, Art. 31, rights, if appropriate.

c. Any information disclosed in response to official questioning or in connection with any military or civilian investigation will not be considered information disclosed for the purpose of self-referral for treatment or assistance.

d. A voluntary disclosure of a past incident of abuse during an unrelated clinical counseling session should be handled on a case-by-case basis.

3–26. Communication with commanders

a. When a Soldier is under investigation/assessment for spouse and/or child abuse, the case manager or responsible counselor will—

(1) Initiate and maintain communication with the unit commander. This requires the following:

(a) Written notification of the incident prior to the CRC. Figure 3–5 shows a suggested format for notifying the unit commander that a report has been made and is being assessed.

(Office symbol) (Date)

MEMORANDUM FOR Commander, (Personal and Confidential) (soldier's unit and unit address)

SUBJECT: (Name, SSN of soldier)

1. The (installation name) case review committee (CRC) has received a report of (child abuse/neglect or spouse abuse) involving (name of victim) and (name of alleged offender). The report alleges that (provide a brief description of the report and include any existing documentation of physical injury and date treated).

2. A multidisciplinary assessment and investigation will be conducted and findings will be presented to the CRC for a determination. If determined unsubstantiated, the case will be closed and you will be advised. If determined substantiated, a comprehensive treatment plan will be developed and recommendations will be forwarded to you.

3. Involvement in the resolution of family violence is a command responsibility that is outlined in AR 608–18, paragraph 1–7. Therefore, you are invited to participate in the CRC process and concur/nonconcur with the CRC's findings and recommended treatment concerning (name of alleged offender). You may contact (name of point of contact) for further coordination (phone number).

(Signature block)
CRC Chairperson

Figure 3–5. Sample memorandum notifying unit commander of alleged abuse

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(b) Notification of CRC meeting and review dates.

(c) After the CRC meeting, a written outline of the treatment plan and CRC recommendations in accordance with DOD 6400.1–M and SPAM/CHAM. (See para 4–4.) Figure 3–6 illustrates notification made to a commander regarding the case determination and recommended treatment services.

(Office symbol) (Date)

MEMORANDUM FOR Commander, (Personal and Confidential) (soldier's unit and unit address)

SUBJECT: (Name and SSN of soldier)

1. The (installation name) case review committee (CRC) has received a report of (child abuse/neglect or spouse abuse) involving (name of victim) and (name of alleged offender). (If appropriate, note documented physical injury and date treated.)

2. The CRC has assessed this report and determined it to be (substantiated or unsubstantiated). (Name of the case manager) has been assigned as the case manager and will schedule and monitor treatment and follow-up determined by the CRC.

3. In accordance with AR 608–18, a DA Form 7517 (DA Child/Spouse Abuse Incident Report) will be forwarded to The Commander, U.S. Army Medical Command, ATTN: MCHO–CL–H (ACR), 2050 Worth Road, Room 108, Ft. Sam Houston, TX 78234-6010, (and, if applicable, to the county Child Protective Service or other agency name).

4. The CRC recommends (name of soldier) be command-directed to report to (location) for treatment beginning (date, time), and subsequently as scheduled. (Name of case manager), the assigned case manager, may be contacted at (phone number) for further coordination (include specific information on type, duration, and purpose of treatment and strongly encourage the spouse to participate).

5. Recommended action for case stabilization (has or has not) been forwarded to Personnel Command.

6. The point of contact for this correspondence is (name, position, rank, and phone number of CRC Chairperson).

(Signature block)
CRC Chairperson

Figure 3–6. Sample memorandum providing commander with case review committee case determination and treatment plan

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(d) Reports on the Soldier's attendance and cooperation with the treatment plan.

(e) Evaluation of the Soldier's progress in treatment.

(f) If FAP cases have multiple problems, request commanders initiate deletion or deferment from OCONUS locations, (See paras 7–1 through 7–4 and 7–9).

(2) Notify the unit commander of any subsequent acts of abuse or any failure to participate in the prescribed treatment plan.

b. The unit commander will notify the case manager of—

(1) Pending disciplinary or administrative action.

(2) Subsequent acts of abuse.

(3) Unit activities that impact on treatment.

(4) Permanent change in station (PCS)/ETS of the Soldier.

(5) His or her concurrence/nonconcurrence with the CRC's treatment recommendations. (See fig 3–7 for suggested format.)

(Office symbol) (ARIMS record number) (Date)

MEMORANDUM THRU

First addressee (Chain of command)

Second addressee (Chain of command)

FOR Commander, medical treatment facility, ATTN: Case review committee chairperson, (insert address)

SUBJECT: (Name and SSN of alleged offender)

1. I have read the CRC's case determination and treatment plan for (name of alleged offender).

2. I agree/disagree with the CRC's case determination. (If disagree, indicate why.)

3. I support the treatment recommendations (in whole/partially). (If partially, indicate to what extent.)

4. I disagree with the recommendation(s). (If so, indicate why.)

AUTHORITY LINE

(Signature block)
Alleged offender's commander

Figure 3–7. Sample response to case review committee recommendations

3–27. Family advocacy program intervention and support services

Each installation is required to ensure the following services are available to Soldiers involved in cases of abuse and to their Families:

a. Services for children and Families. Services that foster changes in parental behavior, parent-child relationships, and home environment and those that offer the abused victim protection and treatment for physical and psychological damage will be provided by the MTF.

(1) Installations are required to provide case management, counseling, and civilian foster care or EPC services or have MOAs with civilian agencies for these services.

(2) Respite day care, support groups, and other relevant services are to be provided based on an installation needs assessment and available resources. Respite day care provides temporary childcare relief to Family members and other caretakers of children who may be at risk for abuse or neglect. Respite care such as Mother's Day Out or childcare services can be planned and can act as a preventive service. In an emergency situation, short-term crisis care for abused or neglected children can be provided in childcare settings. The FAPM will develop local procedures and accountability measures when OSD funds are used to support respite care. The FAPM will approve Families for respite care in conjunction with the CRC.

b. Services to address child sexual abuse. Each installation MTF must either have or have access to treatment staff trained to address child sexual abuse.

(1) All youth victims or offenders eligible for MTF treatment in child sexual abuse cases will receive appropriate treatment.

(2) Installation program services must include treatment for the offender and members of the Family separately and jointly as needed, individualized treatment plans, and monitored program participation. The CRC will report program progress, program completion, and program failure to the commander at least quarterly.

c. Programs to address spouse abuse.

(1) *Abused spouses.* A basic program for abused spouses will include—

(a) Crisis intervention.

(b) Counseling.

(c) Emergency housing accommodations and temporary shelter. The shelter arrangement or emergency accommodation used will depend on the situation and the installation resources. If the abuser is a Soldier, the commander can order him or her to move into unit-controlled barracks, place conditions on the Soldier's liberty, or direct the Soldier to remain within specified limits pending disposition of the offenses. Civilian shelters, transient billets, temporary quarters, or an installation shelter or safe house system also may be used.

(d) Support services, such as legal service, financial counseling, victim advocacy, and housing and employment referral assistance as part of the overall treatment plan.

(e) Support groups that reduce isolation and foster self-confidence by providing interaction, support, and special information.

(2) *Abusive spouses.* SWS will establish a program for abusers stressing the goals of stopping the abuse and accepting personal responsibility for behavior. The MTF SWS will implement treatment models that view abuse as a learned behavior and stress the abuser's ability to learn self-control and develop behavioral alternatives (for example, abusers or violence management groups).

d. Services to address out-of-home child abuse. The MTF will provide counseling and support services to victims of out-of-home child abuse and their Families and to abusers who are caregiving staff who are authorized treatment at the MTF.

e. Transitional compensation for abused dependents. See para 4–4*e* and AR 608–1.

3–28. Treatment for civilians

Civilian Family members of active duty Soldiers, retired Soldiers, and DOD civilian employees and Family members who are victims and are authorized treatment at an MTF should be offered counseling or other appropriate intervention by the MTF to the extent that resources are available. Their participation in FAP is voluntary. Commanders should encourage Family member involvement in the treatment process.

3–29. Reassignment, deletion, or deferment of moderate or severe cases

a. The CRC will make a timely recommendation to unit commanders on the prognosis of Soldiers and Family members in treatment as a result of spouse or child abuse.

b. Families with multiple moderate or severe problems generally cannot receive the level of intense services necessary to ameliorate their abuse. Consequently, these Families should not be reassigned/transferred to OCONUS locations or CONUS locations with limited resources. Every effort should be made not to disrupt the services in place and to facilitate the continuity of care. In less severe cases, a Soldier may request or a commander may recommend reassignment. An early termination of a duty assignment in a foreign country is appropriate when reassignment is the only means to provide treatment to a Soldier or Family member or to protect a victim from further abuse. The Soldier or unit commander also may request the Soldier's deletion or deferment from reassignment in appropriate cases when reassignment would prove detrimental to the progress of the Soldier or Family member receiving professional counseling or treatment for spouse or child abuse. (The appropriate procedures can be found in AR 614–200, AR 614–30, and paras 7–6 and 7–7*b* of this regulation.)

c. Requests for deletion, deferment, or reassignment of moderate and severe abuse cases will be submitted to AHRC by the substantiating CRC using DA Form 3739 (Application for Compassionate Actions) and Family Advocacy Case Treatment Plan. The Chief, SWS will forward the form letter to U.S. Total Army Personnel Command, ATTN: TAPC–EPC–S, 2461 Eisenhower Ave., Alexandria, VA 22301, with a copy furnished to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418. Appropriate documentation is—

(1) Statement from the commander identifying any personnel action taken against the Soldier and containing a recommendation as to the disposition of the request.

(2) Professional diagnosis/assessment of the case as a threat-to-life, EPC, moderate, or severe abuse case and prognosis of the Family problem from the CRC chairperson.

(3) Supporting letters or assessment summaries from specialists (for example, a pediatrician, psychologist, psychiatrist, certified Family therapist, social worker, or chaplain) or other professional persons working to assist the Family.

(4) Summary of data on the sponsor and spouse's extended Family (when assignment close to relatives is requested).

d. Routine cases will not ordinarily require reassignment, deletion, or deferment; however, each request submitted will be reviewed individually.

e. Upon AHRC approval of deletion, the Soldier will be stabilized in the current assignment for 1 year. However, the Soldier will be considered available for immediate assignment at the end of the stabilized period unless a request for extension of the stabilization is submitted by the Soldier and approved by AHRC. The request should include—

(1) Documentation from the CRC chairperson that the Soldier or Family is progressing in treatment and requires only limited additional treatment.

(2) A statement provided by the unit commander indicating that the Soldier has a good service record and demonstrated potential for further service.

f. Soldiers who do not meet either of the criteria in *e*, above, should be considered for elimination.

3–30. Treatment referrals to Child Protective Services

The CRC will not close a case that the local CPS agency or court has accepted unless the case is transferred to another jurisdiction. The CRC will follow the procedures prescribed in chapter 7 of this regulation when a case is transferred to another civilian jurisdiction. CPS acceptance of a case does not relieve the CRC of the responsibility to ensure that adequate protection and necessary services are provided. At a minimum, a CRC case manager will be assigned to serve as liaison to the CPS and courts. The case manager will—

a. Notify the unit commander of case progress.

b. Coordinate services to ensure maximum use of the military medical facilities.

c. Monitor progress toward treatment goals.

d. Staff the case with the CRC.

e. Provide all available records and information to the guardian ad litem when a court has appointed one.

f. Provide all additional records and information to the victim advocate when one has been appointed by the court or assigned by FAP.

g. Provide all additional records and information to CPS or courts as they become available, to ensure that the agency/court has up-to-date and complete information on the case.

h. Coordinate all requests from a civilian court for witnesses, affidavits, and physical, documentary, and medical evidence with the SJA. All communications on these matters should be attorney-to-attorney-that is, between the lawyer designated in the SJA office to serve as liaison with local civil authorities in accordance with para 1–8*l*(14) and the lawyer handling the court case from the State, county, or district attorney's office.

Chapter 4
Disciplinary and Administrative Actions

4–1. Application of guidance on disciplinary and administrative actions

The guidance in this chapter on disciplinary and administrative actions against Soldiers accused of spouse or child abuse applies to all forms of spouse and child abuse occurring within the Family. It does not apply to spouse or child abuse that results in the death of the victim or to any abuse that occurs outside the Family, such as in a CYS setting (either quarters- or facility-based). This chapter, like the other chapters, provides no procedural rights or privileges with regard to the processing and disposition of allegations of misconduct that are not otherwise provided by the UCMJ, the MCM, or other regulations governing administrative and disciplinary actions.

4–2. Policy

The FAP includes a program of rehabilitation and treatment that does not preclude disciplinary and administrative actions deemed appropriate by the Soldier's commander against Soldiers accused of spouse or child abuse.

4–3. Types of dispositions

a. Unit commanders must investigate allegations of spouse and/or child abuse according to provisions of AR 27–10, paragraph 3–14 and R.C.M. 303. (See also para 3–12 of this regulation on the requirement to notify MP when abuse is a criminal offense.)

b. Disposition of criminal offenses involving abuse can include the full range of administrative or UCMJ actions.

4–4. Considerations

a. Commanders should consider CRC recommendations, especially regarding rehabilitative potential, when taking or recommending disciplinary and administrative actions against Soldiers that may be detrimental to the Soldier's continued military career or future promotion opportunities or to the financial or social well-being of his or her Family members. Commanders are not required to delay the processing of such disciplinary and administrative actions to await the receipt of CRC recommendations. These actions include, but are not limited to, the following:

(1) Court-martial.

(2) Nonjudicial punishment (to include filing determinations).

(3) Letters of reprimand, including local or permanent filing determinations.

(4) Administrative discharge.

(5) Denial of reenlistment, including bars to reenlistment.

(6) Termination of government Family housing. (See para 3–22*c* on points to be considered in terminating housing.)

(7) Advance return of Family members to the United States from an overseas command. (See para 3–22*f*(3) on procedures to be followed.)

(8) Bars to entering the military installation in conjunction with discharge or PCS. (See para 3–22*d* on the use of bar orders.)

(9) Curtailment of the Soldier's military tour or duty in the overseas command. (See para 3–22*f*(4) on the procedures to be followed.)

b. Consistent with the interests of justice and the needs of the accused, in addition to the factors listed in R.C.M. 306(b), the commander should consider the following before taking or recommending disciplinary and administrative actions against Soldiers in spouse or child abuse cases:

(1) The seriousness of the alleged offense and the weight and availability of the evidence supporting it.

(2) Matters in aggravation or extenuation surrounding the commission of the alleged offense.

(3) Matters in mitigation including, but not limited to—

(a) The accused's military record and potential for further service.

(b) The manner in which the abuse was discovered (for example, whether the abuse was uncovered during a self-referral or as a result of a report to or investigation by the MP).

(c) The accused's potential for rehabilitation based on the recommendation of the CRC.

(4) The impact that disciplinary and administrative action against the Soldier will have on his or her treatment.

(5) When disciplinary or administrative action against a Soldier is determined to be appropriate, the commander should consider the recommendations of the CRC regarding retention of the Soldier in the Army, protection of the victim from further abuse, and maintenance of the Family.

c. When disciplinary or administrative action is contemplated against a Soldier determined to be treatable who has demonstrated rehabilitative potential into the society at large, a commander may choose to take appropriate action to allow successful completion of a treatment program and continued service.

d. In overseas locations where DA civilians are involved, consult the local SJA.

e. Commanders should consider the possible availability of transitional compensation for dependents when contemplating initiating disciplinary action, administrative separation, or preferring court-martial charges based upon a dependent-abuse offense. A Family member may become eligible for transitional compensation payments pursuant to 10 USC 1059 only if the conviction or administrative separation is based upon a dependent-abuse offense. (See AR 608–1.)

Chapter 5
Army Central Registry

5–1. Definition and function of the Army Central Registry

The U.S. Medical Command (MEDCOM), Fort Sam Houston, maintains an Army-wide, centralized data bank containing a confidential index of victim-based reported spouse and child abuse cases. The ACR is referred to as a registry of child and spouse abuse and is used to assist in the early identification, verification, and retrieval of reported cases of spouse and child abuse. The ACR consults with other Service abuse registries and furnishes on-demand responses to queries from Congress and the Executive branch. The ACR is responsible for all data functions—including its programming, processing, quality improvement, standardization—and provides user training, technical assistance, and guidance.

5–2. ACR incident reporting procedures

a. DA Form 7517 is used to determine the existence of previous abuse reports and to compile and analyze Army-wide statistics and management data. DA Form 7517 is also used to provide background checks on individuals involved in ACS Family advocacy programs; applicants, volunteers and employees in CYS programs; and AHRC for drill sergeants and recruiters.

b. The CRC chairperson will submit an automated DA Form 7517 for every report of child or spouse abuse. Multiple submissions of the substantiated report (for example, an initial report, subsequent report, reopen incident report, transfer, or case closure) are required. All incident reports will be forwarded to The Commander, U.S. Army Medical Command, ATTN: MCHO–CL–H, 2050 Worth Road, Room 108, Fort Sam Houston, TX 78234–6010, in accordance with the established protocol.

c. Abuse cases will be reported as follows:

(1) The CRC will prepare and submit an initial incident report form for every case, whether substantiated or unsubstantiated. Privacy Act information (for example, names and Social Security numbers (SSNs)) will be excluded from reports pertaining to unsubstantiated cases. Data on unsubstantiated cases are used to determine workload only and is not used for identification purposes.

(2) Cases involving more than one victim in the same Family will be reported separately.

(3) The following procedures will apply for deciding sponsorship:

(a) In those instances where the mother and the father are both active duty military, the children will be reported under the mother's sponsorship (in other words, her SSN) in accordance with AR 40–66, paragraph 4–1*b*.

(b) In instances of spouse abuse involving maltreatment of each spouse, every effort will be made by the clinician performing the assessment and by the CRC to identify the primary aggressor. A DA Form 7517 will be submitted only for the primary aggressor using his or her individual SSN.

(4) Only on rare occurrences will incidents be reported to the ACR where is the offender is unknown.

(5) A CRC case determination of substantiated or unsubstantiated is required prior to submitting the initial incident report. Only the CRC's finding that the abuse is unsubstantiated or substantiated will determine the case status of the victim. The initiation or completion of judicial or administrative proceedings against an alleged offender, if one has been identified, is not required in order to make a determination that a report is substantiated or unsubstantiated.

(6) Incident reports should be completed by the CRC case manager and sent to the ACR for submission to the database within 10 working days following the CRC determination of case status. However, in no case will the DA Form 7517 be delayed longer than 30 calendar days following determination of case status by the CRC. Subsequent transactions (for example, supplemental reports) will be submitted within the same time frames.

(7) Locally retained copies of all written reports generated by the automated system to the ACR will be signed and dated by the authenticating official (Chief, SWS or CRC chairperson) for the case files.

(8) If the CRC later determines that an incident initially reported substantiated is actually unsubstantiated–unresolved or unsubstantiated–did not occur, the CRC chairperson will send a case-correction memo with copies of DA Form 7517 indicating changed findings to the ACR.

(9) When the ACR receives the corrected report, the administrative information contained in section I of the DA Form 7517 will be changed to unsubstantiated–unresolved or unsubstantiated–did not occur; all identifying information remaining in sections II, III, and IV will be destroyed.

(10) For the purpose of submitting a closure on a substantiated initial or subsequent incident, a reopened case, or a transfer-in case, the following applies in designating the purpose for case closure:

(a) Intervention/treatment no longer needed—Soldier/Family has completed treatment recommendations/accomplished treatment goals.

(b) Maltreatment no longer present—no subsequent incident of abuse has occurred within 1 year of the previously reported incident of abuse, and treatment is deemed completed.

(c) Sponsor and/or Family members no longer eligible for care.

(d) Victim died.

(e) Victim refused treatment.

(f) Offender refused treatment.

(g) Case transferred to another MTF with ongoing treatment requirements.

(11) Incident reports will be submitted on all out-of-home child abuse cases when the CRC determines a case is substantiated or unsubstantiated.

(12) Incident reports will be submitted on all fatalities if the CRC determines that the death of the victim was the result of an incident of child or spouse abuse.

(13) Report transfer transactions to monitor and track continued services for victims of substantiated abuse who move from or to another location. Closure transactions are considered only after treatment is deemed complete by the gaining MTF.

5–3. Retention and retrieval of Army Central Registry information

The ACR is responsible for monitoring the access to and retrieval of case information. The local CRC chairperson is responsible at the local level for safeguarding case information according to law and regulation.

a. Army Central Registry statistical data. ACR statistical data will be maintained for both child and spouse abuse for a period of 25 years.

b. Processing individual requests.

(1) Process requests submitted by individuals seeking information pertaining to themselves from the ACR according to the provisions of AR 340–21. Process requests submitted by individuals seeking information from the ACR pertaining to third parties according to the provisions of AR 25–55.

(2) Written Freedom of Information Act or Privacy Act requests for ACR data will be forwarded to the ACR. The written request must conform with the requirements of AR 25–55 and/or AR 340–21 and contain any other information that may be required to identify the requested individual information. If an individual other than the subject of the case makes the request, the requester must provide, as part of the request, the subject's signed, written consent to release of the individual's information.

(3) Written responses from the ACR will comply with FOIA and/or Privacy Act requirements and include a copy of the computer printout if the background check is positive.

(4) Refer unauthorized telephonic requests, agents from other DOD organizations, subpoenas, or written queries for FAP CRC case-specific information to the appropriate MTF patient administration division (PAD) office.

c. Processing official requests.

(1) The CRC chairperson will provide the ACR and the servicing MTF Chief, PAD office with a list of CRC representatives authorized to access the ACR. These representatives will be limited to the CRC chairperson, the FAPM, and officially designated CRC case managers. The list will be updated as personnel changes occur, or minimally once a year, specifying the type(s) of information each individual is allowed to retrieve (for example, preemployment screenings, previous histories on specific individuals, or previous reported incidents of abuse and local statistics).

(2) Before information is released, the ACR and/or MTF PAD personnel will verify that the requester is an officially designated CRC representative authorized to receive the type of information requested.

(3) Authorized CRC representatives may make written, telephonic, or electronic requests to the ACR. CRC requesters will provide the ACR with the name, duty title, duty address and duty telephone number, the SSN of the subject of the record (victim, sponsor, and/or offender, as appropriate), and the basis for the request. Such requests will be made only in the performance of official duties and responsibilities and will not be made on behalf of individuals in their private capacity in lieu of a proper FOIA/Privacy Act request.

(4) The CRC chairperson, the FAPM, or officially designated CRC case managers will perform CRC queries to obtain historical abuse information that may be found within the ACR and that is included with other FAP assessment information when making CRC determinations in abuse allegations.

(5) The CRC chairperson, the FAPM, or officially designated CRC case managers will perform preemployment queries for the purposes under AR 608–10.

(6) The CRC chairperson, the FAPM, or officially designated CRC case managers will perform CRC queries for purposes of preemployment screening and prior CRC case histories and not for reasons of promotion boards, commanders review, and so on. Individuals with a CRC case history will not serve on the CRC regardless of position held.

(7) The ACR will conform to the following procedures when providing telephonic responses to CRC representatives. At the time of the call—

(a) If requested, the ACR will send a copy of all existing records of child/spouse abuse on file directly to the authorized CRC representative. The ACR will send a copy of the computer printout through the MTF PAD to the requesting CRC representative.

(b) If no existing record of child/spouse abuse is on file at the ACR, the ACR will provide a negative response to the authorized CRC representative electronically or by telephone.

d. Prior incident checks. Pursuant to routine background checks, the ACR will check the following individuals for prior incidents of substantiated child/spouse abuse:

(1) FAP applicants, volunteers, and employees.

(2) CYS program applicants, volunteers, and employees.

(3) FCC applicants and current members of the applicant's household above the age of 12.

(4) Actual and prospective drill sergeants and recruiters.

(5) Actual and prospective CRC members.

5–4. Requests for statistical information

All requests for statistical information will be made according to AR 40–66. Information for research purposes must be requested through the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418. The Chief, SWS, the CRC chairperson, or the FAPM may make requests for statistical information on their installation directly to the ACR.

Chapter 6
Records Management

6–1. Scope of policy on records management

This chapter (except for para 6–8) applies to all ACR records and CRC files (AR 25–400–2, file no. 608–18) that contain medical records of substantiated cases of spouse or child abuse, extracts from law enforcement investigative reports, correspondence, CRC reports, follow-up and evaluation reports, and other supporting data relevant to individual Family advocacy case management files. Access to such records is governed by the same criteria as records maintained at the installation and at the ACR (See para 5–3.)

6–2. Policy on sharing case-record information

To the extent permitted by applicable law and regulation, social workers, physicians, dentists, nurses, and law enforcement personnel, both civilian and military, may share investigative leads, information, and records to ensure that all facts are fully developed given the total resources and means available. However, because of the sensitive nature of such records, such individuals should exercise great care to ensure that only relevant information is disclosed to those employees (military or civilian) of DOD who have a need for the information in the performance of their official duties. (See AR 340–21, chap 3.)

6–3. Establishment of the case review committee file

a. A file will be prepared for each person treated or evaluated for suspected child or spouse abuse. The CRC file is under the administrative control of the MTF PAD. The file will be housed in and maintained by the MTF in a locked and secured file cabinet maintained in a secured office system. At no time will FAP files be maintained in individual desks or offices. A sign-out system will be in place for removal and return of FAP files from the secured system. All files will be secured at the close of the duty day. If geographic distances or other considerations preclude this, alternate arrangements for housing and maintaining CRC files must be coordinated through the chain of command of the activity that will be assuming that responsibility and must be approved by the MTF commander. Unique local arrangements will be described in the installation MOA.

b. The CRC file will contain the information and documents relating to the diagnosis, assessment, treatment, and disposition of abuse. (See DA Pam 608–17 for guidance.)

c. The CRC files will be maintained according to the following:

(1) *Substantiated.* Maintained onsite for 2 years. Transfer to National Personnel Records Center (NPRC) 2 years after the end of the calendar year in which the CRC determination was made or treatment ended. Records will be maintained for 25 years after the end of the calendar year in which the CRC determination was made or treatment ended.

(2) *Unsubstantiated–unresolved.* Transfer to SWS and maintained on site for 2 years. Transfer to NPRC 2 years after the end of the calendar year in which the CRC determination was made or treatment ended. Records will be maintained for 25 years after the end of the calendar year in which the CRC determination was made or treatment ended.

Note. Unsubstantiated–unresolved cases may be referred to SWS or other mental health services for treatment. Case files may be maintained as an at-risk case or a voluntary services case.

(3) *Unsubstantiated–did not occur.* Transfer to SWS and maintain on site for 2 years. Cut up and destroy 2 years after the end of the calendar year in which the CRC determination was made. During the period of retention, if there is a new report on the same Family, the record may be used within 12 weeks to provide demographic and assessment information about the Family so that a total reassessment may not be required.

6–4. Access to records by individuals

a. Access includes the review of a record or obtaining a copy of the record or parts thereof.

b. The individual about whom a FAP record pertains will be granted access to the record unless—

(1) The Surgeon General has invoked an applicable exemption from the disclosure provisions of the Privacy Act (AR 340–21, chap 5).

(2) The record is information compiled in reasonable anticipation of a civil action or proceeding. (Refer to 5 USC 552a(d)(5) for denying access on these grounds.)

c. When releasing copies of records to commanders and/or supervisors in the conduct of their official duties, all third party information will be redacted from the copy by SWS prior to release of the copy to PAD.

d. Individuals requesting access to their records maintained at the installation may make a written request to the MTF commander. Requesters should provide their full name, SSN, current duty address, date and location of treatment (or other details that will assist in locating the record), and signature. The PAD will forward the request and a copy of the record constructed in accordance with DA Pam 608–17 to the Access and Amendment Refusal Authority (OTSG) following coordination with the CRC chairperson for a determination on the release of the records. (See para 6–8 for access to medical records.)

e. Process third-party requests (for example, requesters seeking access to another person's records) under the provisions of AR 25–55, AR 340–21, and AR 40–66.

f. Drill sergeants or recruiters may request copies of their records through the PAD at the MTF where any alleged incident occurred.

6–5. Access to records outside Department of Defense

a. Records may be disclosed outside DOD without the consent of the subject individual for the routine uses included in the published system notice.

b. The following disclosures outside DOD are contained in the published system notice and are compatible with the purpose for which the information was collected and maintained by the Army. Information may be disclosed to—

(1) Officials and employees of the components of the DOD and other departments and agencies of the Executive Branch of government in performance of their official duties relating to coordination of Family advocacy programs, medical care, and research concerning child abuse and neglect and spouse abuse.

(2) The Attorney General of the United States or his or her authorized representatives in connection with litigation or other matters under the direct jurisdiction of the DOJ or carried out as the legal representative of the Executive Branch agencies.

(3) Federal, State, or local governmental agencies either when it is deemed appropriate to use civilian resources in counseling and treating individuals or Families involved in child abuse or neglect or spouse abuse, or when it is appropriate or necessary to refer a case to civilian authorities for civil or criminal law enforcement.

(4) The National Academy of Sciences, private organizations, and individuals for health research in the interest of the Federal government and the public and authorized surveying bodies for professional certification and accreditation, such as the Joint Commission for the Accreditation of Healthcare Organizations.

c. In addition to those disclosures indicated in the system notice (*b*, above), the following blanket routine uses, among others, apply with regard to the release of information outside DOD (AR 340–21, para 3–2):

(1) *Law enforcement.* Relevant records may be referred to an appropriate Federal, State, local, or foreign law enforcement agency if the record indicates a violation or potential violation of the law.

(2) *Congressional inquiries.* Records may be disclosed to a congressional office in response to a congressional inquiry made at the request of an individual who is the subject of the record. Records should not be disclosed to a congressional office in response to a congressional inquiry made by a third party on behalf of the subject of the record without the express written consent of the subject.

6–6. Disclosure within Department of Defense

The Army generally is prohibited from disclosing a Privacy Act record to a third party without obtaining the prior written consent of the individual who is the subject of the record. One exception to the general rule is a disclosure made to officers and employees of DOD who have a need for the record (or the information within the record) in the performance of their official duties. (See AR 340–21, para 3–1.) Such officers and employees may include commanders, trial counsel, and MP and USACIDC law enforcement personnel. The Army may disclose the applicable record, or the fact that no record exists on a particular individual, to the following persons for the stated purpose:

a. Authorized CYS personnel for background checks on—

(1) Applicants for positions as FCC providers.

(2) Applicants for employment with CYS facilities.

(3) Employees of CYS facilities.

b. Authorized FAP personnel for background checks on—

(1) Applicants and employees of Family advocacy paid and volunteer positions.

(2) EPC and respite care providers.

(3) CRC members.

c. Authorized AHRC personnel for the purpose of screening for special duty assignment as a drill instructor or recruiter.

6–7. Disclosure pursuant to court order

A record will be disclosed pursuant to the order signed by a judge of a court of competent jurisdiction; however, reasonable efforts must be made to notify the individual who is the subject of the report if the legal process is a matter of public record. (See AR 340–21, para 3–l*k*.) An order signed by a clerk of court on behalf of the judge or a subpoena signed by an attorney will not suffice. A court of competent jurisdiction may include any Federal, State, local, or foreign court with jurisdiction to issue the order for the record in question. Confidential sources will be revealed when the court order so directs. Individuals receiving such court orders should consult with the SJA prior to release of information.

6–8. Special category records

a. The official treatment record (OTR) or health record of individuals treated as a result of substantiated spouse or

child abuse will be coded as special category records as authorized in AR 40–66, paragraph 4–4*a*(10). A record so marked must contain a Standard Form (SF) 600, Chronological Record of Medical Care, identifying the diagnosis of spouse or child abuse and stating "an additional file exists in SWS." Records so designated must be hand-carried by health care personnel between clinics and the records room. When a child with a record marked in such a manner is seen in a treatment facility, medical health care professionals should evaluate the child for further symptoms of abuse. If present, such symptoms should be documented in writing. A colored strip of tape will be placed in the empty block on the lower right edge of the front cover for substantiated cases. The file folder also should be marked with a colored 3 by 5 inch card attached to the upper right hand corner of the front of the folder with the following statement printed on it: "This record is a special category record."

b. When the CRC classifies a case as substantiated, the case managers will notify the custodian of the OTRs, who will ensure that both the medical and, where appropriate, dental OTRs are properly coded. Also, when the CRC considers other Family members associated with the case to be at risk, the chairperson will notify the custodian of the OTRs, who will ensure that the OTRs are color-coded in the same manner.

c. The appropriate case manager will make a brief notation in all color-coded records stating the nature of the incident or injury.

d. When the CRC closes a case, the case manager will notify the custodian of the OTRs, who will ensure that a new DA Form 3444 (Terminal Digit File for Treatment Record (Orange)) is prepared for each individual in the Family who has a color-coded record. (Merely removing the colored tape is insufficient to ensure confidentiality because a mark will remain on the jacket due to the adhesive used.) In an open case where a sponsor's Family is being transferred to another duty station, the OTRs will be mailed to the gaining MTF, in accordance with AR 40–66, paragraph 5–24.

6–9. Advice of staff judge advocate

The SJA will be consulted for advice whenever necessary to resolve legal issues involving access to FAP records or the disclosure of the identity of a confidential source.

6–10. Establishment of Army Community Service Family advocacy program records

a. An ACS FAP record (nonmedical) will be established for each client who receives ACS FAP prevention/education services and/or EPC services. The record will be maintained and held in the current files area in a locked and secured file cabinet with access limited to ACS/FAP personnel. Retention schedules are published in AR 25–400–2.

b. The ACS FAP record contains information and documents from various programs and activities such as stress management classes, parenting education classes, couple communications groups, parent-child groups, marital enrichment programs, new-parent support programs, Family wellness programs, and military no-contact orders.

c. All information gathered will be safeguarded in accordance with AR 340–21.

6–11. Security of information

a. Electronic and paper CRC case file information, ACR records, and data reports from DA Form 7517 are considered sensitive and must be guarded against disclosure to anyone who does not have an official interest in the case.

(1) Reports or file cabinets/drawers will be left secured when not in use.

(2) Data listings, computer generated reports, computer equipment, and accessories will be guarded or logged in/out and secured when not in use to prohibit or guard against intentional or unintentional display or disclosure to anyone who does not have an official interest in the case.

b. Computer identification/passwords will not be shared.

c. Unsecured terminals may be used to transmit facsimile communications to customers provided they are "standing by" and the transmittals are marked "for official use only" by the sender; the receiver will telephonically verify receipt of the transmission.

d. DA Form 7517 data transmission, receipt date, time, sender, and recipient will be documented in the appropriate case file.

Chapter 7
Transfer of Cases

7–1. Conditions that warrant managing the transfer of cases

This chapter outlines procedures for managing and transferring all open spouse and child abuse cases when the CRC has determined that abuse is substantiated and—

a. The Soldier or affected Family members have moved away or will be moving away from the military installation having responsibility for handling the case and another CRC or a civilian agency should assume the responsibility of managing the case.

b. Relocation of the Soldier either jeopardizes the successful completion of treatment or will further exacerbate the Family's instability or when adequate support services are not available at the new duty station. (See para 3–29*c*.)

c. Involves reservists who have been on active duty for 30 days or more duration and have been identified for child and or spouse abuse that requires continued treatment in the civilian community.

7–2. Transfer of spouse abuse cases

a. Procedures for transferring routine spouse abuse cases include—

(1) A case transfer conference (para 7–3*a*) to discuss continued services for the victim and the primary aggressor and, when appropriate, the victim's plan for protection in the new location. If there is a need for specialized medical services for the victim that may be unavailable in certain locations (such as OCONUS), a referral for assessment and screening with the EFMP POC at the nearest Army MTF is a prerequisite for the relocation of that individual. (See para 3–29*c*.)

(2) Transfer of the CRC file (para 7–5).

b. The CRC is responsible for determining when a victim of spouse abuse is at risk of death or serious (in other words, life-threatening) injuries and for arranging for special protection during case transfer. To the extent that extraordinary measures are required for the continued protection of the victim, some of the procedures outlined in paragraph 7–7 can be adapted to fit the needs of the victim during the transfer process. Other measures, such as referral for screening by EFMP POC, protective court orders, and advanced notification of appropriate law enforcement agencies, may also be appropriate.

7–3. Transfer of child abuse cases

The following actions will be performed for all child abuse cases that are to be transferred:

a. Case transfer conference.

(1) A case transfer conference will be conducted between the Family, the case manager, and other interested parties (for example, commander, CPS, court representatives, EFMP POC).

(2) The purpose of this conference is to discuss with the Family the plan for continued treatment services and, in threat-to-life and protective placement cases, military assignment actions. (See *b*, below, for the definition of these cases.) The plan should include, when appropriate, EPC and other services in the location to which the Family is moving and other measures outlined in this chapter that are necessary for the movement and treatment of the Family and the continued protection of the victim.

(3) Obtain parental consent or a court order/judicial authorization in any case where a child is being transported under the supervision of someone other than the parent. If the child has any special educational, medical, and/or psychological needs, a referral must be made to the EFMP POC at the nearest Army MTF to coordinate the transfer to a CONUS location with the necessary facilities. (See AR 608–75.)

(4) If the abused child will not be accompanying the Soldier to his or her next duty assignment, the new location of the child's anticipated residence will be obtained from the Soldier in advance of the child's departure. In appropriate cases, the possibility that a State court will exercise or continue to exercise jurisdiction over the abused child until arrangements satisfactory to that court are made in the new location for the protection of the child will be discussed with the Family.

(5) In cases where a child has been abandoned in an overseas command, every effort will be made to place the child in a State or locality in which parents or other relatives reside or have resided. When a child is to be transferred to a CPS agency in a particular State or locality, the CRC chairperson will inform that CPS of the proposed transfer before the child is escorted to the United States.

(6) Although in some cases a child either may be abandoned or it may be desirable to send the abused child to the new location separate from the parents, in no case will an abused child be retained in an overseas command after both parents have departed, unless the child is required to be retained by an order of the court with jurisdiction in the case.

b. CRC designations. The CRC will classify and document in the case record and on the transfer letter all child abuse cases being transferred as either threat-to-life, protective placement, stabilize treatment, or routine. These designations may be made before or after assignment orders are published. In cases where civilian foster care or EPC is required, the procedures in paragraphs 3–22*e* and 7–6 will be followed.

(1) *Threat-to-life cases.* These cases involve victims of abuse who are at risk of death or serious (in other words, life threatening) physical injury who require or will require immediate civilian foster care, EPC, or emergency measures (for example, medical protective custody) to protect their lives.

(2) *Protective placement cases.* These cases involve child victims of abuse (other than threat-to-life case) where, although the abuse is not life threatening, civilian foster care, or EPC, nevertheless is required or will be required for the protection of the child.

(3) *Stabilize treatment.* Stabilize cases involving multiple problems, moderate or severe abuse, instances when relocation of the Soldier jeopardizes completion of the treatment plan, or instances when adequate resources are not available at the next duty station. (See paras 2–4*o*, 3–24*b*, 3–29*c* and 7–7*b*.)

(4) *Routine cases*. These cases involve all other victims of abuse whose cases have not been designated as threat-to-life, protective placement, or stabilize treatment.

7–4. Case review committee recommendations in spouse and child abuse cases

The CRC will make recommendations to commanders regarding treatment plans, inform commanders of progress, solicit assistance from commanders, and submit required documentation in accordance with paragraphs 3–29 and 7–7 to initiate recommended personnel actions when it is necessary to stabilize the Soldier's assignment or affect the Soldier's reassignment for treatment or protective purposes in spouse or child abuse cases.

7–5. Transfer of CRC files

The losing CRC will send a copy of all CRC files to the gaining CRC prior to the arrival of the Family according to the following procedures:

a. The losing CRC will make contact the gaining CRC via telephone and will submit a written follow-up letter (including case summary) to alerting the gaining team that a case is to be transferred, attaching a copy of the PCS orders or curtailment of tour orders, if applicable. (See fig 7–1 for a sample format.) This letter will be sent to the gaining CRC as soon as the losing CRC is aware of the victim's location and PCS date. If a Family member has been enrolled in the EFMP, the case manager must ensure that the specialized services for the Family member have been coordinated with the gaining EFMP POC.

(Office symbol) (Date)

MEMORANDUM FOR: Chairperson, Case Review Committee (CRC) (at gaining CRC, Medical Treatment Facility)

SUBJECT: Transfer of Family Advocacy Program Case and Record

1. Pursuant to AR 608–18, you are advised that (soldier's name, rank, and SSN) has been reassigned to your area of responsibility for treatment and follow-up for (substantiated) (specify type of abuse or neglect of child or spouse).

2. (Soldier's name and rank) has been assigned to (unit name and address) on or about (date). A copy of the soldier's orders is attached.

3. The recommended treatment plan is as follows: [This needs to be specified so that the gaining SWS can verify that the services needed are available].

4. Request the enclosed form letter be completed and returned to this office by electronic transmission within 1 duty day.

5. Point of contact is (name, rank, and telephone number).

Encl (Signature block)
(Return letter from the gaining CRC) CRC Chairperson

Figure 7–1. Sample of losing case review committee request for transfer of Family advocacy program case

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b. The gaining CRC will comply with the instructions in the transfer letter. The gaining CRC will complete the enclosure to the transfer of the CRC file letter and return it to the losing CRC within 1 duty day. (See fig 7–2 for a sample format.)

(Office symbol) (Date)

MEMORANDUM FOR: Chairperson, Case Review Committee (CRC) (Losing CRC, Medical Treatment Facility)

We have received your case transfer letter and request that you forward the case file to the following address: (insert address)

(or)

We have received your letter of case transfer and do not have the available treatment and/or services that are recommended.

(or)

We have received your letter of case transfer and currently are unable to locate the subject in question. Please advise further if necessary.

(Signature)
U.S. Medical Department Activity
Social Work Service
(Street address)

Figure 7–2. Sample of gaining case review committee reply to request for transfer of Family advocacy program case and file

c. On receipt of the reply from the gaining CRC, the losing CRC will mail the CRC file by certified mail, attaching a Postal Service (PS) Form 3811 (Postal Services Return Receipt). This form may be obtained from any post office. The losing CRC will retain a copy of the file according to local procedures.

d. The gaining CRC will complete the PS Form 3811 acknowledging control of the file and mail the card. These three items (a copy of the transfer CRC file letter, the return letter from the gaining CRC, and the PS Form 3811) will document a successful case transfer.

e. On the departure of the victim, the losing CRC will complete and submit a DA Form 7517 for the ACR to transfer an open case to another installation. A copy of the DA Form 7517 must be included in the case file.

f. Once face-to-face contact with the victim is established at the new installation, the gaining CRC will notify the losing CRC and complete and submit another DA Form 7517 per special instructions for transferring an open case.

g. When routine cases are transferred to Europe, the transfer letter will be sent to the European Regional Medical Command (ERMC), ATTN: Social Work Consultant, ERMC, CMR 442, APO AE 09042. The social work consultant will—

(1) Ascertain the final assignment of the Soldier.

(2) Determine the servicing MTF and alert the gaining CRC of the pending transfer.

(3) Return the enclosure to the losing MTF so that the losing MTF may send the case record to the gaining MTF.

7–6. Judicial authorization for civilian foster care or emergency placement care services

When the CRC determines that child abuse is substantiated and civilian foster care or EPC is required, placement will be accomplished whenever feasible through the judicial system of the State or host nation having or assuming jurisdiction over the child. Judicial authorization will be sought by the gaining CRC through coordination with the local CPS even in cases where the parents of the child have consented to foster care placement. In foreign countries, the judicial system of the host-nation court having jurisdiction over the child will be used to place a child in EPC in appropriate cases following coordination with the servicing SJA. In situations where judicial authorization cannot be obtained and emergency action is required to protect the life of an abused child, consult the SJA for guidance on the procedures to be followed. (See paras 3–20 and 3–22*e* for guidance and emergency procedures available.)

7–7. Transfer from the United States to foreign countries

a. Due to limited medical and social service support in foreign countries, a Soldier stationed in the United States will not be reassigned to a foreign country on an accompanied tour in a CRC-designated threat-to-life, protective placement, or stabilize treatment case until after coordination between CPS and the court having jurisdiction over the case (when there has been CPS and/or court involvement) and one of the following occurs—

(1) The commander has determined, following a review of the recommendations of the CRC, that, although the victim will be residing with the offender, the risk of further abuse is substantially reduced and necessary treatment adequately provided at the new location. In such cases, the losing CRC will notify the gaining CRC about the case.

(2) The conditions in (1), above, have been met and an EFMP screening has been accomplished identifying any special medical needs. If the Family member is enrolled, coordinate with the gaining EFMP POC to ensure the availability of services within OCONUS. (See AR 608–75.)

(3) A placement of the child with a Family in the United States has been accomplished through the courts and the child will not accompany the abusive parent to the foreign-duty assignment.

b. In all other CRC-designated threat-to-life, stabilize treatment, and protective placement cases, the CRC recommends a reassignment, deletion, or deferment request. The Soldier should forward the request to Total Army Personnel Command, ATTN: TAPC–EPC–S, 2461 Eisenhower Avenue, Alexandria, VA 22331–0450, with a copy furnished to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418. If the Soldier does not initiate a request for deletion/deferment or reassignment, the commander may initiate a personnel action for the good of the command and the Family. These actions do not preclude the CRC chairperson from submitting a request to TAPC for deletion, reassignment or deferment as indicated in paragraph 3–29*c* with a copy furnished to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.

7–8. Transfer within the United States

The reassignment of a Soldier within the United States who has a child in foster care because of child abuse should be coordinated with AHRC through the PSB, the EFMP POC, the losing and gaining CRC, the CPS, and the courts losing and acquiring jurisdiction in the case. Deletion or deferment should be considered in cases where the CRC recommends against reassignment, or where reassignment will interfere with ongoing treatment. See paragraph 7–7*b* for the procedures to be followed in deleting and deferring Soldiers from reassignment.

7–9. Transfers from foreign countries to the United States

The procedures in this paragraph apply to the transfer of threat-to-life cases and protective placement cases from foreign countries to the United States.

a. Threat-to-life cases.

(1) The chairperson of the losing CRC will alert the appropriate IMA or specific ACOM, ASCC, and DRU, contact the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418, and promptly send the information and documents outlined in (a) through (c), below, to the HQDA FAP POC by the most expeditious means possible, including express mail if necessary. The following documentation is required in order to transfer a threat-to-life case:

(a) Cover letter from the CRC chairperson containing—

1. Identification and assignment data on the Soldier including SSN and military occupational specialty (MOS). If permanent change of station (PCS) orders have been issued, a copy of the orders and amending orders should be attached to the letter for HQDA use, and, if available, a copy of curtailment of tour paperwork. Requests for reassignment, deletion, or deferment, as appropriate, will be made through HQDA AHRC according to the procedures outlined in paragraph 7–7*b*.

2. Identifying information on the victim and offender, a description of the type of abuse that occurred, and the CRC case determination as required by paragraph 7–3*b*.

3. Current status of the case, including pending criminal charges and likely disposition (for example, court-martial, administrative discharge, or civilian criminal charges).

4. CRC recommendations for placement of the child, treatment of the Family, and EFMP screening/enrollment, including (if applicable) the factual basis for the conclusion that the child is at risk of death or serious injury if custody is returned to or retained by the Family.

5. Transfer plan and recommended treatment plan.

6. CRC prognosis regarding the feasibility of returning the abused child to the parents if the child has been in EPC in the foreign country.

7. The results of the case transfer conference, including the stated wishes of the parents regarding EPC and their plans as to where and with whom the abused child will live during or en route to the Soldier's new duty assignment.

(b) Complete copies of CRC records, including all items indicated in paragraph 6–3*b* (except x-rays); a copy of the record of the UCMJ, Art. 32, hearing, if any; CID/MP reports of investigation; copies, if any, of the host-nation court orders and certified translations; results of the ACR background check; and copies of all DA Form 7517 transactions.

(c) A one-page summary providing specific case background data (for example, history of abuse, past treatment, and other services).

(2) The HQDA FAP POC—

(a) Coordinates with AHRC and HQDA EFMP to determine assignment locations where there are valid requirements for the Soldier's grade and MOS and with the MEDCOM to locate services that meet Family members' special medical and treatment needs.

(b) Contacts the CRC chairperson at the selected installation to determine whether or not civilian courts and installations are willing and able to exercise jurisdiction in such cases and to provide required services.

(c) Confirms the assignment that meets the total Family need with AHRC and requests a date for reassignment in order to allow required coordination to be completed prior to the departure of the child and Family. AHRC will forward assignment instructions as required to the gaining and losing commands. HQDA will notify the gaining IMA or specific ACOM, ASCC, and DRU FAPM.

(d) Advises the CPS in the geographic location of the abused child's anticipated future residence (if of long duration and different from the general location of the Soldier's next assignment) and provides such information and records that will allow continuation of foster care or other protective services.

(e) Contacts the Interstate Compact Project POC as appropriate to facilitate the transfer between State agencies.

(f) Coordinates with CPS in the civilian jurisdiction to which the child is being taken in all cases where there is no Army installation nearby.

(3) The gaining CRC in the United States will—

(a) Assign a case manager to present all available case information to the local CPS.

(b) Notify the losing CRC when all necessary arrangements for the child's placement have been initiated.

(c) Request, in appropriate cases, that the SJA at the gaining installation appoint legal counsel to represent the abused child.

(d) In coordination with the SJA of the gaining CONUS installation and the local CPS, present the case records to the local court having jurisdiction over such cases when the child and the records arrive at the gaining CONUS installation. (See para 3–30 for procedures to be followed.)

(4) In cases where a competent medical authority (DOD 4515.13–R, chap 5) attests to the medical need to aeromedically transport the abused child to the United States, or where other arrangements have been made to bring the child directly to the gaining installation in the United States, a member of the CRC of the losing command familiar with the case will accompany the child, whenever feasible, to the MTF of the gaining installation in the United States. The CRC member or designated unit representative accompanying the child will hand-carry all records and information referenced in (1), above. The abusive parent ordinarily will not accompany the victim. Upon arrival, the child will be taken to the MTF and admitted until placement in civilian foster care or other protective arrangements are possible. The gaining CRC will coordinate these arrangements in advance of the child's arrival in order to expedite the child's placement. A physician should examine the child before placement.

(5) On the departure of the victim, the losing CRC will complete and submit a DA Form 7517 for the ACR to transfer an open case to the gaining installation.

(6) When the victim arrives at the new installation, the gaining CRC will complete and submit another DA Form 7517 according to special instructions for transferring an open case.

(7) The losing CRC chairperson will coordinate with the HQDA FAP POC regarding the measures taken to ensure continued protection of the child. An escort, with the appropriate parental consent or court order, accompanies the child and delivers the records to the gaining C, CRC, or a copy is given to the CPS caseworker, as appropriate. (See para 1–8*b*(13) for guidance regarding escorts, and see sample format at fig 7–3.)

(Date)

I, the parent/legal guardian of (name of child), a child of (age) years of age, hereby authorize (name) (state description of person transporting child, (for example, a social worker or nurse)), who is assigned to (agency of office), to transport the child on commercial or military aircraft and appropriate means of ground transportation on or about (date) to the medical treatment facility at Fort (installation) by the most direct route for the purpose of allowing continued medical care and treatment.

I realize that my child may unexpectedly incur some other illness or sustain an injury either during travel or while at the medical facilities.

Because I am unable to accompany my child, I authorize and give my consent to all attending medical personnel within the system and facilities referred to above to treat and care for my child including all reasonable care needed for that condition or complication of it.

This authorization covers any emergency condition that involves the life or death of my child as well as any nonemergency condition. If my child resists medical attention instructions, I give my consent to all medical personnel to use any reasonable discipline that a licensed physician considers necessary.
I also give my permission to place my child on any Department of Defense-owned or controlled aircraft or other vehicle so that he or she can be transported to or from a medical facility.

(Signature of parent/guardian)
(Typed name of parent/guardian)
(Home phone)
(Office phone)

(Signature of witness)
(Typed name of witness)
(Address of witness)

Figure 7–3. Sample consent for medical care and transportation in nonaeromedical evacuation of Family advocacy program cases

b. Protective placement cases. Coordination with HQDA is not required to transfer protective placement cases.

(1) The chairperson of the losing CRC will—

(a) Provide the documentation listed in *a*(1), above, to the chairperson of the gaining CRC.

(b) Notify the CRC chairperson at the gaining installation that a protective placement case is being transferred and provide additional information and documentation necessary for the initiation or continuation of protective placement.

(c) Arrange and coordinate the transportation of the abused child and escort, if appropriate. (See *a*(4), above, for the procedures to be followed.)

(d) Mail the records to the gaining installation in the United States prior to the arrival of the child except for cases in which the records are hand-carried and delivered to either a CRC member or the CPS case worker, as appropriate (in other words, cases where an escort accompanies the child).

(e) Prior to the departure of the victim, the losing CRC will complete, submit, and include with the case file a copy of the DA Form 7517 for the ACR to transfer an open case to the gaining installation.

(f) Obtain an appropriate court order and/or parental consent for medical care and transportation of the child in any case in which the child is being transported to the United States in the custody of someone other than a parent.

(2) The chairperson of the gaining CRC will—

(a) Coordinate with the CPS in the geographic location of the abused child's anticipated future residence and provide information received from the losing CRC that will help in planning for the initiation or continuation of protective placement.

(b) Assign a case manager to present all available case information to the local CPS prior to the victim's arrival at the gaining installation.

(c) Notify the losing CRC when all necessary arrangements for the child's placement have been initiated.

(d) Complete and submit another DA Form 7517 according to special instructions for transferring in an open case when the victim arrives at the anticipated future residence.

Chapter 8
Out-of-Home Cases in Department of Defense Sanctioned Activities

Section I
Prevention of Out-of-Home Abuse

8–1. Department of the Army policy on prevention of out-of-home abuse

DA policy is to provide a safe and secure environment for all Army personnel and their Families, prevent out-of-home child abuse, and promote early identification and intervention in allegations of out-of-home child abuse in DOD-operated or -sanctioned activities (for example, CYS programs, DODDS, DODESS, Chaplain's programs, Boy and Girl Scouts, and MWR programs).

8–2. Prevention of child abuse in out-of-home settings

a. Child abuse may occur in out-of-home settings despite an effective child-abuse prevention program. Occurrences of abuse adversely affect the children, the parents, and the organizational staff and damage the public image of the Army.

b. Army installation activities (CYS, for example) that supervise or sponsor activities in which children are involved will—

(1) Screen and reverify every 5 years all staff, volunteers, and FCC providers and Family members according to applicable law, regulations, and organizational policies. The ACR will assist in providing background checks of volunteers, applicants, and employees in CYS programs, ACS FAPs, DODDs, DODESS, Chaplain's programs, Boy and Girl Scouts, and MWR programs. The agency directors will develop local procedures for requesting and reviewing this information.

(2) Provide adequate supervision of staff and volunteers.

(3) Encourage parents to observe and contribute to the activity's program.

(4) Provide safety education programs for children to the extent that local resources are available.

(5) Train staff and volunteers on behavioral and physical indicators of abuse and on abuse reporting procedures.

(6) Observe children for evidence of child abuse or neglect.

(7) Prepare a child abuse SOP for coordination with the FAPM. SOPs will include procedures to prevent and respond to child abuse situations and address the following topics—

(a) Child supervision.

(b) Discipline/touch policy.

(c) Facility security (if applicable).

(d) Child abuse training.

(e) Internal reporting and child abuse identification (familial abuse and abuse within a DOD-operated or -sanctioned activity.

(8) Develop employee, volunteer and parent handbooks that contain information on child abuse identification and reporting and on acceptable discipline policies.

(9) Encourage DOD-operated or -sanctioned activities to establish resource libraries containing training and educational materials on child abuse and neglect that are appropriate for employees.

8–3. Training

a. All persons working in DOD-operated or -sanctioned activities will receive written and verbal guidance from FAPM on the following topics within the first 3 months of employment, prior to FCC certification, or as part of volunteer orientation sessions.

(1) Internal reporting procedures.

(2) Legal requirements on reporting child abuse.

(3) Policies on discipline and use of corporal punishment.

(4) Identification of behavioral and physical indicators of abuse.

(5) Parent access policy.

(6) Touch policy.

(7) Field trip procedures.

(8) SOPs designed to minimize the risk of child abuse occurring in a DOD-operated or -sanctioned activity.

b. All persons working in DOD-operated or -sanctioned activities will receive training from FAPM on avoiding the appearance of abuse and protecting themselves from unwarranted accusations of abuse.

c. An update of the subjects above will be included as part of ongoing annual in-service training requirements.

d. The director or principal of a DOD-operated or -sanctioned activity is responsible for planning and organizing all training. Training in identification and reporting will be coordinated with the FAPM. The FAPM will assist in providing the training and serve as a resource person.

8–4. Child abuse safety education

Child abuse safety education programs will be set up for children ages 6–18 years in CYS settings and in schools operated on Army-controlled property (see para 3–2*f*).

a. The FAPM is responsible for the overall child abuse safety education program on the installation and must keep a record of all training, indicating the age group addressed, date, and number in the group.

b. Activity directors will coordinate all child abuse safety efforts with the FAPM to ensure that the staff is aware of reporting procedures.

c. All child abuse safety education programs will be developmentally appropriate for the age group. Activity managers will notify parents in writing in advance of all child abuse safety education programs.

8–5. Background screening requirements

a. FAPMs will assist DOD-operated or -sanctioned activity directors in developing records screening procedures to be used in hiring employees, obtaining persons who provide gratuitous services, volunteers, and certifying FCC providers.

b. Background checks are required by DODI 1402.5 for all civilian providers involved in childcare services that have regular contact with children. The categories of providers include individuals hired with appropriated funds (APF) and nonappropriated funds (NAF) for education, treatment, health care, childcare, or youth services and individuals employed under contract, such as computer lab or homework instructors. Background checks for these employees include a set of fingerprints that are taken by law enforcement personnel designated by the PM's office and are processed through the FBI identification check and the State Criminal History Repositories (SCHR) in each State where the individual has resided during the 5 years prior to hire. A national agency check (NAC) and a national agency check and written inquiries (NACI) through the Civilian Personnel Advisory Center (CPAC)/Civilian Personnel Operations Center will be completed for government employees prior to hiring. These individuals are also subject to installation records check (IRC) requirements and a criminal investigation division (CID) records check, to include a Defense Central Investigation Index check.

c. Personnel may be hired/contracted conditionally pending completion of NACI/NAC, SCHR, and CID, provided the hiring activity can provide line-of-sight supervision (LOSS) by a cleared employee. The use of video monitoring equipment in child-occupied areas monitored by a cleared employee will also satisfy the LOSS requirement.

d. The Office of Personnel Management offers an option to conduct childcare national agency check and written inquiries (CNACI). The CNACI is a combined check that includes the NACI for APF employees or NAC for NAF employees, the SCHR check for both APF and NAF employees, and equivalent checks for contract employees. Hiring activities may use this option to complete NACI/NAC and SCHR requirements. Child and youth services programs will use the CNACI option and follow latest CFSC guidance for completion of CNACI checks.

e. Employees and new applicants will sign a statement of understanding acknowledging management's intent to conduct checks on DA Form 7214 (Applicant Acknowledgement of Employer Obligation) and a release/consent form authorizing the employer to obtain information from the SCHR on DA Form 7215 (Release/Consent Statement).

f. Local nationals are subject to host-government laws and CID and FBI identification checks.

g. Military members will have an IRC and, if no security clearance exists, a CID check.

h. IRC and CID checks are required for FCC providers, FAP personnel, EPC and respite care providers, specified volunteer positions such as coaches, and summer hires involved in the provision of childcare services. The IRC, at a minimum, should include checks conducted by the MP, ASAP, local civilian police, the MTF for Family advocacy (to include the ACR and mental health records), and any other records checks as appropriate.

(1) Record screening procedures involve a review of available law enforcement and other records for any prior instances of substance abuse or relevant misconduct. The hiring, recruiting, or certifying official will develop procedures for requesting and receiving this information. When the application is for FCC certification, background record checks of all Family members over the age of 12 living in the household will be completed. The availability of certain records depends on the government nature of the hiring or recruiting activity and the position being filled.

(2) The ACR check will be obtained through the CRC chairperson or FAPM as established by installation procedures.

(3) Local military and civilian law enforcement records checks will be obtained through the PM and should include a check of the host government, CID, and FBI (if the individual lived in the United States since age 18). Local nationals must have IRC, CID, and local government checks.

(4) The ASAP check is obtained through two sources. Enrollment data of individuals currently participating in the ASAP are contained at the local ASAP clinic. Prior to enrollment, data are maintained at Headquarters, Department of the Army and are accessible through the installation ADCO. Requests should be made to both the ASAP clinic and the ADCO office.

i. In addition to IRC and CID checks, FCC providers, substitute providers, FCC Family members age 12 and older, and other authorized individuals residing in the FCC home must complete Housing Office and Sponsor Unit Commander checks. FCC providers' children age 12 and older must complete a school counselor check.

j. Appropriate activity directors should, at a minimum, follow these procedures:

(1) Personally review all applications for accuracy of information (for example, overlapping dates of previous employment).

(2) Interview applicant.

(3) Check via telephone with all former employers listed for the past 3 years and do the following:

(a) Verify employment dates.

(b) Verify reasons for leaving.

(c) Determine general work aptitude and habits.

(d) Clarify any concerns noted in the preemployment interview.

(e) Clarify any concerns about employment reassignments.

(f) Check personal references via telephone.

k. When derogatory information is received on APF/NAF applicants or contracted employees, activity directors should take appropriate action pursuant to applicable provisions of AR 215–3, AR 608–10, and this regulation. A program review board such as that established in AR 608–10 will be convened and will recommend to the installation/tenant commander, as appropriate, the suitability of the employee. The chairperson of the program review board will notify the individual of the derogatory information, allowing him or her to challenge the accuracy and completeness of the information. Derogatory information includes, but is not limited to—

(1) A conviction for a sex crime.

(2) An offense involving a child victim.

(3) A substance abuse felony or a violent crime.

l. No waivers to background checks will be granted for CYS employee or FCC program applicants, nor will FCC providers be provisionally certified before all checks are completed and evaluated.

m. Employees requiring a background check should receive a record reverification at a minimum every 5 years. This procedure consists of an IRC and a CID name check.

8–6. Persons providing voluntary service in childcare services

Volunteers may be placed in CDS systems prior to completion of background checks provided that they work under CYS LOSS and are never left alone with children. (See AR 215–1 and AR 608–10 on the acceptance of voluntary services in MWR activities.) Activity managers will—

a. Have each volunteer complete an application form to include information about the volunteer's arrest and conviction record and a signed waiver authorizing background checks as required above.

b. Assess the volunteer's attitude about discipline or abuse.

c. Evaluate the volunteer's education and work experience directly or indirectly related to children.

d. Conduct a preservice interview.

e. Assign new volunteers to an experienced/screened supervisor within the DOD-operated or -sanctioned activity.

f. Ensure that all regularly scheduled volunteers working directly with children attend a 2-hour training session that includes the program's disciplinary policy, child abuse identification and reporting procedures, and overall program policies.

g. Check via telephone at least two references provided by each volunteer. Deny the application if the volunteer fails to provide references.

h. Provide each volunteer with a program policy handbook and a written job description. Ensure all volunteers sign a policy statement acknowledging their awareness of the program's policies. Such policy statements will be identical to those signed by activity employees.

Section II
Reporting of Out-of-Home Child Abuse

8–7. Report point of contact for out-of-home child abuse

a. All allegations of child abuse in a DOD-operated or sanctioned activity will be reported to the RPOC, who in turn will notify the CRC chairperson and the appropriate law enforcement agency.

b. Installation reporting procedures and the RPOC phone number will be posted in each DOD-operated or -sanctioned activity. The DOD hotline number must be prominently displayed in the activity.

c. Each activity director will develop internal reporting procedures for all suspected instances of child abuse or infractions of rules relating to the care of children.

8–8. Evaluation of allegation

a. The RPOC will notify the MP, FAPM, and CRC chairperson of every allegation of child abuse as soon as he or she receives the report. The CRC chairperson will work cooperatively with the law enforcement agency to promptly assess reports of abuse and will consult with personnel in the activity involved, the FAPM, and the supporting SJA, as appropriate.

b. When the report involves DODDS/DODESS personnel, the Chief, SWS, in consultation with the FAPM and SJA, will assess and determine whether the allegation meets child abuse criteria or is an infraction of corporal punishment policy. The Chief, SWS will send a letter of results (see para 6–6) to DODDs indicating whether referral to CRC is indicated or a policy infraction has occurred. Release of information regarding FAP cases by the Chief, SWS will be limited in nature and mailed directly to DODDs Headquarters, ATTN: HQ DODEA, 4040 North Fairfax Drive, Arlington, VA 22203–1635.

8–9. Department of the Army reportable and nonreportable child abuse

a. Department of the Army reportable child abuse is child abuse that occurs in a DOD-operated or -sanctioned activity that includes any of the following:

(1) Any child sexual abuse regardless of whether injury occurs.

(2) Any child abuse resulting in the death of or major physical injury to the child.

(3) Any child abuse involving the deprivation of necessities that is determined to be widespread, chronic, or potentially life threatening.

b. If the allegation is not specifically related to child abuse but alleges an infraction of a regulatory standard (such as a prohibition regarding discipline/corporal punishment), the Chief, SWS will make a written record of the information and send it to the director of the appropriate DOD-operated or -sanctioned activity and advise the CRC and the FAPM. Unless the infraction constitutes child abuse, it will neither be referred to the full CRC for consideration nor reported to the ACR. The activity director or principal will take appropriate disciplinary action where necessary to resolve allegations that are considered policy violations. The activity director will submit a plan of corrective or disciplinary actions to the Chief, SWS.

c. Listed below are the responsible supervisory officials in various childcare and child-oriented activities:

(1) Army-certified foster homes (OCONUS) or respite care providers—FAPM.

(2) CYS programs including child development centers (CDCs); FCC homes; Child and Youth Liaison, Education, and Outreach Services (CLEOS); school-age services; middle school programs; teen programs; and youth sports programs—CYS coordinator.

(3) Chaplain activities—chaplain.

(4) DODDS/DODESS—principal.

(5) Other DOD-/Army-sanctioned activities—program director.

8–10. Initial reporting procedures

The installation FAPM will be notified of all abuse allegations (as identified in para 8–9*a*) and will be provided a copy of the SIR pursuant to AR 190–40, paragraphs 1–4*b*(3) and 1–4*c*(1), to facilitate reporting requirements to higher levels of command. Procedures established for reporting DA reportable child abuse are in addition to and do not supersede requirements outlined in AR 190–40. The FAPM will follow the procedures below for notifying the IMA or specific ACOM, ASCC, DRU, and HQDA FAPM.

a. Within 48 hours of receiving a report of abuse in a DOD-operated or -sanctioned activity, the installation FAPM will telephonically provide necessary information to the IMA or specific ACOM, ASCC, and DRU and HQDA FAPM and complete DA Form 7318 (Initial Report of Child Abuse in DOD-Operated or Sanctioned Activities).

b. All reports will be mailed through the IMA or specific ACOM, ASCC, and DRU to the Assistant Chief of Staff for Installation Management, CFSC–FP–A, ATTN: FAPM, 4700 King Street, Alexandria, VA 22302–4418, within 5 working days following the initial telephonic report. CFSC–FP–A will distribute the reports to appropriate HQDA program managers and DOD, as appropriate.

c. The FAPM will make follow-up/interim reports using DA Form 7318–1 (Follow-up/Interim Report of Child Abuse in DOD-Operated or Sanctioned Activities) when—

(1) Significant changes in the status of the case occur (for example, the arrest of a suspect, dismissal of pending criminal charges, or firing of an employee).

(2) Required by IMA or specific ACOM, ASCC, and DRU or HQDA.

(3) Significant changes develop resulting in increased community sensitivity (for example, a victim is suspected of being exposed to a sexually transmittable disease).

d. A closeout report using DA Form 7318–2 (Closeout Reports for Reports of Child Abuse in DOD-Operated or Sanctioned Activities) is required after all investigations (for example, command-initiated, police, or grand jury investigations) have been completed. The submission of a closeout report need not be delayed until the submission of a final law enforcement report or the completion of related briefs or appellate review. FAPM will complete DA Form 7318–2. The closeout report will include, if applicable, a copy of an approved waiver relieving a CDC or a center-based setting from the requirement for two employees being present in all childcare areas during hours of operation.

Section III
Intervention

8–11. Investigation of out-of-home child abuse cases

The procedures for coordinating the investigation of child abuse cases on the installation, including those alleged to have occurred in DOD-operated or -sanctioned activities, will be addressed in an internal installation MOA (in accordance with para 2–14 and Managing Out-of-Home Child Sexual Abuse: An Installation Handbook). Installations must work promptly and effectively to protect the victim(s), minimize further trauma, and initiate the investigative process. Joint interviews of victims by law enforcement personnel and social workers are recommended to minimize trauma. Initial handling of the investigation often proves critical to later efforts to prosecute suspected offenders.

a. When the responsible law enforcement agency and/or CRC receives a report of child abuse that has occurred in a DOD-operated or -sanctioned activity, the FAPM will notify the installation commander responsible for the activity concerned.

b. The CRC, when appropriate, will assist in the investigation, check with ACR for prior reports on any suspected offender, and include any suspected offender on a DA Form 7517 to the ACR. The CRC clinical assessment and determination should proceed and not be suspended or delayed awaiting a CID determination of criminal action. The two systems are cooperative in the interview process and in the sharing of information but separate in function.

c. The activity director will—

(1) Provide access to administrative files, attendance sheets, work schedules, client lists (for example, parents, children, addresses, and phone numbers) to investigators and other Army personnel who have an official need to know.

(2) Provide access to staff for investigative interviews.

(3) Take notes, observe facts, and be alert to signs and symptoms of abuse in children in order to aid in fact collection during the investigative process (for example, keep a daily staff journal).

(4) Provide information approved by the strategy team to the PAO or parents (see para 8–12).

d. When another Federal, State, or foreign law enforcement agency assumes primary responsibility for the investigation, USACIDC will work jointly with that agency whenever possible and will—

(1) Locate potential victims who have transferred from the local area using information provided by the FAPM, activity director, and supporting CPAC. Leads will be forwarded to the USACIDC unit nearest the victims' new address with a request that the potential victim and his or her parents be interviewed regarding the investigation.

(2) Coordinate with, if appropriate, the local CRC chairperson, FAPM, and medical personnel prior to interviewing potential victims and their parents.

e. Other actions relating to management of the allegation include the following:

(1) The activity director will coordinate with the servicing civilian personnel action center and labor counselor regarding employees suspected of abuse. Such employees will be reassigned to duties with no contact with children, placed on administrative leave, or suspended pending completion of the investigation. Volunteers will be reassigned to duties with no contact with children or suspended pending completion of the investigation. In an instance where there is not an identified offender, no single childcare provider will be left alone with children.

(2) Management personnel will maintain daily program operations as their first priority.

(3) Management personnel will assess the need for additional personnel to handle the added workload, if any.

(4) After careful assessment, activity directors will develop a staffing plan that ensures maximum safety of the children.

(5) The activity director will be available to talk with parents, will keep a chronological log of events, and will keep the staff informed (to the extent it is appropriate) of case development through staff meetings. (See figure 8–1 for a sample memorandum to parents regarding alleged incidents of abuse.)

(6) FCC providers and EPC parents accused of abuse will be prohibited from providing childcare for children (other than their own children or legal dependents) until such time that the allegation of child abuse is determined by the CRC to be unsubstantiated.

(Date)

Dear Sponsor:

The commander has been apprised of incident(s) of alleged child sexual abuse reported to have occurred at (the activity). Immediately upon receipt of the report, proper law enforcement authorities were notified and concurrently the child was provided a thorough physical examination by physicians trained to handle cases of this nature. Thereupon, the child and the parents began a professional program of treatment to deal with the situation. On the day notification was received, the employee believed responsible was removed from his or her position and assigned duties with no contact with children.

Our records reflect that the employee implicated in this incident may have provided care to your child(ren).

We have been in touch with health care professionals and experts in this area. Procedures have been developed to fully inform you of the facts and provide services to your children. This process also gives professionals the opportunity to obtain relevant information concerning any possible inappropriate contact from any children who might have been exposed to this suspect without further traumatizing the child(ren) involved.

We have established a child abuse help line at (telephone number) for parents to call for answers to any questions they might have. The case review committee/social work service personnel staff the line during regular duty hours. An answering service is provided after duty hours so that parents can express their concerns and request a call back. Calls will be returned as soon as possible.

Our health care professionals have put together the enclosed checklist of the most often exhibited symptoms of child abuse. In the event your child(ren) exhibit any of these symptoms, we request that you contact (insert contact name and telephone number) immediately. Please do not question your children or conduct any kind of investigation. We have arranged to have trained professionals, interview your child(ren) with your approval. Improper questioning might well impede a child's ability to recall events, color his or her recollection and make it difficult, if not impossible, to get a true reading of what really happened.

As a follow-up, we are committed to providing treatment, care, and counseling for any of the patrons of the (activity) who may seek our assistance. We will, of course, continue working with law enforcement authorities to support any further actions that might be warranted.

Please call the child abuse helpline if you have any questions.

Signature
Director of community activities

Figure 8–1. Sample memorandum to parents regarding alleged incidents of abuse

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8–12. Strategy team

An installation strategy team will be established to guide the installation's response to the allegation. The strategy team will work with local authorities as appropriate to determine if screening for multiple victims is necessary. The strategy team chairperson, normally the DCA or Chief of Staff, will report directly to the installation commander. The installation FAPM will serve as the action officer and subject matter expert in working with the strategy team. The FAPM will coordinate the overall installation response plan to include community awareness and information and services for parents and affected program staff.

a. A response plan must be developed to address the following issues:

(1) Corrective action or measures to be taken within the facility to ensure the safety of children (to include reassignment of the suspected offender pending completion of the investigation).

(2) Identification of a lead investigative agency/agent to coordinate interviewing, identify pool of potential victims, assign interviewing teams (social workers and criminal investigators), and develop matrix and offender profiles as appropriate.

(3) The overall installation plan for communication with the press and public, services to victims and their parents, services for staff, and staff rights. (See fig 8–1.)

(4) In order to minimize rumors, an individual will be designated to serve as a Family liaison officer to keep Families informed of how the investigation is proceeding and provide information on available resources. This person should not be closely involved in the case (for example, FAPM, SWS, or affected activity personnel). Actions to support the Family may include an information and referral support line to answer parents' concerns and refer them to professionals for screening and parent support groups.

b. Members of the strategy team should include—

(1) DCA or Chief of Staff chairperson.

(2) USACIDC.

(3) PAO.

(4) CPAC.

(5) PM.

(6) FAPM.

(7) CRC chairperson/Chief, SWS.

(8) Pediatrician.

(9) SJA.

(10) Program activity director (for example, CYS).

(11) Civilian members of the team may include the FBI, U.S. Attorney, or others deemed appropriate by the installation commander.

8–13. Medical evaluation

a. Medical priorities. Medical priorities are—

(1) Physical/mental well-being of the victim(s).

(2) Collection, documentation, and control of medical/legal evidence in accordance with established MTF protocol using the sexual assault examination kit, the child sexual abuse/neglect protocol, photographs, and laboratory work as necessary. Collection and documentation of evidence will be in conjunction with the investigative process.

(3) Follow-up care for patient(s)/victim(s), to include medical and psychological care, CRC referral, and support for the victim's Family.

b. Medical responsibilities. Any service or department within the MTF receiving a child patient alleging physical or sexual assault in a DOD-operated or -sanctioned activity will contact the Chief, SWS and Chief, Pediatrics.

(1) Pediatrics will—

(a) Examine the child (victim) and make appropriate referrals/consultations for follow-up care for the alleged victim.

(b) Care for the physical injury.

(c) Document the injury.

(d) Collect evidence as indicated by the injury and/or requested by the investigating officer.

(e) Provide information to the investigating officer.

(f) Report findings to the Chief, SWS (CRC chairperson).

(2) SWS will—

(a) Respond to the notification by sending a staff member to the victim (and Family) to provide assistance, chaperon service, and counseling.

(b) Notify USACIDC.

(c) In conjunction with USACIDC and local CPS (if involved), interview the victim.

(d) Call an emergency CRC meeting as necessary.

(e) Provide short-term counseling for the child (with Family, as appropriate).

(f) Assign a case manager(s).

(g) Meet with the installation strategy team if one has been formed.

(h) Schedule follow-up for case(s).

(i) Make referrals as needed (for example, child psychiatrists or private practitioners).

(j) Document case(s).

(k) Prepare child for court, if applicable.

(l) Operate a 24-hour helpline through the use of on-call personnel to answer questions/screen potential victims.

(m) Be an ongoing resource.

(n) Provide staff support to reduce the stress of activity staff.

(o) Request additional financial resources to support community referrals.

(p) Present the case to CRC for determination of substantiated or unsubstantiated.

8–14. Treatment for the victim and Family

a. Pediatrics will inform the Family of the child's medical status and obtain SWS support for the Family.

b. SWS will—

(1) Ensure counseling services are provided.

(2) Coordinate with the Family liaison officer if one has been appointed by installation strategy team.

(3) Provide support groups for Families at times convenient for Families.

8–15. Support for the staff of the activity in which abuse occurred

Support to organization staff is a joint MTF/FAPM responsibility. As appropriate, support groups will be provided for the staff of the organization in which child sexual abuse was alleged to have occurred. Support group services may be obtained from outside the military system through contracting (using CYS, FAP, or Command Operating Budget resources) with local community resources or through the military system (AHRC call-up of social work officers and/or utilization of Family-life chaplains).

Section IV
Use of the Department of the Army Family Advocacy Regional Rapid Response Team and the DOD Family Advocacy Command Assistance Team

8–16. Department of the Army installation-assistance teams

DA policy is to provide support to installations to assist in managing the initial investigations of child abuse cases that occur in a DOD-operated or -sanctioned activity, specifically in cases where local resources are not sufficient to adequately manage the investigation.

a. DA has established a multidisciplinary Family Advocacy Regional Rapid Response Team of specially trained social workers, criminal investigators, and pediatricians who can deploy to installations within 48 hours after notification.

b. DOD has established a similar multidisciplinary team, the FACAT, that is an additional resource available to DA installations in such cases. The DOD team is especially useful to ensure adequate and prompt investigation and to avoid the appearance of Service cover-up in highly sensitive cases. Team size may vary from five to seven individuals based on the needs of the installation. Deployments may range from 7 to 10 days.

8–17. Criteria for team deployments

The DA Family Advocacy Regional Rapid Response Team and the DOD FACAT prefer to deploy at the request of the installation commander (or designee) through IMA or specific ACOM, ASCC, and DRU and HQDA (CFSC–FP–A). However, if the situation warrants, the Assistant Secretary of Defense (Personnel and Readiness) may deploy the DOD FACAT and the Assistant Secretary of the Army (Manpower and Reserve Affairs) may deploy the DA Family Advocacy Regional Rapid Response Team without the installation commander's request. Criteria for deployment of either team include but are not limited to—

a. Multiple victims involved in an allegation of child sexual abuse.

b. Situations in which effective intervention as determined by the strategy team exceeds the installation's resources.

c. Circumstances in which potential for extensive adverse media coverage exists.

8–18. Department of Defense hotline calls

The Military Childcare Act was reauthorized in 1996 and requires that DOD establish and maintain a hotline for individuals to report suspected child abuse and safety violations in military childcare programs (for example, CDCs, FCC homes, and CLEOS settings). The procedures outlined below apply only to DOD hotline calls. These procedures will be followed when calls are received by the Office of the Assistant Secretary of Defense (Force Management Policy/Military Community and Family Policy) (OASD, FMP/MC&FP) alleging incidents of child abuse in child development settings.

a. OASD, FMP/MC&FP will notify the HQDA FAPM.

b. The HQDA FAPM will disseminate the information to the appropriate IMA or specific ACOM, ASCC, and DRU telephonically within 1 working day of receipt of referral from OASD, FMP/MC&FP.

c. The IMA or specific ACOM, ASCC, and DRU FAPM will make telephonic notification to the installation FAPM and provide a telephonic report back to the HQDA FAPM within 5 days of the initial report and complete DA Form 7317 (Child Abuse/Safety Violation Hotline Intake Information).

d. HQDA FAPM must provide a telephonic report to the OASD, FMP/MC&FP within 7 days of the initial report. FAPM will complete DA Form 7317–1 (Child Abuse/Safety Violation Hotline Seven Day Follow-up Information).

e. A written status report (memorandum or message format) from the installation will be forwarded by the FAPM through the IMA or specific ACOM, ASCC, and DRU to the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418, within 75 days of the initial report. All reports are subject to more-frequent telephonic updates if deemed necessary by the OASD, FMP/MC&FP or CFSC–FP–A.

f. If the case is not resolved upon the submission of DA Form 7317–1, FAPM will be required to submit DA Form 7317–2 (Child Abuse/Safety Violation Hotline 90–Day Follow-up Information) every 75 days thereafter until the case is closed. In the event circumstances require more frequent updates, reporting requirements will be addressed on a case-by-case basis.

Chapter 9
Emergency Placement Care

Section I
Introduction to Emergency Placement Care and Recruiting, Evaluating, and Training Emergency Placement Care Families

9–1. Concept

a. Emergency placement care is a voluntary or court-mandated service providing 24-hour care in an EPC Family home for eligible children (as defined in AR 608–1, para 1–7) who cannot be cared for by their natural Family or legal guardian. EPC is comparable to the civilian foster care and civilian respite care programs in CONUS. Unless specifically exempted, EPC is provided on a military installation or from U.S. Government-owned or U.S. Government-leased housing off the installation. The EPC manual provided by CFSC–FP–A provides guidance for the management, implementation and supervision of EPC services.

b. The ACS director will assign a POC for EPC, normally the FAPM. If civilian foster care or a CPS agency is available and accessible through the local civilian authority, these services must be used in accordance with a locally established MOA.

c. The Army EPC program is used at Fort Knox and at OCONUS installations. It is intended to provide short-term care generally not to exceed 90 days for Families in crisis until the situation causing placement is resolved, or until longer-term care or placement can be arranged at a CONUS location. Placements more than 90 days in length require IMA or specific ACOM, ASCC, and DRU FAPM approval.

9–2. Recruitment of emergency placement care Families

a. A continuous recruitment effort will be made to identify homes that can provide EPC services and will be based on the EPC POC's assessment of community needs and available resources. The recruitment service will realistically present the abilities needed to provide care for special kinds of children, including children with physical disabilities, mentally impaired children, and emotionally disturbed children. ACS will coordinate with other agencies to recruit EPC Families.

b. The EPC POC will establish contact with potential EPC Families as quickly as possible following the initial indication of interest and will follow up the initial contact with an individual or group meeting designed to have applicants understand eligibility criteria, background checks, and the evaluation process. The screening process will provide potential EPC Families with information to help them decide whether or not they wish to be considered for a home study. Special effort will be made to follow up recruitment efforts promptly with Families who qualify for providing EPC. At the initial screening, if the Family is still interested, the EPC POC will decide whether or not a home study of the applicant Family will be done, and the Family will be given an applicant packet.

c. After completing the evaluation process, the final decision will be made known through a personal conference with the prospective EPC Family within 10 days after the study is completed. During the conference, the EPC POC and/or FAPM will have available for discussion and review: the application; health and reference forms; summary and evaluation of interviews; summary and evaluation of conferences and decisions; a statement regarding the basis for acceptance or nonacceptance for service; an agreement to be signed by the EPC POC and EPC parents that details the working relationships, financial plans, rights, and responsibilities of each; and the license or certification of approval. (See app I for the criteria for selecting EPC Families.)

9–3. Evaluation of emergency placement care Families

a. The evaluation process determines if a prospective EPC Family meets the basic EPC certification requirements, is capable of meeting the needs of children placed in their care, and is capable of working as part of a team with the EPC POC and other agencies and community resources.

b. The evaluation procedures will include:

(1) Interviews (joint or separate) with the FAPM, ACS director, EPC POC, and prospective EPC Family.

(2) Onsite evaluation of the prospective EPC Family's home by EPC POC.

(3) Written documentation, including Family health records.

(4) Family willingness to cooperate with the FAPM's plans for supervision.

(5) References to be provided by the EPC Family to supplement information obtained through interviews and observations.

(6) Completion of an IRC.

c. The evaluation process is completed within 30 days if all required documentation is received promptly. The EPC POC and/or FAPM is responsible for making the final decision regarding acceptance or nonacceptance of a Family to provide EPC Family services and is also responsible for decisions for matching individual children with specific Families.

9–4. Training of emergency placement care Families

a. The FAPM will provide each newly selected EPC Family with 2 hours of local orientation training (for example, module one in the Emergency Placement Care Army Resource Manual) and advise them of the additional training requirements. Those requirements include cardiopulmonary resuscitation (CPR) and first aid training and 10 hours of additional training within 6 months of selection. The training may be from ACS sponsored programs, the Emergency Placement Care Army Resource Manual, or local community adult-education programs. The FAPM or EPC POC must approve the proposed training. The EPC POC will maintain an attendance record for educational meetings, give certificates to EPC parents to recognize their completion of educational requirements, use experienced EPC parents to lead discussion groups, and set up training services that will be convenient for EPC parents.

b. The EPC Family will be involved in an annual reassessment after the Family's acceptance. Reassessment will include:

(1) Appraisal of the EPC POC's and EPC Family's experiences in developing and maximizing the Family's ability to meet the needs of children placed in the home and in helping to reach the goals set for each child and the child's Family.

(2) Written evaluation signed by the EPC POC and the EPC parents with space provided for comment by the EPC parents. (Copies of the evaluation will be given to the EPC parents and included in the EPC Family record.)

(3) Evidence of updated CPR and first aid training and at least 6 additional hours of training from sources noted in *a*, above.

c. One indicator of effectiveness will be based on approval and turnover rates for recruited Families. There will also be an assessment of the extent to which the results of the recruitment service match the service needs of Families.

9–5. Termination of emergency placement care Families

Termination of service by an EPC Family may occur at the request of the EPC parent, the EPC POC, CRC, FAPM, or Chief, SWS. Reasons for immediate termination include child abuse or neglect, illness, financial problems, and relocation of an EPC parent. The procedures for termination will include compiling and reviewing the reasons for termination, a conference with the requesting source and the EPC POC to review the final decision on terminating the service, and a conference with the EPC Family if termination was not at their request.

Section II
Service Components

9–6. Preplacement services

a. When feasible, EPC preplacement policies, procedures, and services will be offered to help the child and his or her Family understand the significance of the placement decision and the ramifications of court commitment or voluntary placement agreement, including what separation may mean for them. Preplacement service helps prepare the child for placement in a new environment, provides the Family with an understanding of what the placement may mean for them and the child, and prepares the Family for its role throughout the placement period.

(1) *Selection of an EPC home.* The EPC POC will ensure that the child and Family will be fully involved in selecting a home to the extent that they are willing and able to participate and to the extent that any home options are available. The Family will be encouraged to identify the general characteristics of EPC homes that might be appropriate for the child and to assist in making a smooth transition. Information about the child's and Family's legal rights and responsibilities and the mutual expectations of command's policies will be discussed and reviewed. Placement will be based on considerations outlined in appendix J.

(2) *Acceptance of a child.* The EPC Family will be helped to make an informed decision regarding their acceptance of a particular child. Consultation will occur with the EPC Family to evaluate the meaning and relevance of any information. The EPC Family will consider the strengths, needs, and general behavior of the child, the circumstances that necessitated placement, the information about the child's Family and relationship to their own Family that may affect the placement, and the important life experiences and relationships that may affect the child's feelings, behavior, attitudes, or adjustments.

b. Provisions for medical care of the child will be discussed. Natural parents will participate, if capable and

available, in plans for the medical care of the child, whether the placement is court committed or voluntary. Health assessments and any needed immunizations will be provided by a qualified health professional prior to placement or, in emergency situations, within 72 hours following placement. Parents who voluntarily place a child with EPC parents will provide a special power of attorney to the EPC parents authorizing routine medical care and hospitalization and access to medical records.

c. The Family's financial obligations for the child while in placement will be discussed and resolved. The costs of EPC are the individual responsibility of the parents whose child or children are placed in emergency care. The amount of payment is determined using CONUS State guidance or regulations, or, in the absence of these, by the OCONUS IMA or specific ACOM, ASCC, and DRU FAPM. ACS will pay EPC parents only when the CRC determines that—

(1) EPC is required for a case determined to be unsubstantiated-unresolved or substantiated child abuse or neglect in order to prevent further abuse or neglect or as part of an ongoing treatment program.

(2) Following a financial readiness assessment the parents or guardians of the child or children are financially unable to pay for the cost of such care. An assessment is not required for every Family needing the EPC program. (See para 3–2*e*(3).)

9–7. Service planning

a. DA Form 5192 (Family Identification Sheet for a Child Receiving Service), DA Form 5193 (Child's Face and Whereabouts Sheet), and DA Form 5195 (Health Data) will be completed to obtain background information essential to developing service planning agreements for each child and Family involved in emergency placement. A sample service planning agreement format and other required information are in appendix K. All parties with legitimate interest in the service delivery process will be actively involved in developing the service plan agreement and will sign the completed agreement. Interested parties include the FAPM and/or the chair of the CRC (usually the Chief, SWS), the child if appropriate, and the Family to the extent of their ability and desire to participate. Each child and Family will be given written and oral information to assure their participation as full partners in the service planning and delivery process. The information will include a description of the policies and procedures and the service planning process; an explanation of the role that each party is expected to play throughout the planning and service delivery process; and the client's rights and responsibilities with respect to service planning and delivery and achievement of long-range, permanent goals. An initial, written service plan will be developed within 7 days of the referral for placement by the FAPM or the Chief, SWS.

b. A joint conference will be held at least every week and at termination of service to review the service plan agreement. All individuals named in the service plan agreement will attend this conference. The purpose of this conferences will be to review the progress that has been made toward achieving the service plan's goals for the child and Family. The conference will assess the current appropriateness and adequacy of the plan, update the plan, agreement, and goal, as needed, and reaffirm the agreement. Termination of service conferences also will determine the outcome of services, assess the service process, and determine the need, if any, for follow-up or postplacement support.

9–8. Placement services

a. Placement services for the child will be designed to help the child express and cope with his or her feelings about being separated from the Family so that these feelings will not interfere with making the placement a constructive experience. Well-planned services also will be provided for the Family on a regular basis according to the service plan and established policies. Each Family will be recognized as unique. Services should be based on an assessment of each Family's strengths and limitations. A list of possible services is found in appendix J.

b. To ensure that EPC promotes the well-being of children in growth and development, the support given to the EPC parents will include periodic review of the placement, and also may include but not require—

(1) Special services for the children (for example, social work or psychological, psychiatric, and educational services).

(2) Additional time for EPC parents to help children cope with multiple problems.

(3) Social work assistance to natural parents in resolving the problems that made EPC necessary and helping natural parents resume their parental responsibilities. (If the return is not possible, see chapter 7 for making long-range plans for the children.)

(4) Consultation about the appropriateness of return for a limited time after the return of children to their own home or the home of relatives.

9–9. Termination and postplacement services

a. Termination of a placement will be anticipated as part of the service plan for the child and Family. Preparation for this event will begin as far in advance of the expected date of termination as possible. When practical, the EPC Family will have at least 48 hours notice prior to removal of the child. EPC POC will work with them and the child to make the transition as smooth as possible. EPC parents who request termination of placement will give at least a 1-week notice and will participate in planning for removal of the child from their home.

b. The plan following termination of a placement may be to place the child in his or her own home, in another EPC

home, in a CONUS civilian foster home, or in the home of a relative. The process outlined in paragraph 9–3 will be followed since relocation can be just as difficult for a child as a first placement. During the transition from one EPC Family to another living arrangement, special emphasis will be placed on adequate communication among the EPC Family, the parents, the child, the new caregivers, and the EPC POC. Services provided during the transition period will be designed to prepare all parties for the separation and to help them cope with their feelings about it.

c. Postplacement services will be planned to meet the individual needs of each child and the child's own Family. Postplacement services may be provided directly or transferred to a civilian foster care agency in CONUS when the situation warrants. Young adults who reach the age of majority and are no longer eligible for EPC Family postplacement services should be made aware of other services offered.

d. Postplacement services will be provided until services are no longer needed, the Family and/or child returns to CONUS, or services are terminated either by the court or by the parents who voluntarily placed their child.

e. Termination and postplacement services are listed in appendix J.

Appendix A
References

Section I
Required Publications

AR 25–55
The Department of the Army Freedom of Information Act Program. (Cited in paras 3–5*d*, 5–3*b*, and 6–4*e*.)

AR 190–30
Military Police Investigations. (Cited in paras 1–8*j*(2) and 3–21*a*.)

AR 195–2
Criminal Investigation Activities. (Cited in paras 1–7*m*(4), 1–8*k*(2), and 3–21*a*.)

AR 215–1
Morale, Welfare, and Recreation Activities and Nonappropriated Fund Instrumentalities. (Cited in para 8–6.)

AR 215–3
Nonappropriated Funds Personnel Policy. (Cited in paras 1–8, 8–5*k* and app I.)

AR 340–21
The Army Privacy Program. (Cited in paras 3–5*d*, 5–3, 6–2, 6–4, 6–5*c*, 6–6, 6–7, and 6–10*c*.))

AR 608–1
Army Community Service Center. (Cited in paras 1–7, 1–8, 2–3, 2–5*d*, 3–27*e*, 4–4*e*, 9–1*a*, and apps B–7*b* , L.)

AR 608–10
Child Development Services. (Cited in paras 1–8, 5–3*c*(5), 8–5*k*, and 8–6 and app I.)

AR 608–75
Exceptional Family Member Program. (Cited in paras 3–22*f*, 7–3*a*(3), and 7–7*a*(2).)

DA Pam 608–17
Instructions for Implementing Army Community Service Accreditation Program. (Cited in paras 1–7*c*(12), 2–6*e*, 2–7*h*, 3–16*d*, 3–16*d*(2)(*c*), 3–29*c*, 6–3*b*, and 6–4*d* and app B.)

DOD 6400.1–M
Family Advocacy Program Standards and Self-Assessment Tool. (Cited in paras 1–1, 1–7, 1–8, 2–3*a*(4)(d), 2–3*b*(2), 2–7*p*, 2–9*b*, 3–26*a*(1)(*c*), and B–6*a*.) (Available at www.dtic.mil/whs/directives.)

Section II
Related Publications

A related publication is a source of additional information. The user does not have to read the related publication to understand this publication.

AFARS Part 5137
Army Federal Acquisition Regulation Supplement. (Available at http://farsite.hill.af.mil/vfafara.htm.)

AR 11–2
Management Control.

AR 20–1
Inspector General Activities and Procedures.

AR 25–400–2
The Army Records Information Management System (ARIMS).

AR 27–10
Military Justice.

AR 27–40
Litigation.

AR 40–66
Medical Record Administration and Health Care Documentation.

AR 40–68
Clinical Quality Management.

AR 165–1
Chaplain Activities in the United States Army.

AR 190–40
Serious Incident Report.

AR 190–45
Law Enforcement Reporting.

AR 195–1
Army Criminal Investigation Program.

AR 210–50
Housing Management.

AR 360–1
The Army Public Affairs Program.

AR 550–51
International Agreements.

AR 570–4
Manpower Management.

AR 570–5
Manpower Staffing Standards System.

AR 600–8–2
Suspension of Favorable Personnel Actions (Flags).

AR 600–8–11
Reassignment.

AR 600–8–24
Officer Transfers and Discharges.

AR 600–20
Army Command Policy.

AR 600–37
Unfavorable Information.

AR 600–85
Army Substance Abuse Program (ASAP).

AR 601–280
Army Retention Program.

AR 614–30
Overseas Service.

AR 614–200
Enlisted Assignments and Utilization Management.

AR 635–200
Active Duty Enlisted Administrative Separations.

DOD 4515.13–R
Air Transportation Eligibility. (Available at http://www.dtic.mil/whs/directives.)

DODD 1030.1
Victim and Witness Assistance. (Available at http://www.dtic.mil/whs/directives.)

DODD 6025.13
Medical Quality Assurance (MQA) in the Military Health System (MHS). (Available at http://www.dtic.mil/whs/directives.)

DODD 6400.1
Family Advocacy Program (FAP). (Available at http://www.dtic.mil/whs/directives.)

DODEA Regulation 2050.9
Family Advocacy Program Process and Procedures for Reporting Incidents of Suspected Child Abuse and Neglect. (Available at www.odedodea.edu/foia/iod/pdf/2050_9.pdf.)

DODI 1030.2
Victim and Witness Assistance Procedures. (Available at http://www.dtic.mil/whs/directives.)

DODI 1342.24
Transitional Compensation for Abused Dependents. (Available at http://www.dtic.mil/whs/directives.)

DODI 1402.5
Criminal History Background Checks on Individuals in Child Care Services. (Available at http://www.dtic.mil/whs/directives.)

DODI 6400.3
Family Advocacy Command Assistance Team. (Available at http://www.dtic.mil/whs/directives.)

48 CFR, Chapter 1
Federal Acquisition Regulations System. (Available at http://www.gpoaccess.gov/cfr/.)

Child Abuse Manual
(Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

Family Advocacy Program (FAP)
(Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

Hot Heads of the House
(Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

Joint Travel Regulations
(Available at http://www.dtic.mil/perdiem.trvlregs.htm.)

Managing Out–of–Home Child Sexual Abuse: An Installation Handbook
(Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

Manual
Emergency Placement Care Army Resource Manual. (Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

Memorandum

MCM 2005
Manual for Courts-Martial United States (2005 Edition).
Subject: Guidelines for the Army New Parent Support Program, Headquarters, Department of the Army, March 2, 2001.

Memorandum
Subject: Policy Changes for Submitting Child and Spouse Abuse Information, Assistant Secretary of Defense (Force Management Policy), August 22, 1997. (Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

Memorandum
Subject: Standards for the New Parent Support Program, Headquarters, Department of the Army, August 2001. (Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

M.R.E. 305, 314(i), 315, 501(b), 502, 503, 507, 513
(Military Rules of Evidence are found within the Manual for Courts-Martial United States (2005 Edition))

Prevention Services for New Parents Implementation Guidelines
(Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

R.C.M. 103(17), 302, 303, 304, 305, 306(b)
Rule for Courts-Martial. (Available in the Manual for Courts-Martial United States (2005 Edition.)

Spouse Abuse Manual
(Available from the Assistant Chief of Staff for Installation Management, ATTN: CFSC–FP–A, 4700 King Street, Alexandria, VA 22302–4418.)

1 USC 112b
United States international agreements; transmission to Congress. (Available at www.gpoaccess.gov/uscode/index.html.)

5 USC 552
Public Information; agency rules, opinions, orders, records, and proceedings. (Available at www.gpoaccess.gov/uscode/index.html.)

5 USC 552a
Records about individuals. (Available at www.gpoaccess.gov/uscode/index.html.)

10 USC Chapter 47
Uniform Code of Military Justice. (Available at www.gpoaccess.gov/uscode/index.html.)

10 USC 1791
Funding for military child care. (Available at www.gpoaccess.gov/uscode/index.html.)

18 USC 13
Laws of states adopted for areas within Federal jurisdiction. (Available at www.gpoaccess.gov/uscode/index.html.)

18 USC 5001
Surrender to State authorities; expenses. (Available at www.gpoaccess.gov/uscode/index.html.)

20 USC 1400
Congressional statements and declarations. (Available at www.gpoaccess.gov/uscode/index.html.)

42 USC 5101
Office on child abuse and neglect. (Available at www.gpoaccess.gov/uscode/index.html.)

Section III
Prescribed Forms

The following forms are available on the Army Electronic Library CD—Rom and the APD Web site (www.apd.-army.mil) unless otherwise stated.

DA Form 5192
Family Identification Sheet for a Child Receiving Service. (Prescribed in para 9–7*a*.)

DA Form 5193
Child's Face and Whereabouts Sheet. (Prescribed in para 9–7*a*.)

DA Form 5195
Health Data. (Prescribed in para 9–7*a*.)

DA Form 7214
Applicant Acknowledgement of Employer Obligation. (Prescribed in para 8–5*e*.)

DA Form 7215
Release/Consent Statement. (Prescribed in para 8–5*e*.)

DA Form 7317
Child Abuse/Safety Violation Hotline Intake Information. (Prescribed in para 8–18*c*.)

DA Form 7317–1
Child Abuse/Safety Violation Hotline Seven-Day Follow-up Information. (Prescribed in para 8–18*d*.)

DA Form 7317–2
Child Abuse/Safety Violation Hotline 90–Day Follow-up Information. (Prescribed in para 8–18*f*.)

DA Form 7318
Initial Report of Child Abuse in DOD-Operated or Sanctioned Activities. (Prescribed in para 8–10*a*.)

DA Form 7318–1
Follow-up/Interim Report of Child Abuse in DOD-Operated or Sanctioned Activities. (Prescribed in para 8–10*c*.)

DA Form 7318–2
Closeout Reports for Reports of Child Abuse in DOD-Operated or Sanctioned Activities. (Prescribed in para 8–10*d*.)

DA Form 7517
DA Child/Spouse Abuse Incident Report. (Prescribed in paras 1–7*c*(9)(*c*) and 2–4*c*.)

Section IV
Referenced Forms

DA Form 2028
Recommended Changes to Publications and Blank Forms

DA Form 3444
Terminal Digit File for Treatment Record (Orange)

DA Form 3881
Rights Warning Procedure/Waiver Certificate

DA Form 5440–28
Delineation of Privileges—Social Work

DA Form 7419–R
Army Community Service (ACS) Accreditation Checklist

PS Form 3811
Postal Services Return Receipt.

SF 600
Chronological Record of Medical Care. (Available at http://www.gsa.gov.)

Appendix B
Family Advocacy Program Standards

B–1. Organization and management

a. The installation has implemented written policies and procedures in accordance with this regulation. Any definition used must comply with regulatory definitions.

b. The installation/garrison commander has appointed and implemented an FAC and a CRC in accordance with this regulation.

c. The installation FAC ensures that written policies and procedures exist that outline the responsibilities to be carried out in incidents of alleged child or spouse abuse:

(1) When indicated, medical assessment and treatment for all Family members in the household by medically trained personnel.

(2) Notification of the Soldier's commander per this regulation.

(3) Notification of military law enforcement and investigative agencies per this regulation.

(4) Notification of the local public Child Protection Services agency (in alleged child abuse cases only) in the United States and where covered by agreements overseas.

(5) Observance of the applicable rights of both alleged victims and offenders.

d. A requirement and authorization exist for an installation FAPM on the TDA, and the commander has made written appointment of a designated individual to implement the FAP.*

e. The installation FAC has developed and evaluated measurable program outcomes in accordance with DA FAP outcomes (self-sufficiency, safety, community cohesion, and personnel preparedness).

f. The installation FAC has established an FAP plan with specific objectives, needs, and strategies in accordance with this regulation.

g. The installation FAC demonstrates efforts to promote cooperation among civilian and/or military authorities to reduce child and spouse abuse rates.

h. The FAP coordinates and collaborates with military installations to provide cost-effective services.

i. The installation/MTF commanders provide FAP personnel with housing and equipment suited to the delivery of FAP services.

j. All purchase of service contracts or agreements with a civilian agency, organization, or individual comply with Part 37, Title 48, Code of Federal Regulations (Federal Acquisition Regulations) and Part 5137 of the Army Federal Acquisition Regulation Supplement.*

k. The installation provides an annual report to DA.*

B–2. Prevention and education

a. The installation has written criteria and priorities for installation FAP prevention activities.

b. The installation FAP conducts a community needs assessment at least every 3 years in accordance with this regulation.

c. The installation FAP has developed and implemented, in accordance with the prevention plan, education programs for the community.

d. The installation commander ensures provision of education for all unit commanders.

e. The installation commander ensures all newly assigned installation personnel receive an orientation to the FAP, available Family support services, and installation FAP policies.

f. The installation commander ensures provision of education on identifying and reporting suspected child and spouse abuse for personnel, contractors, and volunteers who work with or around children.

g. The installation commander ensures provision of education on the FAP and on identification, reporting, and intervention in child and spouse abuse to installation law enforcement, legal, and medical personnel.

h. Activities and services provided through the NPSP–Standard component are available to all eligible Families with child(ren) prenatal to 3 years old, whether they live on or off the installation. Activities include information and referral to military and civilian programs that support parents of infants and young children such as parenting programs, respite care for children, and supervised playtime for children.

i. Activities and services provided through the NPSP–Plus component are available to those identified Families with child(ren) prenatal to 3 years old that have been identified as being at-risk for child maltreatment and/or Family violence. Families participating in the NPSP–Plus component are assessed for risk of child maltreatment and Family violence on a continuing basis in accordance with Army policies contained in HQDA Memorandum, Subject: Guidelines for the Army New Parent Support Program, March 2, 2001.

* Program standards marked with an asterisk are key management controls.

B–3. Investigation and assessment of the complaint

a. The installation commander has designated a 24-hour RPOC to receive reports of alleged child or spouse abuse.

b. Mandated personnel report suspected child and spouse abuse to the FAP.

c. The installation law enforcement ensures FAP receives the incident reports of child and spouse abuse. The installation FAP has access to the installation law enforcement blotter. Installation law enforcement agencies request reports of child and spouse abuse involving military Families from local law enforcement and provide them to the FAP.

d. Installation law enforcement and MTFs develop and follow written protocols for responding to suspected child and spouse abuse incidents.

e. Installations initiate the assessment of alleged abuse incidents in a timely manner.

f. The installation FAP ensures that during the period of investigation and assessment of suspected child abuse the child's Family is provided with sufficient monitoring and immediate support. This is to ensure adequate protection of the child victim(s) and sibling(s) if they are remaining in the parent's or guardian's home or the home of others acting in loco parentis.

g. The installation complies with written policies and procedures in this regulation for protection of victims of spouse abuse.

h. The installation complies with written policies and procedures in this regulation for assessing FAP cases. A clinically privileged professional conducts the assessment. The assessment includes, but is not limited to, the following:

(1) Background checks of previous abuse incidents recorded in the ACR, law enforcement, FAP, and medical records.

(2) Reports of any law enforcement investigations.

(3) Information obtained from collateral contacts (for example, schools, child development centers, and so on).

(4) Interviews with the alleged offender, victim(s), other members of the household, and witnesses, if indicated.

(5) Assessment of the current presenting problems.

(6) Assessment of the functioning of the alleged offender, caretaker(s), victim(s), or other members of the household.

(7) Assessment of the medical findings and history of the victim, alleged offender, and other members of the household, if indicated.

(8) Assessment of the severity of abuse and previous child and spouse abuse incidents.

(9) Assessment of the risk for future abuse.

(10) Assessment of the need for protection of the victim to include, in child abuse cases, the ability of the nonoffending parent to protect and support the child.

(11) Assessment of which clinical, educational, and support services are indicated for the case.

(12) History of spouse and child abuse (witnessed/experienced).

(13) History of substance abuse.

(14) History of mental health treatment (suicidal/homicidal).

(15) History of criminal activity.

(16) Identification of weapons in the home.

(17) Current Family stressors (in other words, financial problems, PCS/ETS moves, deaths and births in the Family, divorce/separation, medical issues, and so on).

(18) History of medical illness.

i. The installation commander ensures all individuals interviewing children for investigation are trained. Training includes—

(1) Interviewing the child as the primary source of information on an age-appropriate basis.

(2) Interviewing the child in a child-centered environment and not in the presence of the alleged offender.

(3) Avoiding the necessity of subjecting the child to multiple interviewing.

j. The installation complies with this regulation, which specifies how a child victim and other children in the victim's household are interviewed by FAP clinical personnel. These include provisions for the following:

(1) Interviewing the child as the primary source of information on an age-appropriate basis.

(2) Collecting information from a child in a manner to protect the child's right to privacy.

(3) Interviewing the child in a child-centered environment and not in the presence of the alleged offender.

(4) Avoiding the necessity of subjecting the child to multiple interviewing.

(5) Ensuring that interviews are conducted by a clinically privileged professional.

(6) Ensuring that the child's statements and written assessments are placed in victim's FAP/CRC case file and protected from release to either parents or guardians (offending or nonoffending) unless ordered for release by the courts.

k. The installation complies with DA policies and procedures contained in this regulation for interviewing victims of spouse abuse, including provisions for the following:

(1) Collecting information from the victims, minor children, and witnesses in such a manner as to protect their right to privacy and safety.

(2) Interviewing is not conducted in the presence of the alleged offender.

(3) Interviewing any minor children in the household.

(4) Ensuring that the victim's statements and written assessments are placed in the victim's FAP/CRC case file and protected from release to the alleged offender unless ordered for release by the courts.

B–4. Intervention and treatment of abuse and neglect cases

a. The installation commander has written policies, procedures, and criteria for the removal of the alleged offender (or other involved persons, as appropriate) from the home.

b. The installation commander has written policies, procedures and criteria for the removal and return of the child victim(s) of abuse or other children in the household when in danger of continued abuse or life-threatening neglect by the offender(s). This is done consistent with applicable laws governing protective custody and includes instructions for safe transit of the child (both CONUS and OCONUS).

c. The installation commander has written policies and procedures for shelter/safe-home referral for victims of spouse abuse. Policies address safety, confidentiality, and the right of the victim to make the decision.

d. Cases will be brought to the CRC within 30 days, unless otherwise documented.

e. To protect victims and prevent further incidents of abuse, installation complies with DA written policies and procedures in this regulation for multidisciplinary CRCs. These include, but are not limited to, the following:

(1) Incident status determination.

(2) Case management.

(3) Intervention recommendations based on assessment as defined in paragraph B–3k.

(4) Case review.

(5) Case closure.

f. CRC intervention recommendations consider educational, clinical, and support services.

g. The installation complies with DA policies and procedures for case closure contained in this regulation. The CRC considers at least the following in making case closure decisions:

(1) Current risk assessment.

(2) Progress or failure to progress in meeting intervention objectives.

(3) Involvement of the Family and/or client in the decision-making process.

(4) Consultation with other agencies and professionals involved in the case.

(5) Consideration of necessary community supports and referrals.

h. In conducting the assessment and determining risk, recantation by the victim is not, in and of itself, used to conclude that the incident did not occur.

i. The installation complies with this regulation for the case management of out-of-home child abuse.

j. When making a level of intervention determination, the CRC uses the matrix of the CHAM and SPAM.

k. EPC provides temporary substitute care that ensures a child's welfare when the natural Family or legal guardian cannot meet that responsibility. EPC may be a voluntary or court-mandated placement providing 24-hour care in an emergency care Family home. The Army EPC Program is used at Fort Knox and primarily in OCONUS areas and is intended to provide short-term care for Families in crisis until the situation causing placement is resolved or until longer-term care or placement can be arranged at a CONUS location. If EPC services are available and accessible through the local civilian authority, these services must be used in accordance with locally established MOAs.

B–5. Case accountability

a. The installation complies with policies and procedures contained in this regulation that establish a file maintenance system.

b. In order to promote prompt intervention in abuse incidents, the installation commander ensures that the CRC reviews every report of abuse and determines a plan for intervention in accordance with this regulation.

c. The installation complies with policies and procedures contained in this regulation for case management and case records.

d. The installation complies with DA policies and procedures contained in this regulation on the transfer of cases to ensure continuity of service.

e. The installation complies with DA policies and procedures contained in this regulation that ensure sharing of information with individuals or military or civilian organizations.

f. The installation complies with DA policies and procedures contained in this regulation that govern who will have access to central registry information.

g. Installation complies with DA policies and procedures contained in this regulation for reviewing contested CRC incident status determinations.

B–6. Family advocacy program staffing

a. The FAP complies with the requirements of DOD Directive 6400.1, DOD 6400.1–M, and this regulation for the roles, functions, and responsibilities of FAP personnel.

b. The installation FAPM will meet the following minimum qualifications:

(1) *Education.* Master's degree in one of the following fields:

(a) Social work.

(b) Psychology.

(c) Marriage, Family and child counseling.

(d) Counseling.

(e) Public administration or public health.

(2) *Credentialing.* Not necessary. If clinical supervision is a requirement of the position, qualifications specified in *c*, below, apply.

(3) *Experience.* Minimum of 5 years of postgraduate experience in community organization or management. At least 2 of the last 5 years in programs dealing with Family violence issues.

c. The clinical supervisor of clinical FAP personnel has the following minimum qualifications:

(1) *Education.* Master's degree in social work or doctorate in clinical psychology.

(2) *Credentialing.* Licensure in accordance with DOD Directive 6025.13. Clinically privileged in accordance with AR 40–68 (DA Form 5440–28 (Delineation of Privileges—Social Work)).

(3) *Experience.* Minimum of 4 years of postgraduate experience, including 2 of the last 4 years of clinical experience in Family violence.

d. Clinical assessment and intervention are provided by a clinically privileged provider. Those professionals providing assessments and treatment services have the following minimum qualifications:

(1) *Education.* Master's degree in social work or doctorate in clinical psychology.

(2) *Credentialing.* Licensure in accordance with DODD 6025.13. Clinically privileged in accordance with AR 40–68 (DA Form 5440–28).

(3) *Experience.* Minimum of 2 years of postgraduate clinical experience, including 1 of the last 2 years in Family violence.

e. Minimum qualifications for FAP practitioners providing education and prevention services and for social service assistants are as follows:

(1) *Education.* Bachelor's degree in one of the following fields:

(a) Social work.

(b) Psychology.

(c) Marriage, Family, and child counseling.

(d) Counseling or behavioral science.

(e) Education.

(f) Community health or public health.

(2) *Experience.* Minimum of 2 years of experience in Family and children's services or community organization, 1 year of which is in Family violence.

(3) *Supervision.* Must be supervised in accordance with this regulation, as applicable.

f. The minimum qualifications for FAP victim advocate coordinators are as follows:

(1) *Education.* Bachelor's degree in one of the following fields:

(a) Social work.

(b) Psychology.

(c) Marriage, Family, and child counseling.

(d) Counseling or behavioral science.

(e) Education.

(f) Community health or public health.

(2) *Experience.* Minimum of 2 years of experience in domestic violence victim advocacy.

(3) *Supervision.* Must be supervised in accordance with this regulation, as applicable.

g. The installation FAP personnel require installation background/records checks in accordance with this regulation (MP, ACR, Drug and Alcohol).

B–7. Program planning and evaluation

The installation complies with DA-directed reports for collection and analysis of information to be used for program planning, administration, interpretation, evaluation, and funding of FAP services.*

Appendix C
Guidelines

Section I
Incident severity index and standards of care for referral, determination, and treatment of child abuse

C–1. Incident severity index
The incident severity index displayed in table C–1 describes the conditions that constitute a mild, moderate, or severe incident of spouse or child abuse.

Table C–1
Incident severity index

Type	Mild	Moderate	Severe
Child physical maltreatment	An incident that resulted in minor injury *and risk of further harm*.	An incident (or ongoing pattern of incidents) that does not meet the criteria of mild or severe.	An incident or ongoing pattern of incidents that resulted in serious injury or substantial negative effect on development, threat of death, serious impairment, loss of function, or death.
Child sexual maltreatment	(none)	(none)	Any incident
Child neglect	An incident that resulted in minor pain, minor emotional harm, or threat to the child's welfare *and the child is at risk for continued maltreatment.*	An incident (or ongoing pattern of incidents) that does not meet the criteria of mild or severe.	An incident or ongoing pattern of incidents that resulted in serious injury, serious emotional harm, substantial negative effect on development, serious impairment, life-threatening situation, or death.
Child emotional maltreatment	A pattern of incidents that resulted in minor emotional harm.	A pattern of incidents that do not meet the criteria of mild or severe.	A pattern of incidents that resulted in serious emotional or psychological harm.
Spouse/partner maltreatment	An incident that resulted in minor physical injury or emotional harm *and risk of further harm*.	An incident or ongoing pattern of incidents that do not meet the criteria of mild or severe.	An incident or ongoing pattern of incidents that resulted in serious injury, chronic interference with personal liberty, serious impairment, or death.

C–2. Referral
All reports of child abuse and neglect will be assessed.

C–3. Assessment
a. The following must be completed within 24 hours after receiving a report of child abuse/neglect:

(1) The social worker will evaluate the victim using the child abuse risk evaluation guidelines of the CHAM. In sexual abuse cases, the MTF social worker, CID, and a CPS worker will conduct a joint evaluation (in CONUS).

(2) A physician will review the victim's medical records and perform a medical evaluation.

(a) In child physical and sexual abuse, the examining physician should consult with a pediatrician at the time of the examination.

(b) The attending physician will coordinate with SWS prior to discharging or releasing the child.

(3) The MTF social worker will notify the alleged military offender's unit commander, senior enlisted adviser, or civilian supervisory equivalent of the following:

(a) The incident.

(b) The protection plan.

(c) That SWS will follow up with the command to ensure compliance with the protection plan.

(4) Local CPS will be notified immediately upon receipt of a child abuse/neglect referral.

b. The following must be completed within 72 hours after receiving a report of child abuse/neglect:

(1) The MTF social worker will contact the appropriate law enforcement agency, who will provide a rights advisement to the suspected offender. The social worker will document in the Family case file that the law enforcement agency was notified and that the rights advisement was conducted.

(2) The interviewing social worker will ensure that the suspected offender is advised of the evaluation process and the limits of confidentiality and will document such in the case file.

(3) The MTF social worker will complete a parental/caretaker and Family assessment.

c. The following will be completed within 7 days after receiving a report of child abuse/neglect:

(1) The MTF social worker will query the ACR for prior Family advocacy reports.

(2) The MTF social worker will contact every collateral organization involved in the case (for example, the police, school, childcare center, community health nurse, and so on) and obtain any pertinent information and documentation.

C–4. Determination

a. The CRC initial and review case presentations will be completed using a standardized case presentation format. (See fig C–1 for the initial case presentation format and fig C–2 for the review case presentation format.)

b. The unit commander or civilian supervisory equivalent of active duty Soldiers will be invited to attend the case presentation of his or her Soldier.

c. In the CRC case determination process—

(1) A majority vote is required to determine that the pertinent facts substantiate a case. The case determination and treatment recommendations will be recorded in the CRC minutes.

(2) A quorum (two-thirds) of the CRC members, including the chairperson on orders, must be present to vote on case determinations. In determining whether a quorum exists, commanders and/or their representatives that are not located within a 50-mile radius of the installation and are unable to attend CRC meetings will be excluded from the calculations.

C–5. Treatment

a. The intervention format must be problem based and goal oriented.

(1) Problem based: each identified problem must be adequately defined.

(2) Goal oriented: each element of the treatment plan must address an identified problem.

b. The social worker will use the child abuse intervention guidelines (CHAM) to determine the specific intervention services needed.

Section II
Child abuse safety risk assessment

C–6. Description of injury

a. Severe physical and/or sexual abuse. (Refer to the child abuse evaluation guidelines in CHAM.)

b. Evidence of repeated and/or frequent abuse.

c. Recurring abuse after initial report and intervention.

d. Child less than 3 years old with physical abuse.

C–7. Family characteristics

a. Child behavior toward the parent that is unduly provocative or obnoxious.

b. Child extremely afraid to return home.

c. Parental characteristics include:

(1) Current psychiatric dysfunction.

(2) Substance abuse history.

(3) Violent criminal history.

(4) Parents persistently refuse intervention and treatment services.

d. Multiple ongoing crises, to include—

(1) Chaotic/dysfunctional Family.

(2) Health problems.

(3) Infidelity.

(4) Separation/deployment/PCS/retirement.

(5) Financial problems.

(6) Lack of social support systems.

Note. The presence of any of the above increases the likelihood of reinjury.

Section III
Guidelines for standards of care for referral, assessment, and treatment of spouse abuse and the spouse abuse safety risk assessment

C–8. Referral

All reports of spouse abuse will be assessed.

Each initial case presentation must include the following:

1. Name of the victim.
2. Case file name.
3. Case number.
4. Date case received.
5. Type of allegation.
6. ACR check.
7. Alcohol and Drug involvement (yes/no).
8. Date of presenting incident.
9. Date of command contact/response, unit, commander/first sergeant.
10. Involvement of MP, CID, civilian police, CPS (yes/no).
11. Children present (yes/no) (names and ages).
12. Description of presenting events.
    a. Client's definition.
    b. Case manager assessment.
    c. Results of collateral contacts.
    d. Results of evaluation referrals.
13. Present suicide/homicide ideation (yes/no) and plan.
14. Medical records review.
15. History of family violence.
    a. History of alcohol and drug abuse.
    b. Administrative actions (yes/no).
    c. Length of present relationship.
    d. Level of education.
    e. Abuse in family origin.
    f. Emotional/psychological problems.
    g. Number of previous marital relationships.
    h. Any weapons in the home.
16. General appearance.
    a. Thought.
    b. Eye contact.
    c. Mood.
    d. Other evaluations/observations (in other words, affect, attitude, and so on).
17. Risk (low, moderate, high) of threat to life.
    a. Strengths.
    b. Problems.
18. Case manager assessment to include imminent risk and potential for risk (risk factors).
19. Recommendation to CRC.
    a. Substantiated.
    b. Unsubstantiated–unresolved, unsubstantiated–did not occur, or voluntary services recommended.
    c. Level of substantiation: mild, moderate, or severe.
20. SPAM/CHAM level of treatment: I, II, III, IV, or V (according to DOD 6400.1–M).
21. Treatment recommendations.
    a. Problems.
    b. Recommended treatment.
    c. Date of completion.
    d. Remarks/changes.
22. PCS/ETS date.
23. Date of presentation, name of presenter, and date of review.
24. Commander/first sergeant present (yes/no).
25. Signature.

Figure C–1. Family advocacy initial case presentation format

Each review case presentation must include the following:

1. Case number/case manager.
2. Presenting events and CRC case determination (to include date of determination).
3. Present any clinically pertinent events (since initial case presentation).
4. Review of treatment plan accomplishments by problem and goal (include level of participation and professional assessment).
5. Recommendations for further action/options:
   a. Continue with current treatment plan.
   b. Monitor.
   c. Revise treatment plan.
   d. Close case.
6. Date of next review.

Figure C–2. Family advocacy review case presentation format

C–9. Assessment

a. The following must be completed within 24 hours after receiving a report of spouse abuse:

(1) The social worker will evaluate the victim using the spouse abuse assessment guidelines in SPAM. The social worker will document referrals to shelters, safety issues with victim and safety plan for children, if indicated. If the victim refuses to be seen, the social worker will document the attempt and the victim's refusal in the Family advocacy case file.

(2) A physician will perform a medical examination on the victim. If the victim refuses a medical examination, the social worker will annotate the refusal in the Family advocacy case file.

(3) A physician will review the victim's medical record for prior spouse abuse incidents.

(4) The social worker will notify the alleged offender's commander, senior enlisted adviser, or civilian equivalent supervisor of the following:

(a) The incident.

(b) The protection plan.

(c) Information regarding possession of weapons, if available.

(d) That SWS will follow up with the command to ensure compliance with the protection plan.

b. The following must be completed within 72 hours of receiving a report of spouse abuse:

(1) The social worker will conduct an assessment of psychological or physical harm of any children residing in the home using the child abuse assessment guidelines in CHAM.

(2) The social worker will assess the potential for reinjury using the spouse abuse risk assessment guidelines in SPAM.

(3) The social worker will advise the abuse victim of his or her resources (such as available victim advocates, location of shelters, and availability of legal advice).

(4) The social worker will query the ACR for prior substantiated cases of domestic violence.

c. Within 7 days of receiving a report of spouse abuse, the social worker will query every collateral organization involved in the case (such as the military police) and obtain any pertinent information and documentation.

C–10. Determination

a. The CRC initial and review case presentations will use a standardized case presentation format. (See figs C–1 and C–2.)

b. The unit commander or civilian supervisory equivalent of active duty Soldiers will be invited to attend the CRC case presentation of his or her Soldier.

c. In the CRC case determination process:

(1) Characterizing a new case as "substantiated" requires a majority vote. The case determination (substantiated or unsubstantiated) along with pertinent facts and treatment recommendations will be recorded in the CRC minutes.

(2) A quorum (two-thirds) of the CRC members, including the chairperson on orders, must be present in order to make a determination. In determining whether a quorum exists, commanders and/or their representatives that are not

located within a 50-mile radius of the installation and are unable to attend CRC meetings will be excluded from the calculations.

C–11. Treatment

a. The intervention format must be problem based and goal oriented.

(1) Problem based: each identified problem must be adequately defined.

(2) Goal oriented: each element of the treatment plan must address an identified problem.

b. The intervention program will comply with SPAM guidelines.

C–12. Content of spouse abuse safety risk assessment

a. Lethality of injury (refer to the spouse abuse evaluation guidelines in SPAM).

b. History of injuries (progressive in severity and frequency).

c. Involvement of lethal weapons/objects.

d. Occurrence during pregnancy.

e. Significant substance abuse/binge drinking.

f. Maintenance of rage after altercation.

g. Offender witnessed domestic violence in childhood.

h. Victim/offender abused as a child.

i. Criminal/UCMJ history.

j. Family medical problems.

k. Current stressors (financial, medical, recent deaths/births, recent moves, pending moves, lack of systems).

l. History of behavior involving verbal or physical threats toward person(s) outside the Family.

m. Threat of abandonment of abuser by victim.

n. Alleged offender in denial and not taking responsibility for actions.

o. Alleged offender threatening children or threatening to take children.

p. Alleged offender has prior history of mental health diagnosis or treatment.

q. Alleged offender engaged in stalking behavior.

r. Unemployed abuser.

Section IV
Domestic violence awareness workshops outline

C–13. Introductions

a. Instructors: background and experience.

b. Participants: where they are from, current job, previous job, something they are good at doing, how they feel and what they think about being here, and how they learned about domestic violence awareness workshops (DVAWs).

C–14. Information

a. SWS programs-what we do and how.

b. Acronyms (CRC, DSS, ACS, DVAW, and so on).

c. Quiz on Family violence.

d. Film on spouse abuse (*Hot Heads of the House* or alternate) and discussion.

C–15. Dynamics of Family violence

a. Definition.

b. Types of abuse.

c. Facts and statistics (child and spouse).

d. Characteristics of an abuser (child and spouse).

e. Characteristics of a victim (child and spouse).

f. Cycle of violence (spouse).

g. Perpetration of violence (child): by whom, when and how managed, effects, complicity.

h. Learned behavior: how, when, results.

i. Why women/men stay in an abusive relationship.

j. Time out: use and misuse.

k. Power and control issues.

l. Film on child abuse and discussion.

m. Effects of battering on children.

(1) Discipline vs. punishment.

(2) Alternate methods of discipline.
n. Review answers to quiz on Family violence.
o. Resources: installation (ACS, SWS, chaplain programs, and so on) and community (men's center, shelter).

C–16. What's next?

a. ACS.
b. Couples.
c. Individual.
d. Family counseling.
e. Group counseling/support groups.
f. Questions.

Section V
Violence management program

C–17. Content

a. Types of abuse.
b. Time-out.
c. Feelings about being here.
d. How we learn about violence.
e. Total behavior basic/genetic needs.
f. Victim's experience.
g. Abuser's experience.
h. Battering cycle of abuse.
i. Triggering actions.
j. Power and control issues.
k. Emotional abuse.
l. Intimidation.
m. Isolation.
n. Economic issues.
o. Emotional abuse.
p. Film.
q. Power and control issues.
r. Using male privilege.
s. Threats.
t. Children.
u. Sexual abuse.
v. Cultural values and beliefs.
w. Control behavior: do log.
x. Stress management.
y. Anger control.
z. Effective communication triggers.
aa. Anger talk up/anger talk down.

C–18. Handouts and audiovisuals

a. Group agreement.
b. Confidentiality statements.
c. Time-out agreement/no-violence contract.
d. Types of abuse (definition).
e. Personality test, stress test, anger log.
f. Film.
g. Anger/scale violence.
h. Awareness packet behavior.
i. Checklist self-evaluation.
j. Control behavior log.

Appendix D
Legal and Jurisdictional Considerations

D–1. Types of legislative jurisdiction

In the United States, there are generally three types of legislative jurisdiction existing on Army installations. Some installations have different types of legislative jurisdiction applying to different geographic areas of the installation. These three types are—

a. Exclusive Federal legislative jurisdiction. This exists in situations where the Federal government has all of the authority that the State would otherwise have to legislate within the land area in question. The State usually reserves the right to serve judicial process on the installation for acts or omissions occurring off the installation, but generally the State can exercise no authority over the installation. However, State criminal laws apply to those on the installation, not as violations of State law, but rather, as violations of Federal law under the Assimilative Crimes Act (18 USC 13). Prosecution can occur in either a Federal district court or Federal magistrate court, or under the UCMJ (if the accused is military), and the decision whether or not to prosecute is made by Federal, not State, officials. State civil laws generally apply to persons on the installation, but those State civil laws requiring enforcement by State officials (for example, child protection laws) only apply to the extent that Federal laws and military regulations do not conflict with State law (see para D–2) and the installation commander invites the State authorities, by agreement or otherwise, to exercise their authority on the installation. Most Army installations in the United States are under exclusive Federal legislative jurisdiction.

b. Concurrent legislative jurisdiction. This exists in situations where the State and Federal government concurrently exercise all of their legislative jurisdiction over the land area in question. State criminal and civil laws apply to those on the installation and, to the extent that there is no interference with the Federal function or military mission (see para D–2), may be enforced by State officials in State courts. Federal officials also may exercise the same authority that may be exercised on installations under exclusive Federal legislative jurisdiction.

c. Proprietary interest. This exists in situations where the Federal government, by lease, easement, purchase, or similar method, has acquired some degree of ownership or right to use the land area or buildings in question, but has not obtained any legislative authority over the land by virtue of that acquisition. As with concurrent legislative jurisdiction, State criminal and civil laws apply to those on the installation. The Assimilative Crimes Act does not apply, and violations of State law may only be enforced in State courts. As with other types of legislative jurisdiction, criminal acts by Soldiers may be punished under the UCMJ.

D–2. Federal supremacy

a. Article VI of The United States Constitution, provides that the "Constitution, and the Laws of the United States which shall be made in Pursuance thereof shall be the Supreme Law of the Land, and the Judges in every State shall be bound thereby, anything in the Constitution or Laws of any State to the Contrary notwithstanding."

b. Regardless of the type of legislative jurisdiction involved, military personnel generally are not subject to State criminal laws or civil laws (in other words, liability for civil damages) for acts done within the scope of their duties, whether occurring on or off the installation, because of the so-called 'Federal Supremacy' doctrine.

c. The Federal Supremacy doctrine does not protect commanders and military personnel from the application of State criminal and civil laws for acts done outside the scope of their military duties and affords no protection to Family members or other civilians residing on or visiting the installation.

Appendix E
Memorandum of Agreement

E–1. Child Protective Services Memorandum of Agreement

Figure E–1 provides a sample format of an MOA regarding matters involving the abuse of children of military Families.

E–2. Domestic violence Memorandum of Agreement

Figure E–2 provides a sample format of an MOA coordinating civilian and military response to domestic violence involving Soldiers and Family members.

1. Purpose.
This agreement establishes written procedures to integrate the exercise of jurisdiction vested in (Simpson County) and (Fort Green) authorities in matters involving the abuse of children of military families.

2. General.
This agreement does not purport to create additional jurisdiction or to limit or modify the existing jurisdiction vested in the parties. This agreement supersedes all previous agreements between (Simpson County) juvenile authorities and (Fort Green) pertaining to child abuse and misconduct.

3. Authority.
The State of (Kansas), through the (Simpson County) juvenile authorities and under the authority granted by (12 Kansas statutes, Section 2113), is responsible for the protection of abused children within (Simpson County). The commanding general, (Fort Green), by virtue of his inherent authority as commander, and through the specific authority granted to him under the Army Family Advocacy Program (Army regulation 608–18) is responsible for the protection of abused children of military families within his command as well as for maintaining law, order, and discipline on the installation. The commanding general's authority to provide protection for children of military families is limited, however, by the lack of a Federal judicial framework in which the status of children can be adjudicated and in which appropriate, judicially managed remedies can be mandated. (Fort Green) therefore, relies upon the (Simpson County) Juvenile Court to exercise its authority, where necessary, in cases of abused children of military families. The exercise of the Court's jurisdiction in cases of child abuse arising on the installation is supported by congressional deference to and reliance upon State child-related statutes (see, for example, The Child Abuse Prevention and Treatment Act, 42 USC 5101; The Education for All Handicapped Children Act of 1985, 20 USC 1400; and The Correction of Youthful Offenders Act, 18 USC 5001), and by developing case law that upholds the exercise of State civil jurisdiction within areas of exclusive Federal legislative jurisdiction, where that exercise of State authority, as is contemplated by this agreement, will not undermine Federal sovereignty.

4. Definitions.
For the purpose of this agreement, the following definitions apply:

a. The (Simpson County) Juvenile Court, hereinafter referred to as the 'Court,' is the court empowered with original jurisdiction to adjudicate child abuse cases in (Simpson County).

b. The (Simpson County) Department of Child Protective Services, hereinafter referred to as CPS, is the agency primarily responsible for the intake, investigation, and management of child abuse cases in (Simpson County).

c. Social Work Service, hereinafter referred to as SWS, is the agency of the (Fort Green) Medical Treatment Facility that is responsible for the intake investigation and management of on-post child abuse and certain military-related incidents and for the collection of information pertaining to off-post child abuse.

d. The Family Advocacy Program, hereinafter referred to as the FAP, is an Army program established by Army regulation that is designed to promote the growth, development, and general welfare of children of Army families by coordinating human services provided to such children and by interceding on their behalf when necessary.

e. The (Fort Green) Case Review Committee, hereinafter referred to as the CRC, is a multidisciplinary team appointed and supervised by the MTF commander to handle cases of military children and families where the children have been, or are suspected to be, abused. The CRC will be the receiving agency for all on-post child abuse cases.

f. The Provost Marshal, hereinafter referred to as the PM, coordinates all law enforcement activity on (Fort Green) and is primarily responsible for investigating crimes involving child abuse on the installation. The PM coordinates such investigations with the U.S. Army Criminal Investigative Command and Federal and State law enforcement authorities, as appropriate.

g. The PM serves as the report point of contact, hereinafter referred to as the RPOC, for (Fort Green) and receives all reports of child abuse occurring on or off post. The RPOC notifies all agencies required to be notified by regulation and this memorandum of agreement (MOA).

h. Child abuse includes child sexual abuse and child neglect and means the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare—including any employee of a residential facility or any staff person providing out-of-home care—under circumstances that indicate that the child's health or welfare is harmed or threatened thereby.

Figure E–1. Sample format for a Memorandum of Agreement (Child Protective Services)

i. Off-post incident is an act of child abuse involving a military family that occurs beyond the boundaries of (Fort Green) and within the jurisdiction of (Simpson County).

j. On-post incident is an act of child abuse involving a military family that occurs within the boundaries of (Fort Green) or that is referred to (Fort Green) from sources outside the jurisdiction of (Simpson County).

k. Military-related incident is an act of child abuse within (Simpson County) not involving a child of a military family but nevertheless of interest to (Fort Green) authorities by virtue of the military status of the alleged offender or of the occurrence of the incident within the boundaries of (Fort Green).

l. Child of a military family is a person under the age of 18 who is a natural or adopted child or stepchild of any soldier.

5. Report and notification requirements.

Every soldier and civilian member of the military community should report information about known and suspected cases of child abuse to the RPOC, any legally mandated reporter (in other words, medical, legal, or mental health personnel) or the appropriate military law enforcement agency. The RPOC or the appropriate law enforcement agency will notify CPS or other civilian authorities, as appropriate, of all on-post incidents of child abuse, in addition to notifying the appropriate authorities on-post as required by Army regulation and agreement. CPS will notify the RPOC of all off-post incidents of child abuse.

6. Intake procedures.

a. CPS and SWS share joint responsibility for the intake of information about child abuse. On-post SWS and law enforcement personnel may initially investigate incidents. When requested by post authorities, and upon approval by CPS, CPS social workers may assist in the investigation of on-post incidents. Prior to entering the installation for any investigation, the CPS investigator will notify the PM office and request assistance if required. CPS will investigate off-post incidents with assistance by other civilian authorities, when appropriate. When requested, and upon approval by post authorities, SWS social workers may assist in investigation of an off-post incident. Military-related incidents occurring within the boundaries of the installation initially will be investigated by military authorities to determine the extent of military criminal and administrative interests involved, and thereafter will be reported to CPS or other civilian authorities, as appropriate.

b. All cases of suspected child abuse will be brought to the attention of SWS. When a report of child abuse is received, SWS will, upon assessment, immediately report information about the cases to CPS. Similarly, CPS, upon receiving a report of child abuse involving the children of military families from sources other than SWS, will provide SWS with the case information as expeditiously as possible.

c. Upon receipt of a report of an on-post incident, SWS will seek, in appropriate cases, authority for temporary protective custody through CPS or the Court. Upon a grant of authority by a juvenile judge, SWS will coordinate with CPS to place the child(ren), will arrange for the initiation of child protective proceedings, and will notify the parties and the Court of the hearing date and time.

d. All children who are removed from their homes on the installation for their own protection will be examined at the MTF prior to being taken off the installation. Parental consent for a medical examination in such cases is not required.

7. Court representation.

Presentation of cases to the Court is the responsibility of CPS working with the county attorney. A representative of the CRC, however, will be made available in appropriate cases to assist in the preparation and presentation of cases before the court.

8. Treatment programs.

a. It is the policy of all parties to this agreement that all available medical and social assets for use in treatment programs will be used, within budgeting, personnel, and regulatory constraints. In all cases involving the abuse of children of military families, any assets of (Fort Green) that are available for use for aid in treatment may be integrated into CPS or Court-mandated treatment plans. Availability of assets will be determined by the CRC, with concurrence of the MTF commander or the (Fort Green) commander, where necessary.

Figure E–1. Sample format for a Memorandum of Agreement (Child Protective Services)—Continued

b. CPS will exercise primary responsibility for the development and implementation of treatment programs for all off-post and military-related cases and for all on-post cases in which there has been court involvement. SWS will exercise primary responsibility for all other on-post cases on a case-by-case basis. Oversight authority for all or portions of a treatment program may be delegated by either primary responsible agency to the other with the concurrence of both in the interests of program efficiency.

c. In the event a SWS treatment program requires intervention by the Court, CPS, working with the county attorney, will seek appropriate judicial remedies, including any necessary modifications to the existing treatment program, and will assume primary responsibility for the implementation of any subsequent court-ordered treatment plan.

9. Records access.
The appropriate records custodian will make available access to military records needed by (Simpson County) authorities for the investigation, processing, treatment or prosecution of child abuse cases according to applicable law and regulations. Request for records should be made through the Patient Administration Division, who in turn will arrange for the release of necessary information.

10. Reports.
CPS will make monthly reports to the CRC on the status of all open cases.

11. Communications.
Effective execution of this Agreement can be achieved only through constant communication and through dialogue among and between the parties. It is, therefore, the policy of the members of this agreement that access to all parties will remain open and that the resulting channels of communication will be used whenever questions, misunderstandings, or complaints arise.

12. Cooperation.
The commanding general, (Fort Green) will ensure the cooperation of all (Fort Green) officials with (Simpson County) representatives. The commanding general will further direct that an installation memorandum of agreement be executed that establishes standing operating procedures among installation agencies in accordance with this MOA.

(Signature)	(Date)	(Signature)	(Date)
(Name)		(Name)	
Presiding Judge		County District Attorney	
(Simpson County)		(Simpson County)	
State of (Kansas)		State of (Kansas)	
(Signature)	(Date)	(Signature)	(Date)
(Name)		(Name)	
Director, (Simpson County)		Major general, USA	
Department of Child Protective Services		Commanding	
		Fort (Green, Kansas)	

Figure E–1. Sample format for a Memorandum of Agreement (Child Protective Services)—Continued

1. Purpose.
To promote a coordinated response by military and civilian authorities to the threat of domestic violence to soldiers and family members on (Fort Green) and in (Pierce County).

2. References.
a. The Privacy Act of 1974, Title 5, Section 552a, United States Code.
b. Fort (Green) Standard Operating Procedure (SOP), Resolving On-Post Issues Involving Protective Orders.
c. Army Regulation (AR) 27–40, Litigation.
d. AR 608–18, The Army Family Advocacy Program.
e. (Insert relevant State code here, e.g., Revised Code of Washington, Sections 10.14.080, 26.09.060, and 26.50.070.)

3. Statement of problem.
The threat of domestic violence to soldiers and their family members is a matter of concern for (Fort Green) and (Pierce County) alike. Continued coordination between civilian and military authorities is essential to reducing the threat and to responding promptly and effectively to domestic violence incidents as they occur. This Memorandum of Agreement (MOA) will promote closer cooperation between (Fort Green) and (Pierce County) authorities by establishing procedures for exchanging information about domestic violence incidents and for processing protective orders issued by state and federal courts.

4. Scope.
This MOA will apply to the investigation and prosecution of any domestic violence offense in which an active duty soldier is or may be an offender or a victim and over which (Pierce County) and (Fort Green) exercise concurrent jurisdiction. The MOA also will apply to the service or enforcement on (Fort Green) of any protective or restraining order issued by a (Pierce County) judge or court commissioner in accordance with the (Washington) State statutes identified in reference 2-e.

5. Understandings, agreements, support, and resource needs.
a. Oversight. The (Fort Green) staff judge advocate (SJA) will be responsible for coordinating and maintaining this MOA.
b. Exchange of information.
(1) When investigating domestic violence offenses, (Pierce County) sheriff's officers will determine whether the alleged offender or victim is an active duty soldier. If the alleged offender or the victim is a soldier on active duty, the investigating officer will write, "Copy to (Fort Green) Provost Marshal Office" (PMO) at the top of the report. Identification and records personnel will forward a copy of the report to the Armed Forces Court Liaison at the following address: Department of the Army, Armed Forces Court Liaison, (County/City Building, Room 601, Tacoma, WA 98402; fax: (253) 798-6616).
(2) Upon receiving a report that an active duty soldier has committed a domestic violence offense off post, the Court Liaison will promptly notify the soldier's chain of command. The command will not initiate nonjudicial punishment proceedings or prefer charges against the soldier without first coordinating with the SJA, which will consult with the (Pierce County) district attorney's office to ensure that no state charges are pending.
(3) Upon request, the PMO, in coordination with the SJA, will provide the (Pierce County) district attorney's office with prior history of on-post offenses involving soldiers and family members. Should the Privacy Act (reference 2-a) restrict the release of the requested records, the SJA will help the requesting (Pierce County) official to obtain the records in a manner consistent with the Act.
c. Processing protective orders.
(1) The SJA, in coordination with the PMO and the (Fort Green) family advocacy program (FAP) manager, has developed an SOP (reference 2-b) defining the responsibilities of (Fort Green) agencies with respect to service and enforcement of state court protective orders on (Fort Green).
(2) Representatives of the SJA, PMO, and FAP will meet periodically to assess the effectiveness of the SOP and to amend it, if necessary, to address more effectively the needs of the military and civilian communities. The SJA will ensure that the (Pierce County) sheriff and district attorney receive copies of the current SOP and any amendments that may be adopted later.

Figure E–2. Sample format for a Memorandum of Agreement (domestic violence)

(3) When serving protective orders on (Fort Green), (Pierce County) sheriffs officers will comply with the SOP. The PMO and SJA will facilitate service of these orders as outlined in reference 2-b and AR 27–40 (reference 2-c).

d. Referral of domestic violence offenders to treatment programs on (Fort Green).

(1) As appropriate, the (Pierce County) district attorney will refer domestic violence cases through (Pierce County) authorities to Social Work Service (SWS), (Madison) Army Medical Center. Consistent with AR 600–18 (reference 2-d), SWS will enroll in a mandatory treatment program any active duty soldier identified as having committed a domestic violence offense. SWS also will recommend treatment for family members, although it cannot compel them to participate in treatment.

(2) SWS will provide written notice to the (Pierce County) district attorney's office and the (Pierce County) sheriff's office that it has enrolled an individual in a treatment program. Upon request, SWS will forward to the (Pierce County) district attorney or the (Pierce County) sheriff's office a copy of the certificate or letter verifying that an individual has successfully completed treatment.

(3) The (Pierce County) sheriff's office will maintain official records on each domestic violence offender and monitor the offender's progress in treatment.

e. Definitions. For the purposes of this MOA, a "domestic violence offense" is a felony or misdemeanor criminal offense under Federal or State law that has as an element the use or attempted use of force or the threatened use of a deadly weapon committed by:

(1) A current or former spouse, parent, or guardian of the victim.

(2) A person with whom the victim shares a child in common.

(3) A person who is cohabiting or has cohabited with the victim as a spouse, parent or guardian.

(4) A person similarly situated to a spouse, parent, or guardian of the victim.

f. Continuing communication. Effective execution of this MOA can be achieved only through continuing communication and dialogue among and between the parties. Accordingly, the parties agree to use channels of communication to resolve questions, misunderstandings, or complaints that may arise. Each party further agrees to conduct meetings, as necessary; to review cases and program issues' and to review this MOA annually.

6. Effective date.
This MOA will enter into effect on (March 1, 2000).

(Signature) (Date) (Name) (Pierce County) district attorney	(Signature) (Date) (Name) Installation commander
(Signature) (Date) (Name) (Pierce County) sheriff	(Signature) (Date) (Name) Federal court (as applicable)

Figure E–2. Sample format for a Memorandum of Agreement (domestic violence)—Continued

Appendix F
Army New-Parent Support Program Standards

F–1. Introduction

a. These standards reflect the core requirements for establishing and maintaining an effective approach to providing intensive home visiting services to eligible Families with children prenatal to 3 years old who have been identified as at risk for Family maltreatment. These standards will be implemented in accordance with other DOD directives, instructions, and policy guidance and in accordance with Army policy and directives. Requests for exemption to these standards (as when partnering with civilian agencies) must be obtained from CFSC.

b. The Army has developed the following desired outcomes:

(1) Supporting readiness by supporting Soldiers and their Families.

(a) Increasing healthy parenting skills.

(b) Decreasing risk for child maltreatment and Family violence.

(2) Increasing military and community resiliency.

(a) Improved coordination of military and civilian resources (for example, parenting activities).

(b) Increased utilization of available services.

(3) Strengthen effective functioning of Soldiers and their Families.

(a) Support and increase successful adaptation to military life.

(b) Decreasing the negative effects of intermittent single parenting (for example, deployment).

c. The coordination of activities at the installation level is the critical factor in determining whether these outcomes can be achieved. The installation commander, FAPM, ACS, chaplain, and MTF play key roles in striving for these outcomes at the installation level. These standards therefore apply not only to the FAP but also to the installation as a whole.

d. The goals of the Army NPSP are:

(1) Contribute to mission readiness.

(2) Support Family member adaptation to military life.

(3) Enhance the knowledge and skills Family members need to form healthy relationships and provide safe, nurturing environments for children to prevent Family violence.

(4) Foster a supportive military community for young military Families.

e. Continuous monitoring and evaluation of installation activities with DOD and Army performance measures (FAP standards, ACS accreditation) are essential to ensure quality of NPSP services.

F–2. Organization and management

a. The installation and IMA or specific ACOM, ASCC, and DRU NPSP POCs will meet at least once a year (via teleconference, video teleconference, or assembling) to facilitate coordination of services and increase consistency in implementation of the NPSP.

b. NPSP activities are scheduled and conducted, consistent with mission requirements, in a manner that fosters and enables maximum participation of both parents in NPSP activities.

c. Funds provided by OSD for the NPSP–Plus component of NPSP are used only for activities to support the screening, assessment, and provision of home visitation services to at-risk Families.

d. All purchase of service contracts or agreements with a civilian agency, organization, or individual will comply with HQDA Memorandum, Subject: Standards for the New Parent Support Program, August 2001, and these program standards.

F–3. New-parent support program

a. The Army NPSP complies with HQDA Memorandum, Subject: Standards for the New Parent Support Program, August 2001, and these program standards.

b. The NPSP is implemented through coordination, collaboration, joint efforts, and partnerships between parenting support programs on military installations and programs from nearby civilian agencies, when available.

c. Activities and services provided through the NPSP are available to all eligible Families with children prenatal to 3 years old whether they live on or off the installation.

d. Activities and services provided through the NPSP–Standard (FAP basic services and education) component include information and referral to military and available civilian programs that support parents of infants and young children, such as parenting programs, respite care for children, and supervised play time for children.

e. All activities and services provided through the NPSP are voluntary and nonstigmatizing and emphasize the parents' strengths.

f. Families with children prenatal to 3 years old who can benefit from additional, more-intensive support are referred to NPSP–Plus services. Families may be self-referred or referred by other agencies such as health care providers, chaplains, social service staff, command, FAP staff, or staff providing NPSP–Standard services.

g. Activities and services provided through the NPSP–Plus component are available to those identified Families with children prenatal to 3 years old who have been assessed as being at risk for child maltreatment and/or Family violence.

h. Families participating in the NPSP–Plus component are assessed for risk of child maltreatment and Family violence on a continuous basis.

F–4. Program accountability

a. The DA CFSC will establish a system of record-keeping for NPSP–Plus services.

b. The DA CFSC will develop a documentation format for NPSP–Plus activities that will be of sufficient detail to ensure continuity and quality of care.

c. The CFSC will develop procedures for—

(1) Coordination of community resources (where available) for parenting activities.

(2) Ongoing assessment of maltreatment risk.

(3) Documentation of services that meet the goals of the DOD NPSP–Plus.

(4) Evaluation of program effectiveness.

d. Army IMAs or specific ACOM, ASCC, and DRU will conduct or coordinate periodic update training to increase the knowledge and skills of those who provide NPSP–Plus services. Training may be presented by the IMA or specific ACOM, ASCC, and DRU or be linked with attendance at Army- or civilian-sponsored training conferences. Training might include such topics as—

(1) Increasing healthy parenting skills.

(2) Decreasing risk for child maltreatment and Family violence.

(3) Supporting and increasing successful adaptation to military life.

(4) Decreasing the negative effects of intermittent single parenting.

F–5. Staffing

a. All personnel who provide NPSP–Plus activities will possess the knowledge, skills, and abilities necessary for their professional certification/licensure and positions.

b. Registered nurses (RNs) who provide services as part of NPSP–Plus must have a current, nonrestrictive U.S. license to practice nursing.

c. All personnel in the NPSP–Plus will receive training on identifying and reporting suspected Family maltreatment.

d. Local installation or State background checks, including an ACR check, will be completed on all personnel in the NPSP–Plus who provide services to parents and their children and will be updated annually.

e. The CFSC will develop curricula that guide prevention activities in support of NPSP–Plus services.

F–6. Program planning and evaluation

a. The CFSC FAPM collects and analyzes information for program planning, administration, interpretation, evaluation, and funding of NPSP–Plus to ensure compliance with HQDA Memorandum, Subject: Standards for the New Parent Support Program, August 2001.

b. The CFSC evaluates the NPSP–Plus at those installations receiving OSD NPSP–Plus funds at least every 3 years as part of the ACS accreditation process.

c. Using the NPSP–Plus reporting systems, continuous and ongoing evaluation is conducted by CFSC that includes, but is not limited to—

(1) Assessing the progress in achieving program outcomes as measured by DOD and Army performance measures. Performance measures will include assessing and implementing a quality assurance process for NPSP–Plus.

(2) Assessing whether the NPSP–Plus, including activities undertaken by contractors, are in accordance with applicable DOD and Army directives.

(3) Assessing the adequacy and efficiency of the resources available to meet NPSP–Plus program objectives.

Appendix G
Privileged Communications

G–1. Definition and purpose of privileged communications

a. A claim of a privilege includes, but is not limited to, the assertion by a person of a privilege to refuse to be a witness in a criminal or civil proceeding, to refuse to disclose any information, to refuse to produce any object or writing, or to prevent another from being a witness or disclosing any information or producing any object or writing. (See M.R.E. 501(b).)

b. The law of the forum (for example, the court or board) determines the application of a privilege. Within the Army, applicable Federal law, military regulations, and executive orders (for example, MCM, 2005 and AR 165–1) determine the protection afforded privileged communications. Within State or foreign courts, applicable State or foreign law determines the existence or scope of a privilege, even for military lawyers or chaplains testifying in those courts.

c. Generally, the purpose of a privilege is to protect the confidentiality of communications made by those seeking help or counseling, not to suppress evidence of crime or to protect people in trouble.

G–2. Communications to physicians

There is no physician–patient privilege in the military. Even if a Soldier consults with a private physician in a

jurisdiction with a doctor–patient privilege, such a privilege is inapplicable to a court-martial or other military proceeding or investigation.

G–3. Communications to social workers and psychologists

M.R.E. 513 contains a limited psychotherapist–patient privilege, which applies to certain communications made to a psychiatrist, clinical psychologist, clinical social worker, or assistant to a psychotherapist. There is no privilege when the communication is evidence either of spouse abuse, child abuse, or neglect or in a proceeding in which one spouse is charged with a crime against the person of the other spouse or a child of either spouse. Additionally, the rule does not negate the requirement to report spouse or child abuse in accordance with paragraph 3–4. Questions concerning the applicability of M.R.E. 513 should be referred to the servicing legal office.

G–4. Lawyer-client privilege

In the military, a client has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of receiving professional legal advice. A military lawyer has no obligation to make a report of spouse or child abuse that comes to his or her attention as result of a privileged communication unless the communication clearly contemplates the commission of a future crime. (See M.R.E. 502.) Acting within his or her discretion, an attorney advising a client who is a spouse or child abuse victim or alleged offender of spouse or child abuse can encourage that person to make a report of such abuse or to seek treatment, as appropriate.

G–5. Communications to clergy

In the military, a person has a privilege to refuse to disclose and to prevent another from disclosing a confidential communication by the person to a clergyman if such communication is made either as a formal act of religion or as a matter of conscience (in accordance with M.R.E. 503 and AR 165–1). A uniformed or civilian member of the clergy working for the military has no obligation to make a report of spouse or child abuse that comes to his or her attention as a result of a privileged communication. Acting within his or her discretion, a member of the clergy may encourage a person who is a spouse or child abuse victim or alleged offender of spouse or child abuse to make a report of such abuse or to seek treatment, as appropriate.

Appendix H
Guidance Regarding Rights Advice Under Article 31, Uniform Code of Military Justice

H–1. Purpose of guidance

The following is provided as guidance based on legal decisions that interpret when UCMJ, Art. 31, warnings must be given. This information is not intended to create any additional rights or expand any existing rights.

H–2. Case managers/social workers

FAP case managers/social workers generally are not required to provide UCMJ, Art. 31, warnings when interviewing a Soldier for the purpose of diagnosis and treatment. If on the other hand, an FAP case manager/social worker questions a Soldier for the purpose of gathering incriminating statements to advance a criminal investigation (in other words, when there is not a medical/clinical reason to ask the question), then the counselor is not acting for the purpose of diagnosis and treatment and should therefore provide the suspect with UCMJ, Art. 31, warnings prior to questioning the Soldier. If the case manager/social worker advises the member of his or her UCMJ, Art. 31, rights using DA Form 3881, then the completed statement will be maintained in the member's FAP record.

H–3. When to obtain legal advice

In those instances in which a social worker either believes that an Article 31, UCMJ rights warning should be given or is unsure, the social worker should obtain legal advice prior to conducting the interview.

Appendix I
Criteria for Selecting Emergency Placement Care Families

I–1. Physical requirements

a. EPC parents will be at least 21 years of age.

b. A written statement from a physician regarding the health and any specific illnesses or disabilities of each member of the prospective EPC Family will be requested as a routine part of the selection process. This will include a thorough review of the military outpatient medical record of each Family member and any specialized treatment

received off the installation. Additionally, there will be a review of any clinical records in the mental health, Family advocacy, and/or drug and alcohol service. Each person present in the prospective EPC home must submit written verification that he or she has taken a tuberculin test and has been found free of disease; other tests may be required as indicated.

c. Physical disabilities of a member of a prospective EPC Family will be evaluated to determine how the person's disability may affect the Family's ability to provide adequate care to EPC children. Evaluation will include how the person's disability may affect a child's adjustment to the EPC Family.

I–2. Factors related to income

a. The FAPM will determine that the income of a prospective EPC Family is stable and sufficient to maintain the EPC Family and that any payment of costs by the natural Family-or, where authorized by the FAPM, if OSD funds are used-is not needed to meet other EPC Family expenses. This need not involve a financial readiness assessment unless there is reason to suspect difficulties. A leave and earnings statement is sufficient.

b. The intention of a prospective EPC parent to maintain employment outside the home will not be considered as a barrier to selection. The EPC POC will consider this factor when making individual placement decisions and will base the decisions solely on the best interests of the child.

I–3. Physical requirement of the home

a. Physical facilities of the home will present no hazard to the safety of the EPC child and will meet housing requirements prescribed in AR 210–50 and AR 608–10.

b. A separate bedroom for an EPC child is not required; however, EPC homes will be capable of providing an EPC child with privacy and a comfortable environment. Individual space will be provided for the child's personal possessions and each child will have his or her own bed. (AR 210–50, para 3–5, notes bedroom authorizations.)

c. It is preferable that no more than two children share one sleeping room. In placements lasting less than 30 days, the supervising FAPM may waive this recommendation. With the exception of very young children (under 3 years of age), the sharing of sleeping rooms by children of opposite sexes is prohibited.

d. Children, other than infants, will not share sleeping quarters with adults in the household except during emergencies.

e. EPC Family homes will be accessible to schools, recreation, churches, other community facilities, and special resources such as medical clinics.

I–4. Factors related to Family composition

a. Two-parent Families will be selected in most cases. However, single-parent Families may be selected if they can effectively fulfill the needs of a particular child. Parents who are geographically separated may be considered on a case-by-case basis.

b. The presence of other children (both the EPC parents' own children and EPC children) and other adults (including extended Family members and unrelated persons) will be considered. Their presence may affect an EPC child. The effect that the presence of another child may have on current members of the home also will be evaluated.

c. The number and the ages of children in a home (both the EPC parents' own children and EPC children) will be considered on an individual basis. The ability of the EPC Family to meet the needs of all children present, the physical accommodations of the home, and the effect an additional child would have on the Family as a unit also are taken into account. It is preferable that an EPC Family cares for no more than two infants under 2 years of age, including the EPC parents' own children. It is also preferable that an EPC Family care for no more than a total of four children, including EPC children and their own children, in the home. (Exceptions may be made to keep siblings together.) All placement decisions include an evaluation of the effects of placing an EPC child in a home where the natural children are approximately the same age and have similar needs.

I–5. Quality emergency placement care parenting

In determining the ability of a Family to provide high quality EPC parenting, considerations will include the commitment of all Family members to the EPC process, the capacity to use good judgment in caring for children, and the ability to let go of the child when he or she leaves the EPC home. It is also necessary for the potential EPC Family to feel and demonstrate genuine concern and affection for each child in the Family.

I–6. Background screening requirements

a. Background checks are required for EPC providers. (See para 8–5*h*.)

b. EPC POC should, at a minimum—

(1) Personally review all applications for accuracy of information (for example, overlapping data of previous employment).

(2) Interview the applicant.

(3) Telephonically check personal references.

c. Appropriate action must be taken when the IRC or other applicant screening reveals instances of misconduct involving children, a history of threatening behavior (verbal or physical), substance abuse, or related misconduct. Consult applicable provisions of AR 608–10 and this regulation, and the SJA for legal guidance when needed.

d. No waivers to background checks will be granted for EPC program applicants, nor will applicants be certified before all checks are completed.

Appendix J
Service Guidelines for Emergency Placement Care

J–1. Services to prevent the need for placement

a. Social work and counseling services.

b. Economic assistance.

c. Employment preparation, job training, and education services.

d. Housing, emergency shelter, and transportation services.

e. Medical services, including outpatient psychiatric care.

f. Childcare services.

g. Child management training and/or new-parent support program.

h. Respite care services.

i. Parenting instruction.

j. Placement with relative or guardian.

J–2. Services to natural Families or guardians to improve conditions that necessitated placement

a. Plan and execute a carefully worked out service of Family and child communication and visitation that will help to develop and maintain a constructive relationship between the child and Family.

b. Help parents fulfill their parental roles and responsibilities to the placed child.

c. Help the Family to accept the service plan.

d. Help the Family use community resources.

e. Help the Family to prepare for the child's return home, or, if return home is not possible, to involve them in making an alternative plan.

J–3. Emergency placement care considerations for placement

a. The extent to which the interests, strengths, and abilities of the EPC Family enable them to relate to the child's needs. Factors include age, interests, intelligence, religion, and cultural background.

b. The capacity of the EPC Family to deal adequately and comfortably with problems that might arise during the child's placement.

c. The extent to which the EPC Family can contribute to the development of the child and help to alleviate specific problems.

d. Personal appeal of the child to the EPC Family and vice versa.

J–4. Children's placement considerations

a. Provide the child with opportunities to express concerns he or she is unable to discuss with EPC parents and help the child to bring these concerns to the EPC parents.

b. Develop the child's understanding of the conditions that necessitated placement and help them deal constructively with those conditions.

c. Help the child to understand and deal with stress situations that may need special attention. These include loss, separation, medical care, hospitalization, social, and school problems.

d. Prepare the child to return home.

e. Help the child understand the reason for the plan if permanent separation from the child's own Family is the plan.

J–5. Services provided by emergency placement care parents to emergency placement care children

a. Transportation to emergency medical services 24 hours a day, 7 days a week; routine and preventive medical, dental, visual, and hearing examinations and immunizations recommended by professionals in each field providing the service; and medical care on a planned or emergency basis for all ill children.

b. Special services for children with chronic health problems, mental or physical disabilities, or learning disabilities.

c. Access to appropriate and available treatment services.

d. Educational opportunities according to the child's individual needs and potential.

e. Respect for the religious experience or the religious preference of the child and Family.

f. Recreational opportunities that allow for the development of social skills.
g. Clothing appropriate to the child's age and size and equipment for special needs and activities.
h. Appropriate diet.

J–6. Support services for the emergency placement care Family

a. Procedures to ensure that on-call assistance is available to the EPC care Family 24 hours a day, 7 days a week.
b. Procedures that clarify the responsibilities of the EPC POC, the child's Family, and the EPC Family.
c. Assistance to the EPC Family in dealing with any problems that may occur during the child's placement.
d. Provisions of support to the EPC Family to help them and the child cope with feelings of separation and grief when a child is to leave his or her home.

J–7. Postplacement services

a. Assistance in understanding new Family roles and behavior after a child returns home.
b. Support for parents who are trying out newly learned, positive child-rearing behavior and applying newly acquired knowledge of child development.
c. Supportive peer group experience for children and parents to reinforce their efforts to create a more-constructive Family situation.
d. Assistance to young adults in finding community resources that can support their independent lifestyles and aid their reentry into the community.

J–8. Termination services

a. The EPC POC will provide each child with the kind of support and assistance needed to prepare for the termination of a placement.
b. Assistance with understanding how the child's own Family has been able to make a plan for return home.

Appendix K
The Service Planning Process

K–1. Service plan inclusions

a. Conditions that require the intervention of the FAPM.
b. Resources that can be used to resolve the problem that necessitated intervention.
c. Actions needed and taken to resolve current problems and assignment of responsibility for all actions.
d. Evidence of change and growth.
e. Anticipated outcomes (that is, the goal of services).
f. Timeframes in which all activities must occur.

K–2. Child record inclusions

a. DA Form 5192 (Family Identification Sheet for a Child Receiving Service).
b. DA Form 5193 (Child's Face and Whereabouts Sheet).
c. DA Form 5195 (Health Data).
d. Casework activities, to include—
(1) Description of the child.
(2) Preplacement activities.
(3) Additional pertinent data, if any.

K–3. Family records inclusions

a. ACS parent service planning agreement (see fig K–1).
b. ACS advocacy parent specific service planning agreement (see fig K–2).
c. EPC program hold-harmless agreement (see fig K–3).
d. Copy of DA Form 5192 (copy from child's record is acceptable).
e. Casework activities to include—
(1) Information on the problem.
(2) Eligibility information for EPC.
(3) Placement plans and process data.
(4) Information on policies and expectations.
(5) Any further planning.

(I/we), (name(s) of parent(s)), the parents of (name(s) of child(ren)), at the present in emergency placement care with (name of family), wish to have (my/our) children returned home permanently. In keeping with this wish, (I/we) understand and agree that (I/we) must participate in planned services designed to change the following problems and behavior, which all parties agree require change prior to such a return. (I/we) understand that failure to comply with the service plan will result in the exploring alternate proposals for (my/our) child(ren), including civilian foster care in the continental United States, guardianship or adoption.

The general goals of the modification service are as follows (list goals):

The first stage of this agreement relates to goals (indicate number). The specific plan for accomplishing these goals is attached. Development of plans for remaining goals depends on (my/our) successful completion of the first stage of the agreement. This agreement will be in effect for (number of days/weeks/months). The first stage of the agreement will be for (number of days/weeks/months), from (date) to (date).

(Signature) (Date) (Name of father, if applicable)	(Signature) (Date) (Name of social worker)
(Signature) (Date) (Name of mother, if applicable)	(Signature) (Date) (Name of witness)

Figure K–1. Army Community Service parent service planning agreement

The (location) Army Community Service (ACS) agrees to offer the following services provided by (person or agency providing service (for example, SWS, Jane Doe, or parent educator)) designed to improve accomplishment of the goals (indicate number) stated on the ACS planning agreement, dated (month/day/year).

(List goals.)

(I/We), (name(s) of parent(s)), agree to the following activities geared to the accomplishment of the goals (indicate number) agreed upon with the (name of local ACS center).

(List activities.)

(Signature) (Date) (Name of father)	(Signature) (Date) (Name of social worker)
(Signature) (Date) (Name of mother)	(Signature) (Date) (Name of witness)

Figure K–2. Army Community Service advocacy parent specific service planning agreement

We (I), (name(s) of parent(s)), the legal parent(s)/custodian(s) of: (insert names of child(ren) and date(s) of birth), hereby release our (my) child(ren) into the full care and custody of (name of emergency placement care (EPC) parents) for a period not to exceed (number of days) for the purpose of emergency placement, such care and custody to be subject to the supervision of the (location) Army Community Service (ACS). We (I) understand that *only in voluntary placements* may we (I) revoke this agreement prior to the expiration of this period by written notice to the Army EPC program, in which event said child(ren) will be returned to our (my) full custody and control no later than 14 days after our (my) notification.

We (I) further agree as follows:

1. While our (my) child(ren) is(are) in the temporary care and custody of the above named EPC providers, said EPC providers will have full control over them, subject to the supervision and assistance of the Family Advocacy Program manager (FAPM), and we (I) agree that said children may participate fully in the activities of the EPC family, including, but not limited to, family trips and excursions within the jurisdiction of the country wherein this placement occurs. We (I) will be notified of recreational travel outside of their country of residence in advance of any trip. We (I) waive/reserve (circle one) the right to grant permission for my child(ren) to undertake travel outside their country of residence.

2. We (I) hereby authorize any licensed medical facility operated or sanctioned by the United States Government to provide our (my) child(ren) named above any and all medical or dental care deemed necessary by a licensed staff physician or dentist, including but not limited to major surgery requiring the use of anesthesia. Such treatment may be administered upon written or verbal permission granted by the above-named EPC providers or the designated ACS representative when such care is deemed necessary by the appropriate medical or dental facility. In the event that verbal permission is given, written consent will be obtained at the earliest available opportunity. We (I) continue to be responsible for hospital and physician costs not covered by medical insurance.

3. We (I) expressly release and discharge the (location) community, its staff and employees, and the ACS and its staff, the Department of the Army, and the United States Government from any and all claims, demands, liability, and damage of any nature whatsoever arising from or in connection with the placement, transportation, or medical/dental treatment of our (my) child(ren), other than that resulting directly from the negligence or intentional conduct of the above-named persons and organizations.

4. We (I) further expressly release and discharge the above-named EPC providers from any and all claims, demands, liability and damage of any nature whatsoever arising from or in connection with the emergency placement, transportation, care, or medical/dental treatment of our (my) above-named child(ren) other than that directly resulting from the negligence or intentional conduct of the EPC providers.

5. We (I) have read this document and expressly understand and concur with the terms within this agreement. We (I) further agree that this document shall remain in full effect for as long as the ACS considers EPC to be necessary for the safety and best interests of our (my) child(ren). We (I) retain the right to revoke this and terminate the custody granted herein, upon 1-week written notification to the ACS.

(Signature) (Date) (Name of father, if applicable)	(Signature) (Date) (Name of ACS representative)
(Signature) (Date) (Name of mother, if applicable)	(Signature) (Date) (Name of witness)

Figure K–3. U.S. Army emergency placement care program hold-harmless agreement

Appendix L
Management Control Evaluation Process

L–1. Function
The function covered by this evaluation process is the U.S. Army Family Advocacy Program.

L–2. Key management controls
a. Annual review.

b. Completion of DA Form 7419–R (Army Community Service (ACS) Accreditation Checklist) as outlined in para 2–12 of AR 608–1.

L–3. Management control evaluation process
See AR 608–1, para 2–12, for a description of the management control evaluation process.

Glossary

Section I
Abbreviations

ACOM
Army command

ACR
Army Central Registry

ACS
Army Community Service

ACSIM
Assistant Chief of Staff for Installation Management

ADCO
alcohol and drug control officer

AMEDD
Army medical department

APF
appropriated funds

ARIMS
Army Records Information Management System

ASAP
Army substance abuse program

ASCC
Army Component Service Command

CAPIT
Child Abuse Prevention and Investigation Techniques

CDC
child development center

CFSC
Community and Family Support Center

CHAM
Child Abuse Manual

CHN
community health nurse

CID
criminal investigation division

CLEOS
child and youth liaison, education, and outreach services

CNACI
child care national agency check and written inquiries

CONUS
continental United States

CPAC
Civilian Personnel Advisory Center

CPR
cardiopulmonary resuscitation

CPS
Child Protective Services

CRC
case review committee

CRO
child removal order

CYS
child and youth services

DA
Department of the Army

DAIG
Department of the Army, Inspector General

DAMO–ODL
Department of the Army Material Office, Office of Defense Logistics

DCA
director of community activities

DCS, G–1
Deputy Chief of Staff, G–1

DCS, G–3
Deputy Chief of Staff, G–3

DENTAC
Dental activity

DHP
defense health program

DMDC
Defense Manpower Data Center

DOD
Department of Defense

DODD
Department of Defense directive

DODDS
Department of Defense dependent school system

DODESS
Department of Defense dependent elementary and secondary schools (formerly *Section 6 schools*)

DODI
Department of Defense instruction

DOJ
Department of Justice

DRU
Direct Reporting Unit

DVAW
domestic violence awareness workshop

EFMP
Exceptional Family Member Program

EPC
emergency placement care (formerly *foster care*)

ERMC
European Regional Medical Command

ETS
expiration term of service

FAC
Family advocacy committee

FACAT
Family Advocacy Command Assistance Team

FAP
Family advocacy program

FAPM
Family advocacy program manager

FARS
Family advocacy research subcommittee

FAST
Family advocacy staff training

FAST–A
Family advocacy staff training–advanced

FBI
Federal Bureau of Investigations

FCC
Family child care

FOIA
Freedom of Information Act

FRC
fatality review committee

HQDA
Headquarters, Department of the Army

IG
Inspector General

INSCOM
U.S. Army Intelligence and Security Command

IRC
installation record check

LOSS
line-of-sight supervision

MCM
Manual for Courts-Martial

MEDCOM
U.S. Army Medical Command

MEDDAC
medical department activity

MOA
Memorandum of Agreement

MOS
military occupational specialty

MP
military police

M.R.E.
Military Rule of Evidence

MTF
medical treatment facility

MWR
morale, welfare, and recreation

NAC
national agency check

NACI
national agency check and written inquiries

NAF
nonappropriated funds

NAFI
nonappropriated fund instrumentality

NPRC
National Personnel Records Center

NPSP
new-parent support program

OASD
Office of the Assistant Secretary of Defense

OCONUS
outside continental United States

OSD
Office of the Secretary of Defense

OTR
official treatment record

OTSG
Office of the Surgeon General, U.S. Army

PAD
patient administration division

PAO
public affairs officer

PCS
permanent change in station

USA HRC
U.S. Army Human Resources Command

PM
provost marshal

PMO
provost marshal's office

POC
point of contact

PS
postal service

PSB
personnel service battalion

R.C.M.
Rule for Courts-Martial

RPOC
report point of contact

SCHR
State Criminal History Repository

SES
Senior Executive Service

SIR
serious incident report

SJA
staff judge advocate

SMDC
U.S. Army Space and Missile Defense Command

SOFA
status of forces agreement

SOP
standing operating procedure

SPAM
Spouse Abuse Manual

SSN
Social Security number

SWS
Social Work Service

TDA
table of distribution and allowances

TJAG
The Judge Advocate General, U.S. Army

TRADOC
U.S. Army Training and Doctrine Command

UCMJ
Uniform Code of Military Justice

USACFSC
U.S. Army Community and Family Support Center

USACIDC
U.S. Army Criminal Investigation Command

USACSA
U.S. Army Center for Substance Abuse

USASOC
U.S. Army Special Operations Command

Section II
Terms

Act of force
An act against another person including, but not limited to: scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, poking, hair pulling, slapping, punching, hitting, burning, use of restraints, use of a weapon (gun, knife, or other object), or use of one's body, size, or strength.

Army Central Registry
An Army-wide index of abuse reports.

Caregiver
An individual or group of individuals in a position of responsibility for the temporary or permanent care and/or supervision of a person of any age who is incapable of self-support due to incapacity. Such care and/or supervision may be provided in the person's home, in a military-sanctioned caregiver's home, at a military-sponsored or military-sanctioned out-of-home care facility or a residential facility, or in an activity conducted at various locations. A caregiver may be—

a. A Family member. An individual who is related by blood or law to the child or incapacitated adult for whom he or she is providing care.

b. Extra-familial. An individual unrelated by blood or law to the child or incapacitated adult for whom he or she is providing care. Ref: Memorandum, Assistant Secretary of Defense (Force Management Policy) (ASD (FMP)), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 14*b*.

Case management
The process of coordinating health and social services so that the client receives the most appropriate care in a timely, efficient manner.

Case manager
The individual who coordinates all of the health, social and other services on behalf of the client or group of clients and monitors the progress of clients through the sequence of the treatment program.

Child
An unmarried person under the age of 18 who is eligible for care through a DOD medical treatment program and 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. The term *child* means a biological child, adopted child, stepchild, foster child, or ward. The term also includes an individual of any age who is incapable of self-support because of a mental or physical incapacity and for whom care in a military medical treatment program is authorized.

Child abuse
The physical or mental injury, sexual abuse or exploitation, or negligent treatment of a child. It does not include discipline administered by a parent or legal guardian to his or her child provided it is reasonable in manner and moderate in degree and otherwise does not constitute cruelty. Ref: Memo, USD (MC&FP), Subject: Domestic Violence and Child Abuse Fatality Reviews, February 12, 2004, Attachment 1.

Child abuse/physical maltreatment
Physical harm, mistreatment, or injury of a child by a parent, guardian, foster parent, or caregiver, whether the caregiver is intrafamilial or extrafamilial, under circumstances indicating that the child's welfare is harmed or threatened. Such acts by a sibling, other Family member, or other person will be deemed to be abuse or maltreatment only when the individual is providing care under express or implied agreement with the parent, guardian, or foster parent. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*c*(i).

Child emotional maltreatment
Acts or a pattern of acts, omissions or a pattern of omissions, or passive or passive-aggressive inattention to a child's emotional needs resulting in an adverse affect upon the child's psychological well-being. Maltreatment includes intentional berating, disparaging or other verbally abusive behavior toward the child, and violent acts that may not cause observable injury. An emotionally maltreated child manifests low self-esteem, chronic fear or anxiety, conduct disorders, affective disorders, or other cognitive or mental impairment. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*a*.

Child neglect
A type of child abuse/maltreatment whereby a child is deprived of needed age-appropriate care by act or omission of the child's parent, guardian, or caregiver; an employee of a residential facility; or a staff person providing out-of-home care under circumstances indicating that the child's welfare is harmed or threatened. Child neglect includes *abandonment, deprivation of necessities, educational neglect, lack of supervision, medical neglect,* and/or *nonorganic failure to thrive.* Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*b*.

a. Abandonment. A type of child neglect in which the caregiver is absent and does not intend to return or is away from the home for an extended period without having arranged for an appropriate surrogate caregiver. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*b*(1).

b. Deprivation of necessities. A type of neglect that includes the failure to provide age-appropriate nourishment, shelter, and clothing. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*b*(2).

c. Educational neglect. A type of child neglect that includes knowingly allowing the child to have extended or frequent absences from school, neglecting to enroll the child in some type of home schooling or public or private education, or preventing the child from attending school for other than justified reasons. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*b*(3).

d. Lack of supervision. A type of child neglect characterized by the absence or inattention of the parent, guardian, foster parent, or other caregiver that results in injury to the child, in the child being unable to care for himself or herself, or in injury or serious threat of injury to another person because the child's behavior was not properly monitored. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*b*(4).

e. Medical neglect. A type of child neglect in which a parent or guardian refuses or fails to provide appropriate,

medically indicated health care (medical, mental health, or dental) for the child although the parent is financially able to do so or was offered other means to do so. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*b*(5).

f. Nonorganic failure to thrive. A type of child neglect that manifests itself in an infant's or young child's failure to adequately grow and develop when no organic basis for this deviation is found. Usually such children register below the third percentile in height and weight. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*b*(6).

Child physical maltreatment

Acts such as grabbing, pushing, holding, slapping, choking, punching, kicking, sitting or standing upon, lifting and throwing, burning, immersing in hot liquids or pouring hot liquids upon, hitting with an object (such as a belt or electrical cord), and assaulting with a knife, firearm, or other weapon that caused or may cause bodily injuries. Such injuries include brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocations or sprains, internal injury, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts. In infants and toddlers, abusive acts include shaking or twisting, which may cause brain damage, subdural hemorrhage, and hematoma. An injury does not have to be visible for physical maltreatment to be present Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*c*.

Child Protective Services

Any State, local, or foreign department, agency, or office that provides child protective services to Families affected by child abuse.

Child sexual maltreatment

Sexual activity with a child for the purpose of sexual gratification of the alleged offender or some other individual. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*d*(i).

a. Exploitation. A type of sexual maltreatment in which the victim is made to participate in the sexual gratification of another person without direct physical contact between them. Exploitation includes forcing or encouraging a child to do any of the following: to expose the child's genitals or (if female) breasts, to look at another individual's genitals or (if female) breasts, to observe another's masturbatory activities, to view pornographic photographs or read pornographic literature, to hear sexually explicit speech, or to participate in sexual activity with another person, such as in pornography or prostitution, in which the alleged offender does not have direct physical contact with the child. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*d*(i)(1).

b. Molestation. Fondling or stroking a child's breasts or genitals, oral sex, or attempted penetration of the child's vagina or rectum. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*d*(i)(2).

c. Rape/intercourse. Sexual intercourse between an alleged offender and a child that involves the penetration of the vagina or rectum, however slight, by means of physical force. The penetration may result from emotionally manipulating the child or by taking advantage of a child's naïveté rather than physical force. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*d*(i)(3)

d. Other sexual maltreatment. All other types of child sexual abuse or maltreatment not included in the definitions of exploitation, molestation, or rape/intercourse. Ref: Memo, ASD (FMP), Subject: Policy Changes for Submitting Child and Spouse Abuse Information, August 22, 1997, paragraph 9*d*(i)(4).

Defense counsel

Army lawyers assigned to the U.S. Army Trial Defense Service, as well as any other lawyer hired by, retained by, or detailed to a Soldier or Family member to defend him or her on a criminal charge or on an adverse military administrative personnel action.

DOD-sanctioned activity

May be either a nongovernmental activity or an activity operated by U.S. Government employees that is involved in the care of children. The care of children may be either the activity's primary mission or its incidental mission in carrying out another mission. Examples include CYS, childcare activities provided as part of Chaplain's programs or as part of another MWR program, FCC, contracted childcare services provided by private organizations, and Boy and Girl Scouts.

Domestic violence

An offense under the United States Code, the Uniform Code of Military Justice, or state law that involves the use, attempted use, or threatened use of force or violence against a person of the opposite sex, or a violation of a lawful order issued for the protection of a person of the opposite sex, who is (a) A current or former spouse; (b) A person

with whom the abuser shares a child in common; or (c) A current or former intimate partner with whom the abuser shares or has shared a common domicile. Ref: Memo, USD (MC&FP), Subject: Domestic Violence and Child Abuse Fatality Reviews, February 12, 2004, Attachment 1.

Emergency placement care
A voluntary or court-mandated service providing 24-hour care and supportive services in an EPC Family home or group facility for eligible children who cannot be properly cared for by their own Families.

Emergency placement care child
A child other than the sponsor's child who resides in the sponsor's home and whose care, comfort, education, and upbringing have been entrusted to the sponsor by either a court, a civilian agency, or a parent of the child on a temporary or permanent basis. An EPC child also includes a sponsor's child who has been placed in EPC by a local civilian authority.

Emotional or psychological harm
Involves impairment of emotional and psychological functioning.

a. Minor emotional harm is transient and limited in scope and impact. Examples include temporary changes in mood or temporary detriment to an individual's self-esteem.

b. Significant emotional harm involves lasting impact that is limited in scope. Examples include prolonged depression, anxiety disorders, acute reactions to trauma or detriment to an individual's self-esteem that effects his or her behavior.

c. Serious emotional harm involves lasting impact that is pervasive in scope and/or results in behaviors destructive to self and/or others. Examples include prolonged serious depression, lasting detriment to self-esteem, impaired capacity to form mature intimate relationships, unwillingness to take action on one's own behalf in emotionally challenging situations, and severe destructive behaviors such as self-mutilation, attempted suicide, or attempted homicide.

Exceptional Family member
A Family member with any physical, emotional, developmental, or intellectual disorder that requires special treatment, therapy, education, training, or counseling.

Exceptional Family Member Program
The EFMP, working in concert with other military and civilian agencies, is designed to provide a comprehensive, coordinated, multiagency approach for medical, educational, community support, housing, and personnel services to Families with special needs.

Extrafamilial abuse
An individual unrelated by blood, law, or marriage and who may be an employee, an independent contractor, or a volunteer in a military-sanctioned or military-sponsored program that provides care for and supervision of a minor or special-needs person by agreement with the minor or individual's parent, guardian or foster parent. Such caregivers include military CYS personnel, military FCC providers including certified provider's Family member over the age of 12, and a teacher, school, or other DOD caregiver. This category includes those staff or volunteers in civilian schools located outside the military installation where the program, service or activity is military-sponsored or -sanctioned.

Family member
An individual whose relationship to the sponsor authorizes entitlement to treatment in a medical facility of the military Services.

Guardian ad litem
A guardian appointed by a court to represent the interests of a child in a child protective case. A guardian ad litem is considered an extension of the court and helps the court decide what is in the best interests of the child.

Home visitor
A nurse or social worker who visits Families with children prenatal to three years of age at their home to assess for risk of child maltreatment and/or Family violence, to provide information and support with pregnancy and parenting education, and to build on Family strengths. There are two experience levels for home visitation service providers:

a. Home visitor. A licensed master's-level social worker or bachelor-level RN. Licensed social workers functioning as home visitors must have 2 years of direct experience in child abuse prevention. RNs must have 2 years of direct experience in maternal/child health, community health, or mental health.

b. Home visitor supervisors. Licensed master's-level social workers and bachelor-level, master's preferred, RNs with

5 years of direct experience in child abuse prevention or a closely related field. They may serve as the supervisor of other home visitors at larger installations.

Installation
A grouping of facilities located in the same vicinity that supports particular functions. Land and improvements permanently affixed there are under the control of the Department of the Army and used by Army organizations. A military community in foreign countries may be equivalent to an installation.

Legal assistance attorneys
Army lawyers who advise and assist Soldiers and their Families on Family law matters. Such matters include marriage, divorce, adoption, paternity, child custody problems, and financial support obligations. In the context of this regulation, a legal assistance attorney also includes a lawyer retained by a Soldier or Family member at his or her own expense to handle such legal matters.

Medical protective custody
Emergency medical care or custody of a child without parental consent that is approved by a MTF commander in cases where the circumstances or condition of the child are such that continuing the child in the care or custody of the parents presents imminent danger to the child's life or health.

Member
The term *member* includes former member of the Armed Forces where appropriate.

New-parent support programs
Programs to support Families through a comprehensive combination of services offered before and after the child's birth may include parent education classes, home visits, support groups, and information and referral to other military and civilian resources. There are two levels of service:

a. NPSP–Standard services are low-intensity general services available to all expectant and new Families, whether they live on or off the installation. NPSP–Standard provides information and referral to military and civilian programs (when available) and may include activities such as parenting programs, respite care for children, and supervised playtime for children.

b. NPSP–Plus services begin with screening and assessment and identify Families with children prenatal to 3 years of age who can benefit from additional, more-intensive support. This component denotes the additional intensive services that should be provided to Families at risk for child maltreatment and/or Family violence. Services may be offered for up to three years. Services are delivered using intensive home visiting and may include role modeling and/or mentoring, pregnancy and parenting education, and referral as needed to appropriate military and civilian agencies.

Offender
A person who abuses children while in a caretaker role or who abuses his or her spouse.

Out-of-home child abuse
Child abuse that occurs in a DOD-operated or -sanctioned activity. The abuser has a caretaking responsibility or is another adult or child who is commonly present in that environment (for example, custodial staff).

Outreach
A method of providing social services by reaching out to potential consumers rather than waiting for them to request assistance at an identified location.

Parent
The father or mother of a child related by blood, a father or mother by marriage (stepparent), a father or mother of an adopted child (adoptive parent), a guardian, or any other person charged with a parent's rights, duties, and responsibilities.

Physical injury
An injury to the skin, tissue, bone, or internal organs of the body.

a. Minor injury. This injury does not compromise the welfare or life of the individual. Examples include minor cut(s) or bruise(s), scratch(es), first-degree burn(s), or an injury not requiring immediate medical attention.

b. Significant injury. This injury may compromise the welfare but not the life of the injured. Examples include multiple cuts and/or bruises or other injuries in various stages of healing, loss of consciousness, second-degree burn(s), or an injury requiring immediate medical attention or medical evaluation in a treatment facility within a short period of time.

c. Serious injury. An injury that is life threatening or results in serious impairment. Examples include respiratory

compromise, any third-degree burn, a limb fracture, skull fracture, gunshot wound, stab wound, injury to a pregnant spouse/partner that could affect the fetus, or an injury requiring immediate emergency services and possible hospitalization to prevent death or serious impairment.

Primary aggressor
In the instance of spouse maltreatment, the primary aggressor is the person who maintains the power and control in an abusive incident regardless of which party started the physical or verbal action, the party who continued the dispute, or the party who "provoked" the event. This eliminates the terms *co-battering, mutual battering,* or *mutual spouse abuse* in most cases.

Program standards
Elements that guide the development and ongoing effective operation of installation Family violence prevention or parenting programs.

Protective placement cases
These cases involve child victims of abuse (other than threat-to-life cases) where, although the abuse is not life threatening, civilian foster care, EPC, or a continuation of emergency foster care nevertheless is required or will be required for the protection of the child.

Respite care
A program providing a temporary rest period for Family members responsible for regular care of children who are at risk for abuse or neglect, or regular care of persons with disabilities. Care may be provided either in the respite care user's home or a caregiver's home.

Retired military member
An individual who served on active military service and has been released upon completion of the 20-year service obligation or was medically retired and is eligible for continued military medical care.

Risk
The likelihood of another maltreatment incident occurring. Risk of reoccurrence is based on a complete risk assessment using a DA-approved instrument.

Routine cases
These cases involve all other victims of abuse whose cases have not been designated as *threat-to-life, protective placement,* or *stabilize treatment.*

Senior enlisted advisor
The immediate highest ranking enlisted noncommissioned officer (E–7 to E–9)—usually the command sergeant major, first sergeant, or acting first sergeant—who has control over Soldiers assigned under his or her unit commander.

Soldier
The term *Soldier* includes former Soldier of the U.S. Army where appropriate.

Sponsor
An active duty military member or employee of the DOD who is authorized treatment in a medical facility of the military Services.

Spouse
The term *spouse* means a dependent-spouse and, where appropriate, includes former spouse.

Spouse/partner maltreatment
An incident or incidents that indicate an emerging pattern or risk of further victimization of the spouse/partner. Excluded are behaviors indicative of marital discord with the absence of abusive acts (for example, arguments or disagreements regarding child rearing, financial management, and so on). Spouse/partner maltreatment incident indicators may include one or more of the following:

a. A pattern of intentional acts of berating, disparaging or other verbally abusive behavior that adversely affects the psychological well-being of the spouse or partner.

b. Coercive control and/or threatening behavior including terrorizing behavior (for example, threats to children, pets, or property).

c. A pattern of restricting or withholding economic resources for the purpose of controlling the spouse/partner.

d. A pattern of intentional intimidation for the purpose of controlling the spouse/partner.

e. Isolation of a partner from Family, friends, or social support resources.

f. Chronic intentional interference with cultural adaptation.

g. Physical assault(s) or threat(s) of physical violence with or without a weapon.

h. An act which by itself or in conjunction with other conduct constitutes stalking.

i. Sexual assault(s), threat(s) of sexual assault, or coercing a partner to engage in undesired sexual activity with alleged offender or other persons.

j. Obstructing a partner from receiving medical services.

k. Intentional neglect by refusing or obstructing a mentally/physically incapacitated spouse from receiving appropriate social, mental, or medical services.

Stabilize treatment cases
Cases involving instances of multiple problems, moderate or severe abuse, situations when relocation of the Soldier would jeopardize completion of the treatment plan, or when adequate resources are not available at the next duty station. Such cases require the Soldier remain assigned to his or her current duty station.

Staff judge advocate
A judge advocate so designated in the Army, Air Force or Marine Corps; the principal legal advisor of a command in the Navy and Coast Guard who is a judge advocate. The SJA advises the commander on laws and regulations affecting the command. Does not include attorneys assigned to the U.S. Army Trial Defense Service. (See R.C.M. 103(17).)

Stalking
Actions of a person performed in a repeatedly harassing manner, including but not limited to following another person in a manner to induce, in a reasonable person, fear of sexual battery, bodily injury, or death of that person or that person's immediate Family.

State Criminal History Repository
The State's central record of investigative files. Contains State information, including addresses, phone numbers, costs, and remarks.

Substantiated
An incident has been assessed, with the determination by the CRC, where the preponderance of available information indicates that maltreatment did occur.

System of records
A group of records under U.S. Government control from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual. (See also AR 340–21)

Threat-to-life cases
These cases involve victims of abuse who are at risk of death or serious (in other words, life threatening) physical injury who require or will require immediate civilian foster care, EPC or emergency measures (for example, medical protective custody) to protect their lives.

Transitional compensation
Funds paid monthly to dependent spouses and children pursuant to 10 USC 1059 where a court-martial or administrative separation is based upon a Family member abuse offense committed by a Soldier.

Unit commander
The immediate officer-in-charge or in a position of command who has control over persons subject to military law.

Unsubstantiated–did not occur
An incident that has been assessed, with the determination by the CRC, to be without merit or foundation. The available information that indicates that abuse or maltreatment did not occur is of greater weight or is more convincing clinically than the information that indicates that abuse or maltreatment occurred.

Unsubstantiated–unresolved
An incident that has been assessed by the CRC and the information available is insufficient to support a determination of either substantiated or unsubstantiated - did not occur; and/or an incident that has been assessed where the preponderance of indicators determine low risk of reoccurrence and low severity and for which voluntary services are offered.

Victim advocate
Individual who is paid or a volunteer who acts as a liaison to and for victims of spouse abuse. The victim advocate ensures victim safety, autonomy, and integrity within the intervention system.

Ward
A child (other than the sponsor's child) or adult who resides in the sponsor's home whose care has been entrusted by a court (or voluntarily assumed by the sponsor) because of age or a physical, mental, or emotional disability.

Withholding medically indicated treatment
Failure to respond to the child's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's reasonable medical judgment, most likely will be effective in ameliorating or correcting all such conditions. The term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to a child when, in the treating physician's reasonable medical judgment:

a. The child is chronically and irreversibly comatose.

b. The provision of such treatment would—

(1) Merely prolong dying.

(2) Not be effective in ameliorating or correcting all of the child's life-threatening conditions.

(3) Otherwise be futile in terms of the survival of the child.

c. The provision of such treatment would be virtually futile in terms of the survival of the child and the treatment itself under such circumstances would be inhumane.

Youthful sex offender
A child under the age of 18 years who commits any act of sexual abuse against any person, including another minor child, either against the child's will; through coercion, trickery, or fraud or in an exploitative or threatening manner. Sexual abuse generally may include, but is not limited to, the acts described under the definition of *child sexual abuse*, even when applied to an adult. Children who are not capable of understanding the nature of the act cannot consent.

Section III
Special Abbreviations and Terms
There are no entries in this section.

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