DEPARTMENT OF THE NAVY
HEADQUARTERS UNITED STATES MARINE CORPS
3000 MARINE CORPS PENTAGON
WASHINGTON, DC 20350-3000

MCO 1754.11
MFC-2
26 Mar 12

MARINE CORPS ORDER 1754.11

From: Commandant of the Marine Corps
To: Distribution List

Subj: MARINE CORPS FAMILY ADVOCACY AND GENERAL COUNSELING PROGRAM

Ref: (a) DOD Directive 6400.1, "Family Advocacy Program (FAP)" August 23, 2004
(b) DOD Instruction 6400.06, "Domestic Abuse Involving DOD Military and Certain Affiliated Personnel," August 21, 2007
(c) DOD 6400.1-M, "Family Advocacy Program Standards and Self-assessment Tool," August 20, 1992
(d) SECNAVINST 1752.3B
(e) DOD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011
(f) SECNAVINST 1754.7A
(g) DOD Instruction 6400.3, "Family Advocacy Command Assistance Team," February 3, 1989
(h) DOD Directive 5400.11, "DOD Privacy Program," May 8, 2007
(i) SECNAV M-5210.1, Ch 1
(j) 10 U.S.C. 47
(k) DOD Instruction 1402.5, "Criminal History Background Checks on Individuals in Child Care Services," January 19, 1993
(l) 42 U.S.C. 13031
(m) Manual for Courts-Martial United States 2008 Edition
(n) DOD Instruction 1342.24, "Transitional Compensation for Abused Dependents," May 23, 1995
(o) DoD 6400.1-M-1, "Manual for Child Maltreatment and Domestic Abuse Incident Reporting System," July 15, 2005
(p) SECNAVINST 1752.4A
(q) MCO 1752.5A
(r) BUMEDINST 6230.15A
(s) DOD Instruction 6400.05, "New Parent Support Program," December 20, 2005

Encl: (1) Marine Corps Family Advocacy and General Counseling Program Policy and Procedural Guidance

Reports Required:
I. Defense Manpower Management Center Quarterly Report (Report Control Symbol DD-1754-05(external DD-P&R(Q)2052) par. 3b(2)(b)
II. Serious Incident Report (Report Control Symbol MC-1754-01) Encl (1), Chap 4, par. 6d(2), 9a and 9b, Encl 1, App E, par. 1 and App F, par. 1
III. Child/Spouse Incident Report (Report Control Symbol DD-1754-06(external DD-FM&P(W)2052) Encl (1), Chap 4, par. 6d(3)
IV. Child Abuse or Domestic Violence Related Fatality Notification (Report Control Symbol DD-1754-07(external DD-P&R(A)2175) Encl (1), Chap 4, par. 9c
V. Annual Family Advocacy Program (FAP) Metrics (Report Control Symbol DD-1754-08 (external DD-P&R(Q)2052) Encl (1) Chap 10 par. 3a
VI. Quarterly FAP Metrics Report (Report Control Symbol MC-1754-02) Encl (1), Chap 10, par. 3b

1. Situation. To provide policy and procedural guidance for the effective execution and use of the Family Advocacy and General Counseling Programs (FAP) in order to support the commander's responsibility to prevent and respond to child abuse and domestic abuse, and support and treat eligible beneficiaries with counseling services in accordance with the references.

2. Mission. Commanders shall implement the programs outlined in this Order, and all installation FAPs shall comply with the policies and procedures contained herein. FAP policy and procedural guidance is contained in enclosure (1). Key program elements of FAP are prevention, intervention, and treatment of child abuse and domestic abuse.

3. Execution

a. Commander's Intent and Concept of Operations

(1) Commander's Intent. To ensure personnel tasked with assisting Marines and their families with child abuse and domestic abuse are provided adequate information pertaining to policies, procedures, and responsibilities.

(2) Concept of Operations

(a) This Order should be used in conjunction with references (a) through (s) to ensure compliance with policies and procedures established by the Commandant of the Marine Corps (CMC) and higher headquarters.

(b) Preventing and responding to child abuse and domestic abuse allegations are the responsibility of all Marines. All allegations shall be reported to FAP and military police.

(c) Definitions applicable to this Order are explained in appendix A to the enclosure.

b. Roles and Responsibilities

(1) Marine and Family Programs Division (MF), Manpower and Reserve Affairs (M&RA)

(a) Develop and recommend Marine Corps policy for child abuse and domestic abuse prevention and treatment.

(b) Coordinate the FAP with CMC (ARDB) Records Management, Major Commands, other headquarters, HQMC Staff agencies, and higher headquarters.

(c) Establish and maintain a FAP focused on the functional areas of prevention, identification, intervention, and treatment of child abuse and domestic abuse.

(d) Designate a Headquarters Marine Corps Family Advocacy Program Manager (FAPM) to provide program oversight and guidance.

(e) Identify fiscal and personnel resources necessary to coordinate and effectively implement FAP.

(f) Coordinate efforts and resources among all Marine Corps Community Services (MCCS) activities serving families to promote optimum delivery of services.

(g) Collect and provide data as required by the Office of the Deputy Assistant Secretary of Defense (DASD) for Military Community and Family Policy (MCFP).

(h) Develop policies and procedures for operating FAP, ensuring Commanders receive appropriate guidance.

(2) Headquarters Marine Corps (HQMC) FAP (CMC, MFC-2)

(a) Establish and operate FAP as one component of the Coordinated Community Response (CCR).

(b) Manage the Central Registry system for collecting and analyzing data on child abuse and domestic abuse. Implement procedures for installations to report data within 14 days of an Incident Determination Committee (IDC) determination. Submit data to the Defense Manpower Data Center, at a minimum, quarterly via the chain-of-command. Report Control Symbol DD-1754-05 (external DD-P&R(Q)2052) is assigned to this reporting requirement.

(c) Manage, monitor, and coordinate FAP policy and guidance.

(d) Develop programs and activities that:

1. Contribute to healthy relationships for individuals, couples and families.

2. Provide guidance and technical assistance on prevention programs that focus on early intervention, child abuse, and domestic abuse.

(e) Ensure appropriate quality assurance practices, including but not limited to maintaining a Credentials Review Process and conducting periodic inspections to evaluate FAP operation throughout the Marine Corps per references (a) through (f).

(f) Represent the Marine Corps on the Department of Defense (DOD) FAPM's committee and its various subcommittees and councils.

(g) Maintain liaison with DASD (MCFP) to obtain and maintain current information and developments concerning child and domestic abuse.

(h) Prepare annual budget and manpower requirements and submit justification, via the chain-of-command, to the Office of the Secretary of Defense (OSD).

(i) Provide ongoing education, training, and technical assistance to FAP personnel.

(j) Coordinate requests for activation of the DOD Family Advocacy Command Assistance Team (FACAT) per reference (g).

(k) Coordinate with applicable federal and civilian community resources concerning the operational, medical, and counseling aspects of FAP.

(3) Installation Commanding Generals and Installation Commanders

(a) Ensure that all personnel involved with the coordinated community response (CCR) to child abuse and domestic abuse receive training and comply with their defined roles, functions, and responsibilities in accordance with this Order. The CCR is composed of representatives from the following: Staff Judge Advocate, Provost Marshall Office (PMO), chaplain, Installation Marine and Family Programs (M&FP) Director, and military treatment facility (MTF).

(b) Establish and monitor an installation Family Advocacy Committee (FAC) for the prevention, reporting, investigation, and treatment of child abuse and domestic abuse as outlined in this Order.

(c) Publish written policy establishing a FAC to serve in formulating a CCR, an advisory body to address child abuse and domestic abuse at the installation, policy-making and as the oversight body for the installation FAP.

(d) Establish an IDC to review reports of child and domestic abuse.

(e) Ensure installation FAP funding is adequate to meet mission requirements and complies with guidance in this Order.

(f) Ensure the availability of a 24-hour reporting and emergency response system that is capable of providing immediate protection to victims of child abuse, sexual assault, and domestic abuse on the installation.

(g) As appropriate, establish Memorandums of Understanding (MOU) with Child Protective Services (CPS) and other authorities in the civilian jurisdiction(s) adjoining the Marine Corps installation, to include law enforcement agencies, courts, shelters, and other agencies as appropriate. A sample MOU is located in appendix B.

(h) Ensure that FAP provides training on the prevention of and response to child abuse and domestic abuse to commanders within 90 days of assuming command and annually to the total force.

(i) Issue policy that specifies the installation procedures for responding to reports of incidents of child abuse and domestic abuse in accordance with references (a), (b), (c), and (d). Installation commanders shall cooperate with civilian agencies and observe local laws pertaining to child abuse and domestic abuse incident notifications and reporting. At a minimum, procedures shall ensure that FAP reciprocally report all allegations of child abuse and unrestricted reports of domestic abuse immediately to the appropriate civilian law enforcement agency in accordance with the references.

(j) May establish procedures for registering a civilian protection order on a DOD installation.

(k) For installations outside the continental United States (OCONUS), ensure a sufficient number of Child Development Center child caregiver staff is available to supervise minor children in protective custody.

(4) Installation Marine Corps Community Services Directors

(a) Require development of Standard Operating Procedures (SOPs) for the prevention, identification, reporting, and evaluation of child abuse, domestic abuse, and general counseling and treatment in accordance with this Order and existing MOUs.

(b) Ensure sufficient professional and administrative personnel are hired for effective and efficient operation of the FAP program.

(c) Ensure adequate, up-to-date resources and equipment are available, including computer hardware/software, for FAP mission accomplishment. Ensure acceptable space is available, including individual counseling rooms with handicapped accessibility, or alternative arrangements for handicapped clients and staff.

(d) Ensure sufficient funding to meet FAP baseline operating requirements.

(e) Ensure the FAPM has access to the Installation Commander.

(f) Ensure coordination with other MCCS programs to include, but not limited to, the Exceptional Family Member Program, Marine Corps Family Team Building (MCFTB), and Transition Support Programs in order to maximize service delivery and minimize duplication of effort.

(5) Family Program (M&FP) Director

(a) Ensure FAP services are available to military personnel and their families on the installations or in the adjacent community. Examples of such services are the New Parent Support Program (NPSP), Victim Advocacy (VA) Programs, 24/7 helplines, outreach services, prevention programs and services, counseling, and other direct intervention efforts.

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

(c) Ensure accreditation and quality assurance standards are maintained for FAP and General Counseling.

(d) Ensure that programs have established SOPs for the identification, reporting, and evaluation of adult and child abuse in accordance with this Order and existing MOUs.

(e) Ensure FAP VAs and NPSP staff is resourced correctly to include cell phones and appropriate work space (preferably within the FAP).

(f) Serve as a member of the FAC and the CCR.

(6) Installation Family Advocacy Program Manager

(a) Serve as the Installation Commander's primary representative and subject matter expert on child abuse, domestic abuse, and general counseling.

(b) Administer and direct the installation FAP education and prevention programs; coordinate civilian and community resources; assess the needs of the military community; publicize how to report child and domestic abuse and illustrate available services. In this capacity, the FAPM will have direct access to all commanders on the installation.

(c) Conduct installation FAP personnel actions and contract coordination.

(d) Ensure the privileging status is current for all contract and government service clinical providers. Ensure all

providers who are not currently privileged are operating under a plan of supervision.

(e) Ensure compliance with this Order.

(f) Develop written protocols and installation SOPs for implementation of the local FAP.

(g) Identify alleged incidents of suspected child and domestic abuse, and ensure the appropriate commanding officer and PMO is notified of each incident. Ensure cases of child abuse and domestic abuse are reported in accordance with references (a), (b), (c), and (d).

(h) Ensure that FAP report all notifications of alleged child abuse involving military personnel or their family members within 24 hours and communicate all such reports of child abuse within 24 hours to the appropriate civilian child protective services agency and commanding officer in accordance with references (c) and (d).

(i) Maintain FAP case records per guidelines in Chapter 11 of this Order and references (c), (d), (h), and (i).

(j) Ensure that all incidents brought before the IDC are entered into HQMC Central Registry.

(k) Provide appropriate crisis intervention services when abuse cases involve eligible beneficiaries from other Services.

(l) Interact and form professional liaison consistent with installation MOUs with community support services such as helplines, shelters, legal assistance (on and off base), emergency funding/clothing (Navy-Marine Corps Relief, Red Cross), and other military and civilian family services, as appropriate for the installation.

(m) Establish a coordinated FAP prevention and education plan with all relevant installation agencies including PMO, MTF, and NPSP Home Visitor.

(n) Enhance FAP public relations and implement a marketing plan. Coordinate publication and distribution of notices, articles, flyers, and other FAP publications. Develop, coordinate, and use multi-media resources to educate the military community on FAP services, early recognition and reporting, and installation efforts to prevent child abuse and domestic abuse.

(o) Identify and recommend through the chain of command resources necessary to accomplish FAP mission, including the Family Advocacy Committee.

(7) Commanding Officers shall:

(a) Hold military offenders accountable.

(b) Receive training on the prevention of and response to child abuse and domestic abuse within 90 days of assuming command and annually thereafter.

(c) Ensure completion of FAP IDC training prior to participation in IDC per Chapter 2.

(d) Appoint a primary and secondary officer to receive training and participate in the IDC. Secondary appointees participate in the IDC only in the event that the primary appointee is unavailable. This requirement only pertains to those unit commanders who are convening authorities.

(e) Participate in the IDC.

(f) Support Clinical Case Staff Meeting (CCSM) treatment recommendations.

(g) Notify the installation FAPM when orders are pending to reassign service members and/or family members with open FAP cases.

(h) Ensure all Marines attend annual educational/awareness briefings on prevention of child abuse and domestic abuse.

(i) Report to FAP all suspected and alleged incidents of child abuse and domestic abuse occurring on the installation or involving military personnel or their families.

(8) Commanders Located at Installations Without a M&FP

(a) Refer service member in need of treatment or counseling to the closest military installation with a FAP.

(b) Follow-up on status of case outcome.

c. Coordinating Instructions. Leadership is key to child abuse and domestic abuse awareness, prevention, and response. The commander's role in awareness and prevention is to:

(1) Establish clear standards for personal behavior, and hold offenders accountable.

(2) Establish a climate that confronts the beliefs and values that contribute to behaviors which facilitate child abuse and domestic abuse.

(3) Continuously educate their Marines on how to prevent incidents of child abuse and domestic abuse, while also encouraging victims and witnesses to report these incidents when they occur.

4. Administration and Logistics

a. The currency, accuracy, and completeness of publication and distribution of this Order, and changes thereto, are the responsibility of CMC (MFC-2).

b. Maintenance of this Order is the command's responsibility.

c. Submit recommendations for changes to this Order to CMC (MFC-2) via the appropriate chain of command.

d. Developers, owners, and users of all Marine Corps information systems have the responsibility to establish and implement adequate operation and information technology controls including records management requirements to ensure the proper maintenance and use of records, regardless of format or medium, to promote accessibility and authorized retention per the approved records schedule and reference (i).

5. Command and Signal

a. Command. This Order is applicable to the Marine Corps Total Force.

b. Signal. This Order is effective the date signed.

R. E. MILSTEAD JR
Deputy Commandant for
Manpower and Reserve Affairs

DISTRIBUTION: PCN 10202567000

Copy to: 7000110 (55)
8145004/81450

LOCATOR SHEET

Subj: MARINE CORPS FAMILY ADVOCACY AND GENERAL COUNSELING PROGRAM

Location: _____
(Indicate location(s) of the copy(ies) of this Order.)

RECORD OF CHANGES

Log completed change action as indicated.

Change Number	Date of Change	Date Entered	Signature of Person Incorporated Change

TABLE OF CONTENTS

Chapter 1

Family Advocacy Program

1. Overview. Child abuse and domestic abuse occurring in the Marine Corps detracts from military performance, negatively impacts the efficient functioning and morale of military units and diminishes the reputation and prestige of the Marine Corps. The Family Advocacy Program (FAP) is a multi-faceted, multi-disciplinary program designed to address child abuse and domestic abuse within the Marine Corps community through prevention, intervention and treatment. Domestic violence is a violation of reference (j).

2. Policy. The Marine Corps supports healthy Marine family programs and procedures established to prevent child abuse and domestic abuse, promote healthy family development, and to protect and treat victims. In carrying out this policy, FAP will:

a. Through a Coordinated Community Response (CCR), promote public awareness within the military community and coordinate professional intervention at all levels of the civilian and military communities, including law enforcement, social services, health services, and legal services.

b. Use evidence-based practice protocols in the establishment and implementation of programming (e.g., Counseling, New Parent Support, Victim Advocacy, Prevention and Education) designed for early identification and intervention within the cycle of abuse.

c. Provide commanders with subject matter expertise and staff assistance in addressing child abuse and domestic abuse.

d. Provide information and education to individuals and families to support strong, self-reliant families and to enhance coping skills.

e. Provide treatment services to eligible beneficiaries who are involved in child abuse and domestic abuse in order to strengthen the family, when appropriate, and prevent the recurrence of abuse.

f. Support at-risk families who are vulnerable to the kinds of stressors that can lead to abuse.

g. Encourage and facilitate self-referral and treatment participation through education and awareness programs.

3. Roles and Responsibilities

a. FAP is a command managed program operating under the umbrella of Marine & Family Programs (M&FP). The M&FP Director is responsible for administrative matters. The FAPM is responsible for daily FAP operations to include ensuring implementation of this Order.

b. Major components of the FAP are: the M&FP Director, Family Advocacy Program Manager (FAPM), Commanders, Family Advocacy Committee (FAC), Clinical Counselors, Prevention and Education Specialists, Victim Advocates (VAs), New Parent Support Program (NPSP) personnel, and administrative personnel.

c. The Installation Staff Judge Advocate. Advises on legal issues involved in FAP per reference (b) and (d).

d. Provost Marshal's Office (PMO). Responds to and investigates all incidents of alleged child abuse and domestic abuse, and when necessary, refers to appropriate investigative service.

e. Command Chaplains. Ensures that pastoral care is available for service members and family members in abuse cases.

f. Naval Criminal Investigative Service (NCIS)/Criminal Investigation Division (CID). Provides a copy of the initial and follow-up reports on all child abuse cases occurring in DOD-operated or DOD-sanctioned activities within 24 hours of receipt to the installation FAPM per references (c), (d), and (g).

g. Public Affairs Officer (PAO). Coordinates with the FAPM for media requests such as the release of public-awareness materials for child abuse and domestic abuse cases.

h. Substance Abuse Counseling Center (SACC) Director. Provides evaluation and counseling services to eligible individuals whose alcohol or drug abuse may play a part in child abuse or domestic abuse.

i. Children Youth and Teen Program (CY&TP) Director

(1) Establishes internal procedures to ensure that all alleged or suspected cases of child abuse are immediately reported to FAP.

(2) Ensures all CY&TP employment applicants are screened for a history of child abuse and/or domestic abuse using the Central Registry per reference (k).

4. Administrative/Disciplinary Actions by Commanders

a. Commanders must be prepared to act decisively in cases involving alleged child abuse and domestic abuse and have 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.

b. The military justice system and FAP clinical intervention are separate processes. Commanders should proceed with administrative and/or disciplinary actions as appropriate prior to:

(1) Receipt of incident determination committee (IDC) decisions.

(2) Completion of FAP clinical assessments.

(3) Formulation of treatment plans.

(4) Initiation or completion of clinical treatment.

c. Commanders are responsible for the security and safety of their service members and must take reasonable steps to protect individuals who lawfully come within their sphere of influence. DD Form 2873, Military Protective Order (MPO), or a similar written MPO shall be issued, and compliance monitored, when necessary to safeguard victims, quell disturbances, and maintain good order and discipline.

d. Commanders shall take all reasonable measures necessary to ensure that a civilian protection order (CPO) is given full force and effect on all DOD installations. Commanders may issue MPOs even if a CPO was already issued; however, MPOs should not contradict terms of a CPO.

e. A commander may issue an MPO to a military member that is more restrictive than the CPO.

f. All persons who are subject to a CPO shall comply with the provisions and requirements of the order. Persons who fail to comply with CPOs may be barred from the installation.

g. Military personnel failing to comply with a CPO may be subject to administrative and/or disciplinary action under the UCMJ per reference (j). DOD civilian employees failing to comply with a CPO may be subject to administrative or disciplinary action in appropriate circumstances. Prior to taking

administrative or disciplinary action, supervisors should consult the servicing legal and civilian personnel offices.

h. Administrative actions ensure victim safety and hold service members accountable. Actions include, but are not limited to, debarment, removal from base housing, revocation of suitability for overseas duty, revocation of a security clearance, or administrative separation processing.

5. Confidentiality

a. FAP information is confidential. All FAP records, including the Central Registry, are maintained under the Privacy Act. Confidentiality is essential to program credibility.

b. To the extent permitted by Federal law and regulation, FAP staff, Department of Defense personnel (e.g., physicians, dentists, nurses, other health professionals, and law enforcement personnel, 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 necessary and relevant information is disclosed to those employees (military or civilian) who have a need for the information in the performance of their official duties.

c. A confidential communication of spouse abuse made by a victim-spouse to a psychotherapist or a VA is now subject to a privileged communication to the extent an exception does not apply per Military Rules of Evidence 513 and 514.

d. Prior to providing counseling services, the counselor must inform the client of the Privacy Act Statement and limits of confidentiality. Clinical providers review and explain the Privacy Act Statement, witness the client's signature, and record the date signed. Clients who decline to sign the statement may still receive services; however, the provider notes that the client refused to sign the Privacy Act Statement.

e. All suspected breaches of confidentiality shall be reported in accordance with local policy and if warranted, investigated. If validated, it may be annotated in the personnel evaluation of the employee who committed the breach. This does not preclude the supervisor from taking additional actions.

6. Exceptions to Confidentiality in FAP

a. FAP staff shall advise clients on the limits of confidentiality.

b. All providers are required to disclose to the unit commander alleged or suspected incidents of child abuse by military personnel or disclosures by a client to harm self or others.

Chapter 2

Training

1. Overview. To establish and maintain FAP training that is consistent with guidance contained herein. Specific attention will be given to training in the functional areas of prevention, intervention, assessment, rehabilitation, treatment, and education.

2. FAC Members. The command shall ensure members of the FAC receive education and training on child abuse and domestic abuse and the community's FAP response. Training should be conducted initially upon appointment to the committee and annually.

3. IDC Members. The FAPM shall ensure that all IDC members and alternate members, including non-core IDC members, are trained on IDC procedures and DOD definitions of child abuse and domestic abuse prior to voting at an IDC and annually.

4. FACAT Members. They shall receive training on the following:

a. Investigating out-of-home child sexual abuse

b. Forensic interviewing.

c. Role of the FACAT.

5. Family Advocacy Program Staff

a. Within 30 days of new employment, FAP treatment providers shall receive the following training:

(1) Privacy Act and Limits of Confidentiality.

(2) Reporting options and procedures.

(3) Overview of FAP directives and services.

(4) IDC process.

(5) DOD definitions of child abuse and domestic abuse.

(6) Community resources.

(7) Staff safety guidelines.

(8) Orientation to the Marine Corps culture.

b. All FAP personnel shall attend the FAST course within six months of employment. All FAP staff who are currently employed as of the date of this Order but have not attended the FAST course within the past 10 years must attend the FAST course within two years from the date of this Order. This should be coordinated through MFC-2.

6. Clinical Providers. Clinical providers shall complete the following training:

a. Within 12 months of employment, assessment skills for use with children and adults.

b. Curriculum and treatment modalities prior to using with clients.

7. Victim Advocates. Within 15 days of employment, victim advocates shall complete the following:

a. Transitional Compensation training.

b. Conduct an in-brief with at minimum VWAP, PMO, SJA, Sexual Assault and Prevention Response (SAPR) PM.

8. Prevention and Education Specialist. In addition to the training required by all FAP staff, the Prevention and Education Specialist shall at a minimum receive training on the following topics:

a. Methods for screening, assessing, and addressing dynamics and risk factors associated with different types of child abuse and neglect and domestic abuse.

b. Tools (evidence-based curricula) that assist Marines and their families in dealing with interpersonal relationships and marriage, improving parenting skills and adapting to stressors of military life.

c. Within 30 days of employment, overview on installation FAP Program and Services.

d. Within 45 days of employment, Headquarters Incident Determination Committee (IDC)/Clinical Case Staff Meeting (CCSM) purpose and process training.

e. Within 90 days of employment, Family Advocacy Staff Training (FAST).

f. Family Advocacy Committee (FAC) purpose and process.

g. Suicide prevention overview.

h. Military briefing creation and delivery.

i. Installation and off-installation child abuse and domestic abuse prevention resources.

9. New Parent Support Program Manager and Home Visitors

a. Training within NPSP. NPSP Managers and Home Visitors shall, at a minimum, receive training on the following topics:

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

(2) Positive techniques which promote developmentally appropriate parenting skills and disciplinary methods, promote positive parent/child communication, and educate parents on the role of attachment in the social emotional development of children and strategies for enhancing bonding and attachment.

(3) Assessing and strengthening adaptation to parenthood.

(4) Strategies to engage and support the service member's role in childrearing, especially during separations due to deployment and other military operations.

(5) Shaken Baby Syndrome, sudden unexplained infant death, and safe sleeping environments.

(6) Postpartum depression and other mental health issues impacting maternal child health.

(7) Infant and childhood nutrition to include breastfeeding support initiatives.

(8) Assessing developmental milestones and referral procedures for indicators of special needs or developmental delays.

(9) Use of community resources, to include accessing formal and informal community networks, which support families in an effort to decrease child abuse and neglect.

b. Training Outside of NPSP. NPSP staff shall assist FAP in providing training and information to commanders, senior SNCOs,

healthcare providers, FAP staff, childcare providers, and community service providers and agencies, when appropriate, to include:

(1) The purpose and organization of the NPSP;

(2) The identification of evidence determined protective and risk factors associated with child abuse and neglect and domestic abuse; and

(3) NPSP referral, assessment, and intervention procedures.

10. Central Registry. The FAPM is responsible for ensuring confidentiality and development of a central registry access list identifying those individuals entitled to access based on an official need to know.

Chapter 3

Prevention of Child Abuse and Domestic Abuse

1. Overview

a. Installation FAPs should have an established Prevention and Education Program with an identified Prevention and Education Specialist. Their services are designed to prevent child abuse and domestic abuse by:

(1) Improving family and individual functioning.

(2) Easing stressors that can aggravate or trigger patterns of abusive behavior.

(3) Creating a community and command awareness of abuse.

(4) Delivering specific educational programs.

b. The Prevention and Education Program provides community-wide education and awareness of high-risk situations that could contribute to family violence to all populations. Prevention and Education Program services are available to eligible beneficiaries on the installation and in the surrounding communities. Child abuse prevention programs will address abuse in both family and out-of-home settings.

2. Prevention and Education Program Services. The Prevention and Education Program selected prevention strategies should focus on teaching skills to individuals who have been identified as at-risk or teaching coping mechanisms so individuals are better able to address indicated risk factors that may contribute to negative family functioning.

3. Required Prevention Programs

a. Installations shall have a life management education skills program, and a parent education and support program, as well as education programs for professionals and paraprofessionals (refer to chapter 2 of this Order).

(1) Life Management Education Program. This program focuses on enrichment workshops that provide knowledge, social relationship skills, and support throughout the life cycle. The goal is to improve life management and coping skills, enhance self-esteem, and improve relationships.

(2) Parent Education and Support Program. Parent education and support programs develop skills in physical care,

protection, supervision, child management and nurturing appropriate to a child's age and stage of development.

b. FAPMs are responsible for coordinating and ensuring that the required prevention programs are available to the installations. However, all prevention services, activities and programs do not need to be programmed within FAP. FAPMs should review available services to avoid duplication whenever possible.

c. Installations that are smaller or limited in staff may use other sections such as chaplains, MCFTB, or community-based programs, to provide services, education, and training. All community-based trainings should meet evidence-based criteria.

d. All curricula for prevention classes that are distributed by MFC-2 must be implemented and utilized with FAP clients at the installation level. Facilitators must be trained in the use of the curriculum.

4. Prevention Activities. The FAPM will develop an annual prevention plan that will guide the installation's prevention programming. The Prevention and Education Program shall offer universal, selected and indicated prevention services and activities. The universal, selected and indicated services will address areas necessary to support the required life management education skills, parent education and support programs, and the education programs for installation staff.

a. Universal prevention services, activities and programs promote wellness for everyone and commit resources to enhance healthy individual, couple, and family functioning. They are usually awareness and information efforts which are provided regardless of risk and before behavior or circumstances occur. Universal services shall be provided through education and awareness efforts.

b. Selected prevention services and programs target at-risk populations or those problems that are considered to contribute most to risk. Selected prevention strategies shall focus on educating at-risk populations or on topics that address high-risk problems.

c. Indicated prevention efforts focus on those Marines and families that have been identified as at-risk and have exhibited early warning signs of behavioral health stressors. Indicated prevention efforts teach skills and coping mechanisms to individuals who have exhibited early symptoms of negative stress expression and have been identified as at-risk.

5. Role of the Prevention and Education Specialist

a. The Prevention and Education Specialist should be prepared to assist FAPM in providing commander's education on prevention services. Commander's education shall include:

(1) Training on the prevention of and response to child abuse and domestic abuse within 90 days of assuming command and annually thereafter.

(2) FAP policies and procedures.

(3) Available FAP services and resources.

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

(5) Information on FAP prevention services.

b. The Prevention and Education Specialist should provide information and training to units. Unit education shall include but is not limited to:

(1) Annual education and training on the extent and nature of child abuse and domestic abuse.

(2) Annual education and awareness on preventing child abuse and domestic abuse.

(3) Annual awareness and training on early recognition of abuse, how to report it and what services are available.

(4) Education on the IDC and CCSM process.

c. The Prevention and Education Specialist shall provide community education. Community education shall include but is not limited to:

(1) Informing the military community of the extent and nature of child abuse and domestic abuse.

(2) Supporting community awareness of child abuse and domestic abuse, including how to report it and what services are available.

(3) Making FAP services known, accessible, and attractive to those in the military community who can best use the services.

(4) Promoting community supports, encouraging early referrals and service collaboration between military and civilian services that address child abuse and domestic abuse issues.

(5) Providing general awareness training on subjects such as causes of stress, aids for improved communication, healthy parent-child relationships, and family wellness programs.

(6) Spearheading monthly awareness campaigns such as Child Abuse Prevention Month and Domestic Violence Awareness Month.

(7) Facilitating classes and workshops that provide skills training and identify coping mechanisms to assist individuals in stress management, couples communication enhancement, parent-child relationship strengthening, marital enrichment, anger control and management, and parent education.

d. The Prevention and Education Specialist shall provide installation professional and paraprofessional education. Installation professional and paraprofessional education shall include but is not limited to:

(1) Annual education to all installation professionals and paraprofessionals who work with children and in DOD-sanctioned activities on the prevention of child abuse and domestic abuse.

(2) Initial two-day IDC/CCSM training within 90 days of appointment to the IDC and prior to participation in the IDC for all members.

(3) Refresher IDC/CCSM 1-hour training offered every 90 days.

6. General Clinical Counseling

a. General counseling offers non-medical, short-term, solution-focused counseling. The intent is to focus clinical counseling on well-defined problem areas amenable to brief intervention/treatment. These include issues such as family or work-related conflicts, grief and loss, or parenting and marital issues.

b. Scope of Counseling Services. Counseling services encompass a wide scope of developmental, preventive, and therapeutic services designed to address the stressors facing today's service members and their families. Clinical counseling protocols include assessment, intervention, and treatment.

c. Client Consent. To adhere to confidentiality and professional counseling ethics and standards, the clinical provider is required to obtain written consent from the client in the following cases:

(1) If a clinical provider desires to record or have a session observed by a supervisor or other clinical provider. Recordings must be maintained in the client's file.

(2) If a case record will be shared with a student intern.

(3) Anytime a third party participates in or observes a counseling session.

(4) If child is to participate in counseling with or without a parent present, written consent from a parent or legal guardian shall be obtained prior to initiation of services. If a parent refuses consent, services cannot be rendered.

7. New Parent Support Program. The purpose of this program is to promote personal and family readiness by providing parenting education and support through home visitation and parent education and support programs. Participation in this program is voluntary. These programs are central to FAP's effort to prevent child abuse and domestic abuse.

Chapter 4

Response to Child Abuse and Domestic Abuse

1. Reporting Child Abuse and Domestic Abuse Incidents. Installations shall establish reporting protocols for handling all reports of child abuse and domestic abuse. The systems shall be available 24-hours-a-day, tailored to each installation's size, location, and other unique factors.

a. Child Abuse. This includes abuse that occurs in a DOD-operated or sanctioned activity for children, (e.g., CY&TP programs). Child abuse is defined in appendix A.

b. Domestic Abuse. This includes both unrestricted and restricted reports of domestic abuse. In instances of domestic abuse reports, victims will have direct access to the victim advocate or the specified individuals identified in paragraph 3b of this chapter. Domestic abuse is defined in appendix A.

c. In most instances, the central location for receiving child abuse and unrestricted domestic abuse reports should be the chain of command and CPS. Procedures for documentation of unrestricted child abuse and domestic abuse reports, initiation of prompt investigation, and notification of unit commander will be established by law enforcement procedures, medical protocols and MOUs.

2. Self-Referral

a. Service members on active duty and their dependant family members, regardless of their location, and Department of the Navy (DON) civilian employees and their family members in a foreign country who are eligible for MTF services may obtain services for child abuse or domestic abuse by self-referral to FAP.

b. Self-referral occurs when only the offender and victim are aware of the abuse prior to disclosure to FAP, and the self-referral was not made under threat of third party disclosure. A service member who comes forward after a spouse discloses child abuse does not constitute self-referral if the service member is the alleged offender. Information disclosed in response to official questioning in connection with any military or civilian investigation is not a self-referral.

c. Marines, family members, and certain DOD-affiliated personnel who are potential or actual offenders or victims of child abuse or domestic abuse are encouraged to seek help early. They may initiate the evaluation and intervention process by

voluntarily disclosing the nature and extent of the abuse or risk to abuse to qualified FAP clinicians.

d. Counselors must advise the client of the counselor's duty to follow established protocol for reporting allegations of abuse as described in paragraph 1 of this chapter.

3. Unrestricted and Restricted Reporting

a. Unrestricted Reporting. Adult victims of domestic abuse who wish to pursue an official investigation of the incident should use standard reporting channels (e.g., chain-of-command, FAP, or law enforcement). All reports of child abuse are unrestricted reports.

b. Restricted Reporting. Restricted reporting affords adult victims access to medical and victim advocacy services without command or law enforcement involvement and can encourage victims to feel more comfortable and safe about reporting domestic abuse. Only adult victims are eligible to elect restricted reporting. Adult victims of domestic abuse who desire restricted reporting under this policy must report the abuse to one of the following specified individuals:

(1) FAP clinician.

(2) VA or VA Supervisor.

(3) DOD healthcare provider.

c. In cases where the adult victim elects restricted reporting, the above-specified individuals may not disclose covered communications to either the victim's or offender's commander or to law enforcement within or outside DOD, except as detailed in paragraph 4 of this chapter. Disclosures made by adult victims in the presence of individuals not specified above may result in an unintended unrestricted report.

d. A physician, nurse, or mental health professional at a MTF will initiate the appropriate care and treatment, and will report the domestic abuse only to a VA or their supervisor or a FAP clinician. The VA or FAP clinician shall contact the victim and provide the victim information about the process of restricted reporting, as compared to unrestricted reporting, and offer victim advocacy services.

e. The victim will elect a reporting option in writing using the Victim Preference Statement form, provided by the VA.

Victims refusing to make an election shall be informed that failure to make an election will result in an unrestricted report.

f. For purposes of command awareness and gathering of accurate data, the FAPM is responsible for reporting restricted reporting information concerning domestic abuse incidents, without providing any identifying information about the victim or offender.

4. Exceptions to Confidentiality and Restricted Reporting and Limitations on Use. In cases in which a victim elects restricted reporting, the prohibition on disclosing covered communications to the following persons or entities will be suspended when disclosure would be for the following reasons:

a. Named individuals when disclosure is authorized by the victim in writing.

b. Command officials or law enforcement when necessary to prevent or lessen a serious and imminent threat to the health or safety of the victim or another person.

c. FAP and any other agencies authorized by law to receive reports of child abuse or neglect when, as a result of the victim's disclosure, the victim advocate or healthcare provider has a reasonable belief that child abuse has also occurred. However, disclosure will be limited only to information related to the child abuse.

d. Disability Retirement Boards and officials when disclosure by a healthcare provider is required for fitness for duty for disability retirement determinations, limited to only that information which is necessary to process the disability retirement determination.

e. Supervisors of the victim advocate or healthcare provider when disclosure is required for the supervision of direct victim treatment or services.

f. Military or civilian courts of competent jurisdiction when a military, Federal, or State judge issues a subpoena or order for the covered communications to be presented to the court or to other officials or entities when the judge orders such disclosure.

g. To other officials or entities when required by Federal or State statute or applicable U. S. international agreement.

5. Restricted Reporting and Specified Individuals

a. If the specified individuals in paragraph 3b of this chapter determine disclosure is warranted or required pursuant to one of the exceptions listed above, the specified individual shall first consult with their supervisor and servicing legal office prior to disclosure.

b. When there is uncertainty or disagreement on whether an exception applies, the matter will be brought to the attention of the Installation Commander for decision.

c. The specified individual should make a reasonable effort to provide the affected victim advance notice of the intention to disclose a covered communication, with a description of the information to be disclosed, the basis for disclosure, and the individual, group, or agency to which it will be disclosed.

6. Reporting Child Abuse and Unrestricted Domestic Abuse

a. Per reference (d) and (l), service members and DON personnel are required to report information about known and suspected cases of child abuse and domestic abuse.

b. The FAP reciprocally report:

(1) All reports of child abuse involving military personnel or their family members within 24 hours of receipt of report and communicate all such reports to appropriate civilian child protective services agency or law enforcement agency in accordance with references (a), (b), (c), and (d).

(2) All unrestricted reports of domestic abuse involving military personnel and their current or a former intimate partner within 24 hours accordance with references (a), (b), and (c).

c. Assessing Child Abuse and Domestic Abuse

(1) When FAP staff receives a report of child abuse or domestic abuse, a credentialed clinician shall be assigned to conduct an assessment of the alleged victim, alleged offender, others living in the home, and potential witnesses.

(2) This assessment shall include gathering information about the act and impact of the reported allegation; the abuse history of the alleged victim(s) and offender(s); risk factors that may affect the frequency, severity, or impact of abuse; and issues that may help determine credibility of each person. This assessment should also include development of a clinical picture

of the persons involved in the incident, a needs assessment, and the initial treatment plan.

(3) When assessing the history of abuse in the current relationship, the client may disclose specific incidents. Disclosures are not the same as reports of abuse.

d. Institutional Child Abuse

(1) Institutional child abuse is that which occurs in a DOD-operated or sanctioned child care setting.

(2) Allegations of institutional child abuse shall be reported by the FAPM to CMC (MFC-2) via phone within 24 hours and in writing within 72 hours of discovery. Report Control Symbol MC-1754-01 is assigned to this reporting requirement.

(3) If the allegation involves institutional child sexual abuse or a fatality, CMC (MFC-2) shall notify DASD (MCFP) within 24 hours of receiving the report from the installation FAPM or designee per reference (g). Report Control Symbol DD-1754-06 (external FM&P(W)2052) is assigned to this reporting requirement.

(4) The FAPM is responsible for notifying the installation chain-of-command. Refer to appendix C for additional details.

e. Individuals and units that are not assigned to a military installation with a FAP shall report incidents of child abuse and domestic abuse to the closest military installation FAP and the appropriate chain-of-command.

f. Incidents involving Reservists participating in monthly drill training periods will be reported to the appropriate chain-of-command. The commander will coordinate with local law enforcement and civilian resources to ensure the availability of VA and other victim-related services.

7. Commanders' Role in Responding to Domestic Abuse. Commanders have a vital role in the CCR to child abuse and domestic abuse. Senior enlisted personnel serving in advisory roles to commanders should also be familiar with the requirements of this section. Commanders shall:

a. Ensure alleged military abusers are held accountable for their conduct through appropriate disposition under references (j) and (m) and/or administrative action, as appropriate.

b. Respond to reports of child abuse and domestic abuse as they would to credible reports of any other crime and ensure victims are informed of available services.

c. Beginning with unit-level commanders closest to the accused, be familiar with the responsibilities delineated in this Order. If necessary, he/she shall involve his or her next higher superior officer in the chain-of-command.

d. Cooperate in making the alleged abuser available to be served with a CPO as needed and consistent with Marine Corps regulations and reference (b). Obtain a copy of the protection order and review it with the servicing legal office.

e. Ensure restricted reporting policy procedures for victims of domestic abuse are fully implemented at the installation level.

f. Refer all alleged or suspected incidents of child abuse or domestic abuse to PMO or the appropriate criminal investigative organization for possible investigation.

g. Consult with the servicing civilian personnel office and the servicing legal office when the alleged offender is a U.S. Government employee.

h. In consultation with FAP staff, ensure a safety plan is prepared and in place, and monitor the victim's safety. Ensure protection of all persons alleged or known to be at risk from domestic abuse by issuing and enforcing an appropriate MPO per reference (b) that is coordinated with those civilian authorities that enforce the protection orders issued by civilian courts.

i. With assistance of FAP, ensure safe housing has been secured for the victim as needed. The preference is to remove the alleged abuser from the home when the parties must be separated to safeguard the victim.

j. Review each law enforcement investigative report with the servicing legal office to determine appropriate disposition.

k. Consult FAP staff to determine if an alleged offender is a suitable candidate for clinical intervention services and his or her level of danger to self, victim, and others.

l. Consult personnel officials to determine if Temporary Additional Duty (TAD) or Permanent Change of Station (PCS) orders that interfere with completion of any directed intervention services should be canceled or delayed. When TAD or PCS cannot be canceled or delayed, coordinate efforts with the gaining

installation to ensure continuity of services with the FAP/VA, and others regarding intervention for both the alleged offender and the victim.

m. Document, as appropriate, that a Service member engaged in conduct that is a dependent-abuse offense when referring such action for court martial and when initiating action to administratively separate, voluntarily or involuntarily, the Service member from active duty so that the family members may apply for transitional compensation benefits per reference (n).

8. Notification Procedures

a. Installation Reporting Requirements to CMC (MFC-2). Any person with a reasonable belief that a child has been physically abused, sexually abused, emotionally abused, or neglected by a care provider in a DOD-sanctioned activity must report it to the appropriate civilian agency and CMC (MFC-2) in accordance with references (c) and (d).

b. Notification of Suspected Child Abuse

(1) Physical abuse, emotional abuse, or neglect. If a report of suspected child physical abuse, emotional abuse, or neglect is made to the FAP, the FAPM shall:

(a) Notify the commanding officer and CPS.

(b) For installations OCONUS, in the event a child/children need to be removed from the home due to allegations of abuse, respective child protective custody facilities are available for use per local regulations.

(2) Sexual abuse. If a report of suspected child sexual abuse is made to the FAP, the FAPM shall:

(a) Notify the appropriate military and/or civilian law enforcement agency.

(b) Contact the appropriate civilian CPS agency, if any, to request assistance.

(c) Forward the report through FAP channels to CMC (MFC-2) within 48 hours as required by reference (d).

(d) Consult with the person in charge of the DOD-sanctioned activity and the appropriate law enforcement agency to estimate the number of potential victims and determine whether an installation response team may be appropriate to address the

investigative, medical, and public affairs issues that may be encountered.

(e) Notify the Installation Commander of the allegation and make a recommendation as to whether an installation response team may be appropriate to assess the current situation and coordinate the installation's response to the incidents.

(f) Provide a follow-up report to CMC (MFC-2) regarding the allegation of child sexual abuse when any of the following conditions exist:

1. There have been significant changes in the status of the case,

2. There are more than five potential victims,

3. The sponsors of the victims are from different military services or DOD components,

4. There is increased community sensitivity to the allegation, or

5. When the CMC (MFC-2) requests a follow-up report.

c. Family Advocacy Command Assistance Team (FACAT)

(1) The FACAT is a multidisciplinary team composed of specially trained and experienced individuals who are on-call to provide advice and assistance on cases of child sexual abuse that involve DOD-sanctioned activities.

(2) CMC (MFC-2) shall:

(a) Designate nominees for the FACAT upon request from the DASD (MCFP) and appoint replacements when vacancies are indicated.

(b) Ensure that commanders and staff are aware of the availability and proper use of the FACAT, and the procedures for requesting a FACAT to assist in addressing extra-familial child sexual abuse allegations covered by this Order.

(c) Encourage timely and comprehensive reporting in accordance with this Order.

(3) Requesting a FACAT. An Installation Commander may request a FACAT through CMC (MFC-2) when alleged child sexual

abuse by a care provider in a DOD-sanctioned-activity has been reported and at least one of the following apply:

(a) Additional personnel are needed to:

1. Fully investigate a report of child sexual abuse by a care provider in a DOD-sanctioned activity,

2. Assess the needs of the child victims and their families, or

3. Provide supportive treatment to the child victims and their families.

(b) The victims are from different military services or other DOD components, or there are multiple care providers who are the subjects of the report, and they are from different military services or other DOD components.

(c) Significant issues in responding to the allegations have arisen between the military services or other DOD Components and other Federal agencies or civilian authorities.

(d) The situation has potential for widespread public interest that could negatively impact performance of the DOD mission.

(4) Deployment of a FACAT

(a) The DASD (MCFP) will deploy and configure the FACAT based on the information and recommendations of the requestor, the installation FAPM, and CMC (MFC-2) per reference (g).

(b) Fund citations to the FACAT members for their travel orders and per diem information regarding travel arrangements are provided through the DASD (MCFP). The FACAT members shall be responsible for preparing travel orders and making travel arrangements.

(c) FACAT members who are subject to references (e) and (f) shall be responsible for arranging temporary clinical privileges in accordance with references (e) and (f) at the installation to which they shall be deployed.

(5) FACAT Tasks. The FACAT shall meet with the installation's designated response team to assess the current situation and assist in coordinating the installation's response to the incidents where indicated. Typically, such tasks include:

(a) Investigating the allegations, while observing the applicable rights of the subject of the investigation,

(b) Conducting medical and mental health assessment of the victims and their families,

(c) Developing and implementing plans to provide appropriate treatment and support for the victims and their families and for the non-abusing staff of the DOD-sanctioned activity, and

(d) Managing public affairs issues.

(6) Reports of FACAT Activities. The FACAT chief shall prepare three types of reports:

(a) Daily briefs for the Installation Commander or designee,

(b) Periodic updates to CMC (MFC-2) and to the DASD (MCFP), and

(c) An after-action brief for the Installation Commander briefed at the completion of the deployment and transmitted to the DASD (MCFP) and CMC (MFC-2).

9. Reporting Abuse-Related Serious Injuries or Fatalities

a. Every case involving death or serious injury requiring hospitalization or resulting in permanent disability to spouse, child, or intimate partner known or suspected to be an act of domestic violence, an act of child abuse, or an act of suicide related to an act of child abuse or domestic abuse is reported by the FAPM electronically within 24 hours of discovery to CMC (MFC-2). Serious Incident Report (SIR) of Serious Injury/Fatality template can be found in appendix D. Report Control Symbol MC-1754-01 is assigned to this reporting requirement.

b. In addition, for those incidents resulting in death, DD Form 2901, Child Abuse or Domestic Violence Abuse Related Fatality Notification, must also be reported to CMC (MFC-2) within 24 hours. The link for this report can be found in appendix D. Report Control Symbol MC-1754-01 is assigned to this reporting requirement.

(1) The absence of FAP history does not preclude an incident from being presented to the IDC to determine if the death was the result of abuse. The case is then entered into the Central Registry per reference (o). The FAPM is responsible for

notifying the local chain-of-command, to include major commands and the collection of case information.

(2) A Fatality Review Committee is conducted at the HQMC level per requirements established in reference (b).

c. CMC (MFC-2) is responsible for notifying DASD (MCFP) and within 24 hours of receiving the initial report from the installation FAPM. An updated report, using the SIR format, is submitted to CMC (MFC-2) every 90 days and at case closure. Report Control Symbol DD-1754-07 (external DD-P&R(A)2175) is assigned to this reporting requirement.

10. Reporting Sexual Assault. FAP shall update the Sexual Assault Response Coordinator (SARC) within 24 hours on any incident of sexual assault. In sexual assault incidents, the FAP will provide counseling and advocacy services to ensure victim safety and support. However, sexual assault is a criminal act punishable under reference (j) as well as civilian law. Adult victims of sexual assault may have a restricted reporting option. The VA will provide additional information regarding restricted reporting. Sexual assault cases involving active duty service members are reported per references (p) and (q).

Chapter 5

FAC, IDC, and CCSM Overview

1. Overview. FAP is a command-managed program operating under the umbrella of M&FP. The commander of each installation shall ensure a FAC, an IDC, and a CCSM are established and maintained per this Order.

2. Family Advocacy Committee

a. Effective intervention in domestic violence requires involvement of many community resources working together as a CCR. Fragmentation of program planning, needs assessment, service delivery and program evaluation can be a detriment to Marine Corps support services. No single agency or department can adequately plan, provide, or evaluate the total array of services required.

b. The FAC sets an example for Marine Corps and civilian communities by operationally functioning as a CCR that provides policy and program level oversight for the FAP. FAC members are responsible for:

(1) Ensuring FAP implementation is consistent with DOD, DON, and Marine Corps policy, to include coordinated community risk management.

(2) Ensuring the availability and execution of resources for the effective and efficient implementation of the FAP.

(3) Ensuring a sufficient number of qualified personnel (military, civil service, contractors, and volunteers) is available to meet FAP program requirement.

(4) Ensuring a 24-hour-a-day mechanism is established for receiving reports of alleged domestic abuse and/or child abuse, including reports received from military and civilian law enforcement agencies, MTFs, CPS, and individuals.

(5) Ensuring the development of an installation FAP Order and annual FAP Plan. The FAC has reviewed the specific objectives, strategies, and activities of the annual written FAP plan to ensure it is based on a review of the most recent installation needs assessment, empirically supported risk factors for child abuse and domestic abuse, trends in the installation's risk management approach to child abuse and domestic abuse, the most recent accreditation review of the FAP, and the evaluation of the installation's CCR to child abuse and domestic abuse.

(6) Ensuring execution and ongoing evaluation of the annual FAP plan based on the full coordination and collaboration of all relevant Marine Corps activities and civilian organizations.

(7) Monitoring all program prevention and treatment metrics.

(8) Ensuring a case accountability system is established per references (c) and (d), this Order, and accreditation standards.

(9) Identifying and coordinate MOUs to facilitate military and civilian collaboration on and off the installation in support of a CCR and reviews all MOUs annually.

(10) Ensuring prevention, education, and training efforts are implemented, aimed at making Commands and military personnel and their families aware of the scope of child abuse and domestic abuse issues and the need for a community-centered approach.

(11) Ensuring FAP is receiving support from subordinate Commands of the installation to establish a CCR for the prevention of child abuse and domestic abuse, protection of victims of domestic violence and offender accountability.

(12) Reviewing installation policies and procedures to ensure notification of appropriate agencies in incidents of child abuse and domestic abuse.

(13) Ensuring written policies and procedures are developed to establish a local response to allegations of child sexual abuse using the DOD FACAT as a model, per reference (g).

(14) Ensuring written policies and procedures are developed to respond to fatalities due to child abuse and domestic abuse, and incidents of child abuse in DOD-sanctioned activities.

(15) Elevating to the Command any identified system concerns or constraints impacting the effectiveness of FAP and the CCR.

(16) Recommending local changes when required due to new Marine Corps policy, changes in the population served, and problems identified in needs assessment and program evaluation, and emerging community needs.

c. FAC Structure

(1) The FAC will be a multi-disciplinary team appointed in writing by the Installation Commander. FAC will advise on installation FAP's procedures, training, policy matters, program evaluation efforts and will address the overall administrative details of the FAP.

(2) The commander of each installation shall serve as Chair to the FAC, or if unavoidably absent, may delegate the position to that of a military field grade officer.

(3) The FAPM is the subject matter expert and will provide logistical support for the FAC.

(4) The FAC members shall have functional responsibility for prevention, identification, reporting, investigation, diagnosis, and treatment of child abuse and domestic abuse. In addition to the chair person, and the FAPM, the FAC must include the following at a minimum:

(a) Installation Command Sergeant Major.

(b) M&FP Director.

(c) FAP Prevention Specialist.

(d) SJA.

(e) MP, CID, or NCIS.

(f) Chaplain.

(g) MTF representative.

(h) DOD EA School Representative if applicable.

(i) Other representatives as deemed appropriate by the FAPM.

d. Permanent Members' Functions. The FAC meeting will be held at least quarterly. Minutes will be maintained that reflect the following content areas (as determined by the FAPM in conjunction with the Installation Commander):

(1) Recommendations for FAP programs and procedures.

(2) Improvements for ensuring a CCR.

(3) Resourcing issues.

(4) Identification of long range, intermediate, and immediate FAP needs and action for implementation to include corrective action plan.

(5) Accreditation monitoring and oversight on corrective actions.

(6) Community trends/risks that involve FAP.

(7) Analysis/discussion on installation level quarterly data on child and domestic abuse.

(8) Results of evaluation on prevention training program.

(9) Identification and monitoring of quality improvement concerns.

e. Installation FAP Standard Operation Procedures (SOP). The installation FAP SOP specifies the FAC as the policy recommending, implementing, coordinating, and overseeing body for the installation FAP. The Order defines the membership, functions, and responsibilities of FAC per DOD, DON, and Marine Corps policies, and ensures local written policies and procedures are in place to:

(1) Protect a victim during the investigation and assessment phase and to hold offenders accountable.

(2) Ensure the timely sharing of findings among the various military and civilian organizations involved in investigations to the extent authorized by Privacy Act and local MOUs.

(3) Protect the rights of everyone involved in an investigation.

(4) Ensure all minors in a household where child abuse has been alleged receive a medical assessment and treatment by medically trained personnel.

(5) Clearly delineate the roles of FAP staff and military and civilian law enforcement agencies or CPS in responding to and investigating an incident.

(6) Notify the Command and other appropriate agencies when an allegation of abuse is received. CPS is notified in alleged cases of child abuse reported in the United States of America.

(7) Ensure overseas investigations are adapted to host nation laws, Status of Forces Agreement, and local requirements and practices.

3. Incident Determination Committee

a. Purpose. The purpose of the IDC is to decide which referrals for suspected child abuse or unrestricted domestic abuse meet the DOD criteria found in appendix E that define such abuse, requiring entry into the FAP Central Registry. This decision is known as the Incident Status Determination (ISD). Referrals presented to the IDC shall also include incidents of alleged abuse or neglect in which the victim has died in connection with such alleged abuse or neglect. The IDC will occur at the location that has the Primary Managing Authority for the case.

(1) With respect to child abuse incidents, an ISD may differ from a case substantiation decision made by a civilian CPS agency. Such differences may occur because the DOD criteria that define the type of abuse may be more or less inclusive than the criteria used by the civilian CPS agency and because the IDC may have different or more information than the civilian CPS.

(2) An IDC meeting is not a disciplinary proceeding under references (j) and (m) and the evidence rules and requirements for due process for disciplinary proceedings do not apply to IDC meetings and determinations.

(a) A commander may not take administrative or disciplinary action against a service member based solely upon the ISD for an act of child abuse or domestic abuse, or intimate partner abuse allegedly committed by that service member. This in no way increases or restricts a commander's ability to determine appropriate accountability for an offense committed by the service member.

(b) When making an initial disposition with respect to an act of child abuse and domestic abuse, a commander my consider information that was presented to the IDC. Additionally, information presented to an IDC may also be introduced into evidence applicable to the proceeding in question. This in no way increases or restricts a commander's ability to determine appropriate accountability for an offense committed by the service member.

(3) In rare circumstances with complex cases, the IDC may decide that available information is insufficient to make a determination within the required timelines. The motion to table a case may be made by any IDC voting member and shall be voted

upon by all members. These cases are reviewed monthly to ensure a determination can be made in a timely manner. Commanders are encouraged to not wait for ISD results prior to taking action, if any, upon service member.

b. Composition. The IDC will be a multi-disciplinary team appointed in writing by the Installation Commander. The IDC model requires active participation by the installation Chief of Staff as the IDC Chairperson, and unit commanders (battalion/squadron level), or the unit commander's designee, appointed by that unit commander. For installations with a Marine Civilian as a Chief of Staff, a Senior Military Officer equivalent, but not more than one pay grade lower, shall serve as the IDC chairperson.

(1) The committee will consist of the following core members:

(a) IDC Chairperson.

(b) Installation Sergeant Major.

(c) A military officer or Staff Non-Commissioned Officer from Provosts Marshal's Office, Criminal Investigation Division, and/or Naval Criminal Investigative Services.

(d) Judge Advocate from SJA Office.

(e) The FAPM.

(2) All aforementioned parties are voting members. The IDC Chair shall ensure appropriate senior ranking members are appointed from above identified organizations.

(3) The following parties are non-permanent (non-core) members:

(a) Unit Commander

1. The Unit Commander (squadron or battalion level) of the active duty alleged offender or active duty victim, or the active duty sponsor in cases of child abuse, should participate in the IDC and is a voting member. In cases of dual military, both commanders are voting members.

2. Unit Commanders (squadron or battalion level) serving as convening authorities shall appoint a primary and secondary officer to participate in the IDC process. This officer shall not be more than one grade lower in rank than the commander. Additionally, the commander should ensure he/she has

a trained alternate to act in the primary command representative's absence. The secondary command representative should be of the same rank as the primary command representative.

(b) Attendance at the IDC is limited to individuals with an authorized "need to know" or who have relevant information to present. No active duty service member or family member who is an alleged abuser or victim is authorized to attend the IDC, nor is an attorney for such individuals permitted to attend the IDC. However, if additional information is required to determine whether an incident meets the appropriate criteria as outlined in this Order, the IDC Chairperson may invite a non-voting guest to attend and present pertinent relevant information.

c. Notice of IDC Meeting

(1) The IDC shall meet, at a minimum, monthly.

(2) The FAPM shall serve as the IDC coordinator and shall oversee the compiling and distribution of the agenda for each meeting to each IDC member no less than 10 days before the scheduled IDC meeting.

(3) Staff should exhaust all reasonable means to ensure offenders and victims are notified regarding upcoming IDC meeting on their case.

d. Quorum. IDCs shall not make an ISD unless four voting members are present.

e. Deliberations

(1) Relevant Information. The IDC shall only discuss that information related and pertinent to the specific allegation(s) presented, and the criteria each type of alleged abuse requires as set forth in this Order. Such information need not meet the requirements for admissibility under the Military Rules of Evidence under references (j) and (m).

(a) All reports of child abuse and/or unrestricted domestic abuse shall be brought to the IDC for status determination when the alleged offender, alleged victim, or non-offending parent is on active duty.

(b) Any information otherwise protected from disclosure under reference (h) may be disclosed to the IDC in accordance with procedures set forth in reference (h).

(c) The FAPM shall introduce the case. Ensure ISDs

are made on an incident by first identifying each type of alleged abuse. The commander of the sponsor shall open the discussion of the incident by presenting the information that the command has received about the incident. When a law enforcement response or criminal investigation has occurred with respect to the incident, the PMO/CID or NCIS shall present information for the criteria relevant to the incident. Each IDC member and authorized guest may present additional information relevant to determining whether the incident met the appropriate criteria as listed in this Order.

(d) In case of diverging accounts, at the discretion of the Chairperson, the IDC may consider readily available historical information related to abuse and power and control, as well as witness reports, to establish credibility.

(e) Separate allegation numbers will be created for each victim and each incident of abuse.

(f) Victim Impact Statements (VIS) shall not be brought before or considered by an IDC.

(2) ISD Voting. The IDC shall make ISDs within 45 days of the initial report of child abuse or domestic abuse.

(a) Core members or their alternates, and all involved active duty members' commanders or their alternates, shall participate in ISD voting, with the Chair voting last. Each voting member shall cast a vote based on the totality of the available information and on a "preponderance of the information" standard. A Decision Tree algorithm is used to facilitate the voting and assist in making ISDs for cases to be entered into the FAP Central Registry.

(b) The decision whether the incident meets the specified criteria shall be made by a majority vote, the Chair shall cast the tiebreaking vote. The Chair may request information from each IDC member on why they voted as such prior to casting the tiebreaking vote. For purposes of whether or not to enter the reported incident into the Central Registry, recantation by the victim shall not, in and of itself, be used to conclude that abuse did not occur.

(c) Each type of abuse has two possible criteria:

1. Part A: An act or failure to act.

2. Part B: Physical injury or harm or reasonable potential for physical injury or harm, or psychological harm or reasonable potential for psychological

harm, or stress-related somatic symptoms resulting from such act or failure to act.

(d) There may be a Part C containing one or more exclusions that negate Parts A and B criteria.

(e) Some cases will have multiple incidents of abuse perpetrated by the same offender to the same victim disclosed during the initial assessment. In these cases, only one case shall be opened and the IDC shall vote only on the incident that was originally reported. Other incidents that are disclosed during the initial assessment are not considered reports unless they have been reported to other official reporting entities outside of the FAP assessment. However, if the initial report is of multiple incidents of different types of abuse, each of those incidents shall be assessed and taken to the IDC.

(f) If a new allegation of abuse is made after the ISD, then that incident shall be fully assessed and brought before the IDC for voting even if it is similar in act or impact to previously reported incidents.

(3) Voting for Part A. Each voting member shall vote "meets" or "does not meet" criteria for Part A for each type of abuse set forth in this Order.

(a) If the vote indicates that the IDC determined that the incident did not meet the specified criteria for Part A for the type of abuse, the ISD shall be determined as "did not meet criteria." No further IDC discussion or deliberation concerning the incident is required.

(b) If the vote indicated that the IDC determined that the incident met the specified criteria for Part A, the IDC shall consider the Part B criteria. If there are no Part B criteria, the ISD shall be determined as "meets criteria" and no further IDC discussion or deliberation concerning the incident is required.

(4) Voting Part B. If the IDC determined that the incident met the specified criteria for Part A for each type of abuse, each voting member shall vote "meets" or "does not meet" criteria for Part B; each member who voted on part A must also vote on Part B, regardless of agreement of whether or not Part A met criteria.

(a) If the vote indicates that an incident met the criteria for Part A but did not meet the specified criteria for Part B for the type of abuse, the ISD shall be determined as "did not meet criteria." No further IDC discussion or deliberation concerning the incident is required.

(b) If vote indicated that an incident met the criteria for both Part A and Part B for the type of abuse, the ISD shall consider the Part C criteria. If there are no Part C criteria the ISD shall be determined as "meets criteria" and no further IDC discussion or deliberation concerning the incident is required.

(5) Voting Part C. If the IDC determined that the incident met criteria for Part A and B, each voting member shall vote "meets or "does not meet" the specified criteria for any Part C exclusions. If the vote indicates that the incident does not meet the specified criteria for any Part C exclusion, then the ISD shall be determined as "meets criteria." If the vote indicates that the incident meets the specified criteria for Part C exclusion, then the ISD shall be determined as "does not meet criteria."

f. Record of IDC Deliberations

(1) Ensure unit commanders receive a disposition letter on each case brought before an IDC. Disposition letters contain privacy-sensitive information. As such, these letters shall be addressed to the appropriate commanding officer and case manager will notify the family member or other person who is an alleged abuser, victim, or parent of a victim of the ISD determination. No further information pertaining to the IDC and ISD decision process shall be disclosed.

(2) The FAPM shall ensure that an explanation of the FAP process and timelines for reviewing the ISD is communicated to the unit commander of each active duty member involved in an ISD and to the family member of other person who is an alleged abuser, victim, or parent of a victim.

(3) The FAPM shall ensure ISD data is entered into the Marine Corps Central Registry within 15 business days of the ISD. Upon entry completion, the submission is processed for submission to HQMC and the internal Abuse Report is printed from the database and entered in the installation FAP case file.

(4) Minutes of the meetings must be written and kept on file for two years at the local FAP. At a minimum, the minutes will include the following:

(a) Administrative. Date of meeting, members present, members absent, and others present.

(b) Cases. Incident number and type of abuse alleged, referral date, overview of incident, ISD to include

tallied votes for each portion of the decision tree algorithm. No PII will be included in the minutes.

(5) The FAPM shall sign and record the ISD in the offender's FAP record of the incident. The ISD shall be recorded in the FAP record but shall NOT be included or otherwise noted in the medical or service record of any service member or family member.

4. Review of an Incident Determination Committee Decision

a. Information regarding the review process shall be provided to the alleged abuser, victim, or a parent on behalf of a child victim, in a statement of rights during a FAP assessment as well as in the IDC disposition letter.

b. The alleged abuser, victim, or a parent on behalf of a child victim, commander, or initiating IDC member may request, in writing, IDC reconsideration based upon either of the following:

(1) The IDC did not have all the 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 IDC determination or was not considered at such time. This information must have existed or been discovered within 30 days of the IDC determination. Information that is not available due to the requestor's failure to cooperate during intake and interviews is not a basis for a request for reconsideration.

(2) Evidence that the IDC did not follow policy published in this Order. During reconsideration, the IDC will follow the same published procedures for evaluation, presentation, and determination that are used during an initial IDC review. Accordingly, an ISD may be made only if a preponderance of the available information could potentially change the outcome of the ISD. The case re-evaluation and determination will be documented in the record and IDC minutes.

c. The request to the IDC must be made in writing to the installation commander via the requestor's command no more than 30 calendar days after the decision. It must clearly state what relevant information was not presented to the IDC or what published policy or procedure was not followed and the information supporting that position. Only one reconsideration request will be considered for each incident. Treatment will not be suspended, interrupted, or postponed pending the outcome of the review.

d. If the installation commander denies a review of the ISD, a request for CMC (MFC-2) to evaluate the request for ISD review

may be made within 30 calendar days by the requestor. The 30 calendar days starts with the notification of the denial of the request for review from the installation. CMC (MFC-2) will determine if a review is warranted. Service members must submit requests through their chain of command to CMC (MFC-2). Non-service members must submit requests through the FAPM to CMC (MFC-2).

e. If the request for the ISD review is approved at either level, FAP shall notify both the offender and the victim or non-offending parent that an ISD review for their case has been ordered and will be heard by the IDC. In this notification FAP shall provide the date of the pending IDC and offer the involved parties to schedule an assessment with a FAP clinician prior to the IDC date to present any new information about that incident when paragraph 4b(1) is the basis for review. The ISD review shall not be delayed due to a lack of subsequent assessment of the offender, victim, or non-offending parent.

5. Clinical Case Staff Meeting (CCSM)

a. Purpose. The purpose of the CCSM is to clinically consult about the assessment and ongoing case management of interventions with families having allegations of abuse. Safety planning, supportive services and clinical treatment are the core areas of the CCSM. The referral should not be presented to the CCSM until the FAP family assessment is complete. The CCSM operates independently from the IDC and does not need to wait for an ISD in order to make treatment and referral recommendations. Additionally, the CCSM will:

(1) Facilitate supportive services and appropriate treatment for victims of child or domestic abuse who are eligible for treatment in a MTF. If the sponsor fails or refuses to obtain military identification for dependent family members, then the CCSM will report the violation to the sponsor's commanding officer.

(2) Provide coordinated case management, including risk assessment and ongoing monitoring of child abuse and domestic abuse victims' safety, between military and civilian agencies consistent with reference (b).

(3) Recommend specific protective measures to the commander regarding an alleged offender for a victim who is eligible to receive treatment in a MTF. Such measures include an MPO, weapons removal, relocation, escort assignment, restrictions, bar to the installation, removal of child/children, etc.

(4) Recommend clinical intervention and rehabilitation appropriate treatment for alleged offenders who are eligible for treatment in a MTF.

(5) Recommend case transfer and closure decisions.

b. CCSM Attendees

(1) The FAPM or a clinical supervisor shall chair the CCSM.

(2) Attendance at CCSMs is limited to those with clinical expertise in child abuse and domestic abuse and on a case-relevant basis. The FAPM shall exercise discretion in inviting other military or civilian medical, mental health, or clinical social services providers who may add value to the clinical case discussions, including:

(a) In child abuse incidents only, a representative from the civilian CPS agency and/or a representative from NPSP, who is working with the victim.

(b) In domestic abuse incidents only, for the discussion of recommended safety planning, supportive and treatment services for the victim, a domestic abuse VA who has worked directly with the victim.

c. Agenda. The agenda of CCSMs shall include:

(1) A review of newly reported child abuse and domestic abuse incidents, and whether or not the incidents were presented to the IDC.

(2) Open cases, including open cases transferred from another installation. Open cases shall be reviewed:

(a) At least monthly for incidents of child sexual abuse.

(b) At least quarterly for all other incidents.

(3) Open cases recommended for termination of services and case closure. "Met Criteria" cases must remain open for a minimum of one year.

(a) If treatment is not completed after one year from the ISD date, then a clinical supervisor must approve the continuance of treatment on a quarterly basis.

(b) Once the one-year minimum and all treatment are completed, the case file shall be closed.

d. CCSM Discussions. Persons attending the CCSM shall provide clinical consultation to the FAP case manager as needed for each incident to ensure thorough discussion of:

(1) The safety plan and protective measures in place.

(2) The severity of harm.

(3) The results of risk assessments and psychosocial history and the assignment of a risk level.

(4) Clinical intervention, as appropriate, to address the needs of each victim and any other family members for supportive services.

(5) The success of such intervention and supportive services in protecting and assisting the victim, potential changes to or enhancement of such intervention, and supportive services and the appropriateness of terminating such intervention when clinically indicated.

(6) Clinical intervention to address the behavior of each alleged offender.

(7) The success of such clinical intervention in assisting the alleged offender in changing his or her behavior, changes to or enhancement of treatment provided to each alleged offender, and the appropriateness of terminating treatment when clinically indicated.

(8) Coordination of military and civilian service providers for such assessments, supportive services, treatment, and clinical intervention.

(9) With respect to victim safety:

(a) The current VIS describing the impact of the abuse on the victim, including financial, social, psychological, and physical harm suffered by the victim, if any.

(b) The victim's safety plan.

(c) Steps taken by military or civilian authorities to ensure the victim's safety and the safety of any children cared for in the home.

(d) The effect of any new incidents of abuse since the last CCSM discussion of the case on the risk of further abuse or risk of increased severity to the victim.

(e) Recommended changes to the victim's safety plan.

(10) Coordination with the chain-of-command and other community or collateral contacts, such as the CPS agency, schools, law enforcement, VAs, NPSPs, etc.

(11) Recommendations for continued child placement in foster care (for FAPs overseas that are acting as a CPS agency).

e. CCSM recommendations are For Official Use Only-Privacy Sensitive. The CCSM Chair shall ensure all written and electronic communications are appropriately safeguarded, marked, delivered using current established Marine Corps processes. At a minimum, when an IDC has determined an allegation to have "met criteria," the CCSM shall then communicate recommendations of the CCSM to the Commander via properly labeled and safeguarded encrypted email or confidential written correspondence. The recommendations shared with the command are only those regarding the service member belonging to the command and/or if the service member was the non-offending parent in a child abuse case, recommendations for that child(ren).

f. Quorum. The participation by two credentialed clinical social services providers is required to achieve a quorum.

g. Record of CCSM Discussions. Notes of CCSM discussions shall be documented in the FAP record.

h. Confidentiality of CCSM Discussions

(1) The FAP case manager may disclose the results of the CCSM discussion pertaining to:

(a) The victim or non-offending parent of a child victim to such victim or non-offending parent, and to others only as authorized by procedures set forth in reference (h) but may not otherwise disclose the results of the CCSM discussion pertaining to the victim to any other person.

(b) The alleged offender to such alleged offender and to others only as authorized by procedures set forth in reference (h) but may not otherwise disclose the results of the CCSM discussion pertaining to the alleged offender to any other person.

(2) In communicating to individuals noted in paragraphs 5h(1)(a) and 5h(1)(b) of this chapter, the FAP case manager shall not reveal the identity of any person at the CCSM who made specific comments. The FAP case manager shall not disclose any other information from the CCSM discussion to any other person except as authorized by procedures set forth in reference (h).

(3) Any other person who attended a CCSM who also directly provides clinical services to the victim, the alleged abuser, a child cared for in the home or, in a child abuse case, the non-offending parent may, as appropriate and at his or her discretion, disclose the relevant results of the CCSM discussion pertaining solely to such person receiving the clinical services. Such disclosure shall not reveal the identity of any person at the CCSM who made specific comments. The person making the disclosure shall not disclose any information from CCSM discussions to any other person except as authorized by procedures set forth in reference (h).

(4) Information disclosed at the CCSM that is protected from disclosure under reference (h) shall not be disclosed except as authorized by procedures set forth in reference (h).

Chapter 6

Intervention and Treatment

1. General Principles for Clinical Intervention

a. Goals of Clinical Intervention. The primary goals of clinical intervention in domestic abuse are to ensure the safety of the victim and community and promote the cessation of abusive behaviors.

b. Intervention. Successful intervention for child abuse and domestic abuse requires the multi-disciplinary team approach of an effective CCR. Commands, law enforcement, and FAP personnel work in coordination to ensure victim safety. Law enforcement personnel gather investigative facts and FAP staff conducts the necessary assessments and makes recommendations to command regarding victim safety. Steps in intervention include:

(1) Identifying incidents and ensuring immediate safety/protection of victim(s) and family members.

(2) Determining clinical and safety issues pertaining to the incident. Interventions may be an immediate response to a report or may be further developed and enhanced in the CCSM.

(3) Referring the case to IDC within 45 days of report date.

(4) Determining incident status.

(5) Implementing and coordinating treatment plans.

(6) Monitoring open cases.

(7) Closing cases when appropriate.

(8) Referring victim(s) and family members for ongoing services, as appropriate, when a case is closed due to the offender's separation from military service.

c. All treatment curricula that are distributed by CMC (MFC-2) must be implemented and used with FAP clients at the installation level. Facilitators must be officially trained on the use of the curriculum.

d. Professional Standards. Child abusers and domestic abusers who undergo clinical intervention shall be treated with respect, fairness, and in accordance with professional ethics.

(1) Clinical service providers who conduct clinical assessments of and/or provide clinical treatment to abusers are not required to advise individuals of their right against self-incrimination under Article 31, UCMJ, and of their right to legal counsel since the provider's role is based upon therapeutic rather than law enforcement or disciplinary concerns.

(2) Clinical service providers and military and civilian victim advocates must adhere to laws, regulations, and policies regarding safeguarding and disclosure of information pertaining to victims and abusers.

(3) Individuals and FAP personnel providing clinical intervention to persons reported as domestic abusers shall not discriminate based on race, color, religion, gender, disability, national origin, age, or socioeconomic status. Cultural differences in attitudes shall be recognized, respected, and addressed in the clinical assessment process.

e. Clinical Case Management. The clinical service provider has the responsibility for clinical case management.

2. Clinical Treatment

a. All involved parties in a child abuse or domestic abuse case must be offered appropriate treatment or referrals as provided below:

(1) Service members, civilian spouses, or other DOD affiliated personnel alleged of child abuse or domestic abuse incidents shall be offered treatment referral and support services by FAP.

(2) Non-MTF eligible persons shall be offered information and referrals to local agencies that provide shelter, treatment, and support.

(3) Victims and offenders needing intensive or medical mental health services that are not available through FAP services shall be referred to MTFs, TRICARE, and civilian private practitioners; however, this does not preclude brief or solution-focused counseling or therapy to be provided by FAP staff. Referrals for treatment of domestic and child abuse offender and victims will not be made to Military OneSource or to Military Family Life Consultants.

(4) Independent duty personnel east of the Mississippi River (minus Wisconsin) are served by Marine Corps Base (MCB) Quantico, Virginia.

(5) Independent duty personnel west of the Mississippi River (plus Wisconsin) are served by MCB Camp Pendleton, California.

(6) Eastern and Western Recruiting Region is served by MCRD San Diego, California.

(7) Marine Forces Reserve can call (540) 678-6581 or DSN 678-6581.

b. Theoretical Approaches. Based on the results of the clinical assessment, FAP clinicians shall select a treatment approach that directly addresses the abuser's risk factors AND his or her use of violence. Such approaches include but are not limited to cognitive and dialectical behavioral therapy, psychodynamic therapy, psycho-educational programs, attachment-based intervention, and combinations of these and other evidenced-based approaches.

c. Treatment Planning

(1) FAP clinicians shall develop a treatment plan for domestic abuse that is based on a structured assessment of the particular relationship and risk factors present. The treatment plan shall not be based on a generic "one-size-fits-all" approach.

(2) Co-Occurrence of Child Abuse. When a domestic abuser is a caregiver of one or more children in the home, the clinician shall ascertain whether the abuser has allegedly committed child abuse or neglect against such children. If so, the clinician shall:

(a) Notify the appropriate CPS agency, FAPM supervisor, and ensure the child is interviewed by FAP personnel.

(b) Address the impact of such abuse of the child(ren) as a part of the domestic abuser clinical treatment.

(c) Seek to improve the abuser's parenting skills in conjunction with other skills.

(d) Continuously assess the abuser as a parent throughout the treatment process.

(e) Request legal advice from the appropriate SJA and/or legal advisor on whether State law in the jurisdiction where the domestic abuser resides defines a child who has witnessed domestic abuse in the home to be an abused child. Such statutes have been enacted because some studies have shown that

children who witness domestic violence in their home are at higher risk for emotional, health, and learning problems. If such a law is applicable, the clinician shall notify the appropriate CPS agency. If no such law is applicable, the clinician shall encourage the victim to seek an assessment of the child(ren) and appropriate treatment.

(f) Address the impact of children that witness domestic abuse as part of the domestic abuser clinical treatment.

(g) Provide treatment to children who have been impacted by child abuse or domestic abuse.

d. Considerations for Treatment. Clinical treatment may be provided in one or more of these modalities appropriate to the situation:

(1) Group Therapy.

(2) Individual Treatment.

(3) Conjoint Treatment with Substance Abusers. When small numbers of both domestic abusers and substance abusers make separate treatment groups impractical, consideration should be given to combining abusers into the same group. When domestic abusers and substance abusers are combined into the same group, the facilitator(s) must be certified in substance abuse treatment as well as meeting the conditions for FAP clinician qualifications.

(4) Conjoint Treatment of Couples. Conjoint treatment shall be suspended or discontinued if monitoring indicates an increase in the risk for abuse or violence. Conjoint treatment shall NOT be used if one or more of these factors are present:

(a) The abuser:

1. Has a history or pattern of violent behavior and/or of committing severe abuse.

2. Lacks a credible commitment or ability to maintain the safety of the victim or any third parties. For example, the abuser refuses to surrender personal firearms, ammunition, and other weapons.

(b) Either the victim or the abuser or both:

1. Participates under threat, coercion, duress, intimidation, or censure, and/or otherwise participates against his or her will.

2. Has a substance abuse problem that would preclude him or her from substantially benefiting from couples treatment.

3. Has one or more significant mental health issues (e.g., untreated mood disorder or personality disorder) that would preclude him or her from substantially benefiting from couples treatment.

e. Treatment Outside the FAP. If the abuser's treatment is provided by a clinician outside the FAP, the FAP clinician shall follow procedures in accordance with relevant laws, regulations, and policies regarding the confidentiality and disclosure of information to:

(1) Request disclosure of information pertaining to the abuser's treatment for the purpose of monitoring the abuser's progress toward identified treatment goals.

(2) Use any such information disclosed.

(3) Disclose information provided to FAP by the abuser to such outside clinician.

f. Criteria for Evaluating Treatment Progress and Risk Reduction. In determining when treatment shall be ended the FAP clinician shall assess progress in treatment and reduction of risk. If a risk factor is not addressed within the domestic abuse clinical intervention but is being addressed by another clinical service provider, the FAP clinician shall ascertain the progress and/or results of such other treatment from the clinical service provider providing treatment for the other risk factor(s). Treatment should be assessed quarterly in light of information from numerous sources, especially but not limited to the victim, and adjusted to address emergent or exacerbated concerns. In making contact with the victim and in using the information, clinical service providers shall always consider the victim's safety concerns.

g. Closing a Treatment File. A file may be closed when one or more of the following apply:

(1) Successful completion of treatment plan and goals.

(2) Three unexcused absences of scheduled appointments over the course of treatment. FAP must contact command via correspondence notifying them of their Marine's unexcused absence(s).

Chapter 7

Victim Advocacy Program

1. Overview. Each installation will establish a 24/7 Victim Advocacy Program within FAP to provide comprehensive assistance and support to victims of domestic abuse and sexual assault. VAs are assigned to victims of domestic abuse, sexual assault, or to the non-offending parent of a victim of child abuse, who request services, as provided below.

2. General Program Requirements

a. Both immediate and ongoing advocacy services shall be offered to all victims of domestic abuse and sexual assault who are eligible to receive treatment at a MTF.

b. VAs must inform victims of both the restricted and unrestricted reporting options and provide services consistent with the victim's reporting election.

c. Victims who are ineligible to receive treatment at a MTF shall be offered immediate safety planning and referred to civilian support services for all subsequent care needs and services.

3. Victim Advocacy Responsibilities

a. Initial Response. During the initial response to a victim, VAs must:

(1) Ensure victim understands that communication with VA is voluntary.

(2) Inform victim of both restricted and unrestricted reporting options, and ensure the victim makes an election in writing.

(3) Respond to all calls received from victims within 15 minutes.

(4) Assess the situation for imminent danger of life-threatening physical harm to the victim. In the event that there is evidence of imminent danger of life-threatening physical harm to the victim, the VA should immediately contact emergency services. Based on the VA's assessment, if there is a good faith belief that there is an imminent threat to the safety or health of a victim or another person, even if the victim has elected the

restricted reporting option, command or law enforcement will still be notified.

(5) For all sexual assault cases, VAs must update both the SARC and FAP Manager within 24 hours of the incident.

(6) With the active participation of the victim, VA shall assist with the development of an initial safety plan in accordance with DD Form 2893. A copy of the safety plan shall be provided to the victim. The VA should retain a copy of the safety plan only if the victim is eligible for VA services and has agreed to continue services. If the VA retains a copy of the safety plan, the victim must be informed that the plan will be kept in a locked record within the FAP office.

(7) Encourage victim to seek medical care.

(8) Ensure victim is aware of the legal actions available to promote their safety such as MPOs and CPOs. As requested, provide victim with appropriate referrals for these services.

(9) Provide victim information on applicable local resources that offer housing to include shelters, childcare services, clinical resources, chaplain resources, and other military and civilian support services.

(10) VAs shall make contact with the victim when possible. Contact with the victim may include but is not limited to:

(a) Office visit.

(b) Third place neutral location.

(c) Home visit.

b. Ongoing Victim Advocacy. As a part of the ongoing advocacy services to the victim, VAs have the following responsibilities:

(1) Maintain follow-up contact with victims in open cases at a minimum every 30 days.

(2) Ensure that victims in an open case who relocate are provided with the new VA's contact information for continued services.

(3) Ensure the safety plan of the victim is current.

(4) Support the victim in decision-making by discussing all relevant options to include the planning of long-term goals in relation to abuse incident.

(5) If eligible, educate the victim on the Transitional Compensation for Abused Family Members Program and assist them with completing the application.

(6) When necessary, in cases where the military is involved in the investigation or disposition of an offense punishable under UCMJ, assist the victim in contacting the Victim and Witness Assistance Program (VWAP) representative.

(7) Advise the victim of FAP clinical resources.

(8) Accompany the victim to appointments and civilian and military court proceedings that are related to the abuse incident as appropriate and upon the victim's request. VAs will not watch the child during appointments and proceedings.

(9) At the victim's request, VAs will act as liaisons between victim and offender's chain of command for issues related but not limited to:

(a) Safety.

(b) Financial allotment.

(c) Transportation.

c. Advocacy After Duty Hours

(1) VAs shall provide onsite assistance to victims within two hours when:

(a) A victim is at an MTF.

(b) The victim requests a VA.

(c) Law enforcement calls the VA notifying of injuries to victim.

(d) Responding to calls after duty hours.

(2) VAs shall be appropriately compensated via compensatory time/overtime for any hours worked in excess of 40 hours per week when on-call after duty hours. VAs shall also receive reimbursement for local mileage traveled to provide support to victims.

d. Systems Advocacy. Victim Advocates shall promote a CCR for both the prevention and intervention of domestic abuse and sexual assault. As a systems advocate, the VA has the following responsibilities:

(1) Collaborate with other military and civilian agencies to improve support services for victims.

(2) Collaborate with military law enforcement and criminal investigative units to establish protocols to ensure that VAs are notified in domestic abuse incidents and that military and civilian law enforcement receive ongoing training on the VA's role.

(3) Participate in the installation FAC.

e. Training and Public Awareness. In conjunction with FAP Prevention and Education Specialists, VAs should assist with education, training, and public awareness both within the military and civilian communities. The VA's role in training and education include:

(1) Assist in educating command and installation personnel on victim advocate services.

(2) Assist in training civilian service providers on military victim issues and resources.

(3) Assist with planning campaigns for National Domestic Violence Awareness Month and National Child Abuse Prevention Month.

4. Transitional Compensation for Abused Family Members (TCAFM).

a. Purpose. TCAFM is a congressionally-mandated program providing 12 to 36 months of monetary payments and benefits to family members of service members who are separated from the military due to dependent-abuse offenses per reference (n). The program is designed to help ease the unexpected transition from military to civilian life for eligible family members who have experienced abuse. Military dependents are eligible for TCAFM under the following conditions:

(1) Dependent must have been living in the home or married to the service member when the incident occurred.

(2) Service member must have served at least 30 days on active duty.

(3) Service member was convicted of a dependent-abuse offense and the conviction results in separation from active duty under a court-martial sentence or forfeiture of all pay and allowances under a court-martial sentence; or administratively separated from active duty under applicable military service regulations if the basis for separation includes a dependent-abuse offense.

b. Victim Advocate Responsibilities. Victim Advocates have the following responsibilities related to TCAFM:

(1) Educate commands and other relevant installation personnel on the TCAFM.

(2) Educate victims on TCAFM and assist eligible victims with applying for the benefit.

(3) If the victim has been assigned a VA, the VA shall assist in collection of documentation for TCAFM. The minimum required documentation for a TCAFM package is:

(a) DD Form 2698, Application for Transitional Compensation.

(b) Legal documentation that supports separation for a dependent-abuse offense.

(c) Direct Deposit form.

(d) Coversheet.

(4) Serve as the liaison between HQMC TCAFM Program Manager and the respective applicant to ensure that the applicant receives appropriate updates on application status and guidance on all questions regarding the application process.

(5) Once a VA receives a copy of the TCAFM final decision letter from CMC (MFC-2), a copy shall be filed in the victim's FAP file.

Chapter 8

New Parent Support Program

1. Overview. Each installation will establish a New Parent Support Program (NPSP) within FAP to provide educational parenting programs with home visitation as the primary service delivery method. Participation in the program is voluntary. The strength-based program is developed specifically for expectant parents and parents of children from birth to five years of age. The Marine Corps NPSP program offers an expanded version of DOD NPSP services that are divided into three categories: primary prevention (NPSP standard), secondary prevention (NPSP plus) and tertiary prevention (NPSP expanded).

2. NPSP Mission. The mission of NPSP is to promote personal and family readiness by providing parenting education and support. NPSP is part of FAP's effort to prevent child abuse and domestic abuse. Parent education groups and support groups may also provide a venue for services but do not take the place of intensive home visitation services.

3. Program Eligibility

a. Expectant parents and parents of children birth to five years of age who are eligible to receive services in a military treatment facility are eligible for NPSP services. Eligible clients are not limited to first time parents.

b. All Marines, other military service members stationed on Marine Corps installations, and their family members are eligible for NPSP services.

(1) Families from other service member organizations who are not stationed on Marine Corps installations may be eligible to receive services from Marine Corps NPSP as determined on a case-by-case basis, based on staff availability, and at the discretion of the FAPM or NPSP Manager.

(2) Marine Corps families should be given priority for NPSP services.

(3) Waiting list for services should be established based on staff availability, priority of needs and service member affiliation.

c. A standardized screening process will determine who is most at risk and how to prioritize service delivery. Priorities include:

(1) Parents who are assessed through a standardized screening tool to be at risk for child abuse or neglect.

(2) Single active duty females who are pregnant and single active duty members who have a child under one year of age.

(3) Single active duty service members or a family of a deployed sponsor.

(4) Parents who have a "met criteria" case of child abuse or an open case with CPS.

d. Children who participate in play groups shall have on file written documentation of immunizations appropriate for the child's age. Per reference (r), immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) are required for all enrolled children. The installation medical officer, the child's physician, or installation chaplain as appropriate, may authorize exemptions on a case-by-case basis.

e. Services may be provided to those living within a 50-mile radius of a NPSP office or at the discretion of the FAPM.

f. Services are available to eligible families who are not at high risk for child abuse.

g. In cases of limited available resources, families will be provided with resources and referrals to community services.

4. Services Provided

a. Per reference (s), parents may refer themselves to the NPSP, or be referred by their healthcare provider, the command, or any DOD family support program manager who determines that the parent(s) are at risk for child abuse.

b. At the time of the initial referral, a preliminary level assignment will be made based on the nature and content of each request and on the results of the standardized screening tool. If screening indicates potential for risk, the parents are contacted by an assigned home visitor to assess their willingness to participate in services. Services will be offered according to a tiered approach, which is related to risk assessment. An essential approach to all levels of service is an emphasis on the importance of increasing support structures for parents, reducing

isolation and promoting positive parenting practices. Eligible individuals and families may receive home visitation at any level and may participate in classes and group activities.

(1) Level I services are provided to focus on education and support to individuals and families where there is low assessed risk of child abuse and domestic abuse. Level I services focus primarily on prevention efforts (i.e., outreach to the military community with programs such as: parenting classes, play morning, parent support groups, Daddy's/Baby Boot Camp and home visits).

(2) Level II services are for individuals or families for which a moderate to high level of risk has been identified, but there are no known incidents that have "met criteria" of child abuse or domestic abuse in the recent past. Services are focused upon education, support, personal growth, and risk reduction. Home visits are intensive and directed toward preventing child abuse and fostering the coordination of military and civilian resources.

(3) Level III services are for individuals or families that have experienced incidents which were determined to have "met criteria" of child abuse and/or families that are currently being assessed or investigated for child abuse or domestic abuse. Referrals to NPSP are often made by the command. Families served at Level III will often have an open case with FAP and/or CPS. Every effort should be made to involve both parents in home visitation services. Communication regarding recommendation for services is important in maintaining safety, preventing recurrence of abuse, and ameliorating the effects of previous abuse of family members.

(a) Level assignments may be changed at any time based on ongoing assessment.

(b) If a staff member is uncertain whether to assign a Level I or Level II, a Level II should be assigned.

(c) Families with open FAP and/or open CPS cases must be assigned at a Level III.

(d) Assignment of NPSP Home Visitor (HV) to a Level III case may be held pending a FAP risk assessment being completed in order to maximize NPSP staff safety.

5. Case Records. A case record is opened when an individual or family specifically referred for or requesting home visitation services is assigned a home visitor. Participants of parenting education groups and other family support activities do not have

open NPSP case files unless they are assigned a HV. The Program Manager or designee of NPSP ensures that NPSP cases are opened, transferred, and closed in accordance with DOD policy and guidance.

6. NPSP Case Documentation. The FAPM or NPSP Manager ensures that home visitors assess for the risk of child abuse on a continuing basis and that this is documented in the case record at each visit. Additionally, the Program Manager ensures that home visitors implement a protocol for services which include an intervention plan with clearly measurable goals for parents, based on needs identified by the standard screening instrument, and document the staff member's clinical assessment in collaboration with the family. Case records are kept in NPSP files, not in FAP files if there is an open FAP case.

a. Declining Services. Participation in NPSP services is voluntary regardless of the referral source. If a referred individual or family member declines home visitation services when contacted by an NPSP staff member prior to opening a case, the staff member should offer referrals to other MCCS or community services. The declination should be documented and referral sources notified following FAP guidelines.

b. Disclosure of Information

(1) Individuals seeking NPSP records about themselves will be provided the requested records in accordance with reference (h).

(2) Every effort will be made to secure an Authorization for Release of Information; however, all home visitors are mandated reporters and will disclose information to the appropriate case manager and command in the event of an open abuse case.

(3) Families shall be informed that if they relocate their case record will, upon their written request, be transferred to the NPSP at the receiving duty station.

7. Frequency of NPSP Home Visits. NPSP personnel will exercise professional judgment in determining the frequency of home visits based on the assessment of the family. Home visitors will make no less than two home visits to each family per month, unless assessment and documentation indicate otherwise.

8. Crisis Intervention. NPSP home visitors are not first responders and are not on-call 24-hours-a-day. Families shall be instructed on how to contact military and civilian resources in crisis and emergency situations. Home visitors should follow FAP

guidelines regarding crisis situations and reporting systems and procedures if a crisis occurs during a home or office visit with a family.

9. Handling Reports of Child Abuse and Domestic Abuse. Home visitors are required to follow local FAP protocol for reporting all suspected child abuse and domestic abuse allegations. In addition, it is the responsibility of the home visitor to:

a. Inform the client at the first home visit that a home visitor is mandated to report suspected child abuse to civilian and military authorities and to report domestic abuse to FAP.

b. Explain that military requirements provide for sharing of certain information that may affect readiness with those who have a need to know.

10. Safety for Home Visitors. FAP procedures must be in place to ensure minimal risk and maximize personal safety prior to conducting a home visit.

a. Home visitors shall have access to a government-issued cell phone and carry it with them during all home visits.

b. NPSP staff must be notified of all new allegations of child abuse or domestic abuse made on an existing NPSP case.

c. A risk assessment must be completed by FAP prior to the home visitor beginning or re-starting home visitation services.

d. FAPM and/or NPSP program manager may assign staff to work in pairs or may meet with parents in alternative settings besides the home in order to maximize staff safety.

11. Childcare. Childcare is provided to families participating in NPSP prevention classes. NPSP staff will not provide childcare services in the course of their duties.

12. Staff Supervision. The NPSP Manager, or FAPM for installations without a NPSP Manager, shall supervise NPSP employees.

Chapter 9

Risk Management

1. Coordinated Community Response

a. Overview. A coordinated community response (CCR) to child abuse and domestic abuse is the preferred method to enhance victim safety, reduce risk, and ensure offender accountability. In a CCR, the training, policies, and operations of all civilian and military human service and mental health providers are closely linked. Since no particular response to a report of child abuse and domestic abuse can ensure that a further incident will not occur, selection of the most appropriate response shall be considered coordinated community risk management.

b. Responsibility for Coordinated Community Risk Management. Overall responsibility for managing the risk of further child abuse and domestic abuse, including developing and implementing an intervention plan when significant risk of lethality or serious injury is present, lies with:

(1) The service member's commander, when the service member is the offender.

(2) The commander of the military installation on which the civilian is housed, when the civilian offender is accompanying U. S. military forces outside the United States.

(3) The appropriate civilian authorities within the United States, when the civilian family member or DOD employee is the offender within the United States.

c. Implementation. CCR requires the commander of the military installation to develop and participate in local military and civilian coalitions and/or task forces to enhance inter-organizational communication and strengthen program development. MOUs should include local governments and other branches of military service when located in close geographical proximity.

d. Risk Assessments. FAP conducts periodic risk assessments of all open cases in order to evaluate the risk level of reoccurrence of abuse. Increased levels of risk are reported to appropriate agencies for applicable interventions.

e. Risk Management and Deployment

(1) When an incident of abuse occurs in the days leading up to a deployment, a FAP assessment is conducted as quickly as possible.

(a) Every effort is made to interview the service member before the deployment.

(b) A safety assessment shall be conducted with family members regardless whether or not an interview with the deployed service member occurred.

(c) Case management and therapeutic services should be provided to all family members throughout the process. If at all possible, the case manager should coordinate with appropriate mental health providers within the deployed area to interview and assess the deployed service member if the assessment does not occur prior to the deployment.

(2) IDC will be held within required timeframes regardless of deployment status.

(3) The forward command must notify the parent command when a deployed service member who is an alleged offender in an active child abuse or domestic abuse incident will return to the parent command. In coordination with FAP, the parent command should implement procedures to reduce the risk of child abuse or domestic abuse.

2. 24-Hour Emergency Response Plan. The Installation Commander must issue a written policy setting forth the installation's 24-hour emergency response plan to child abuse and domestic abuse incidents and must ensure all installation commands and tenant activities are aware of and comply with the plan.

3. Ensuring Safety of Victims. FAP, working in conjunction with the command, must offer victims of available supportive and safety options. There are four basic administrative/judicial proceedings that are available and deemed appropriate on a case by case basis:

a. Restriction or Pre-trial Confinement.

b. MPO and CPO.

c. Shelter.

d. Child Removal Order (CRO)

(1) A CRO is designed for short-term placement of a child into a place of safety, and is more likely needed OCONUS where CPS is not available. When there is no suitable adult to protect a child victim, a CRO is issued by the alleged offender's commanding officer (or the Installation Commander in cases where the family resides in government quarters or in which good order and discipline aboard the installation is threatened). When CPS has legal responsibility for removal of the child, they shall be contacted and given decision authority for the removal of the child(ren) per references (c) and (d). Refer to appendix F for additional details.

(2) Protection of Children. The Installation Commander shall issue a written policy setting forth the procedures and criteria for:

(a) The removal of child victim(s) of abuse or other children in the household when they are in danger of continued abuse or life-threatening child abuse.

(b) Safe transit of such child(ren) to appropriate care. When the installation is located OCONUS, this includes procedures for transit to a location of appropriate care within the United States.

Chapter 10

Quality Assurance and Program Evaluation

1. Overview. Installation FAPs will develop a Quality Assurance plan to ensure that credentialed counselors provide required and relevant services in a timely manner.

a. Installation Commanders shall issue written policies for the regular collection, use, analysis, reporting, and dissemination of FAP information. By doing this, commanders ensure accurate and comparable statistics essential to attain the following:

(1) Planning, implementing, and evaluating the CCR to child abuse and domestic abuse.

(2) Identifying unmet needs and/or gaps in services.

(3) Determining FAP resource needs and budget.

(4) Developing FAP policies.

(5) Administering and evaluating FAP activities.

b. The FAC will ensure that local program evaluation is conducted for the FAP.

2. Evaluation of FAP Programs. Evaluation of FAP services provides a method for quantifying program effectiveness, improving clinical assessment, and enhancing program management. All areas of FAP will be incorporated into annual FAP planning and will be evaluated. Installation FAP program evaluation efforts will address the following:

a. Program goals and objectives.

b. Specific program metrics.

c. Effective use of resources (employee caseload, materials, such as handouts, videos, etc.).

d. Clinical Quality Management (CQM) activities, (e.g., client/command feedback, records audit, and credentialing and privileging).

e. Training activities for staff per chapter 2 of this Order.

3. Statistical Reporting

a. CMC (MFC-2) reports statistics to the Office of the Secretary of Defense (OSD) in accordance with OSD policy issuances and guidance per reference (c). Report Control Symbol DD-1754-08 (external DD-P&R(Q)2052) is assigned to this reporting requirement.

b. Each installation submits the following metrics on a quarterly basis to CMC (MFC-2):

(1) FAP Metrics.

(2) Prevention Metrics.

(3) NPSP Metrics.

(4) Clinical Metrics.

(5) Victim Advocacy Metrics.

(6) Report Control Symbol MC-1754-02 is assigned to this reporting requirement.

4. Records Audit

a. The FAPM shall ensure that an administrative review of a random sampling of 10 percent of open and 5 percent of closed cases of all clinical providers at least quarterly. The purpose of the administrative review is to ensure completeness of the chart and compliance with case management documentation.

b. A peer review shall be conducted on a random sampling of 10 percent of open and 5 percent of closed cases at least quarterly. The purpose of the peer review is to evaluate the appropriateness of assessments, treatment plans, referrals, and termination of treatment and to ensure complete and timely documentation.

c. The audited records are signed and dated that the audit has occurred. Results are documented in the provider's Individual Credentialing File (ICF).

5. FAP Staffing

a. Requirements. The FAP complies with requirements of references (a), (b), (c), (d), and this Order for the roles, functions, and responsibilities of FAP personnel. Installation FAP personnel require installation background/records checks in accordance with this regulation per reference (k).

b. Clinical Providers. All personnel who conduct clinical assessments of and/or provide clinical treatment to domestic abusers shall have these minimum qualifications:

(1) A Master's or Doctoral-level human service and/or mental health professional degree from an accredited university or college.

(2) A clinical license in good standing in a State that authorizes independent clinical practice.

(3) One year experience in child abuse and domestic abuse counseling or treatment.

c. FAPM. FAPMs shall meet each of the following standards:

(1) Education and Licensure. Compliant with paragraph 5b of this chapter.

(2) Privileging. Clinically privileged at the Tier III level in accordance with this Order.

(3) Experience

(a) A minimum of four years post-graduate professional experience is required. Two of these years must include documented post-licensure clinical experience in couples/family and children's services, or two years post-graduate clinical experience in family/domestic violence, or two years mental health counseling with individuals and families.

(b) A minimum of two years of post-licensure as a clinical supervisor of professional clinical providers.

(c) Shall possess a range of administrative, management, prevention, and direct service experience.

(d) Be capable of handling the complex issues associated with spouse and child abuse.

d. Clinical Supervisors. Clinical supervisors of clinical FAP personnel shall meet each of the following standards:

(1) Education and Licensure. Compliant with paragraph 5b of this chapter.

(2) Privileging. Clinically privileged at the Tier III level in accordance with this Order.

(3) Experience. A minimum of four years post-graduate professional experience is required. Two of these years must include documented post-licensure clinical experience in couples/family and children's services or two years post-graduate clinical experience in family/domestic violence, or two years mental health counseling with individuals and families. Experience must also include a minimum of two years of post-licensure experience as a clinical supervisor of professional clinical providers.

e. Credentialing. All personnel who conduct clinical assessment, provide clinical treatment, and/or supervise clinical care must be credentialed in accordance with this Order and reference (f).

(1) Initial credentialing shall be completed prior to an offer of employment.

(2) Application for renewal of initial credentials shall be completed after one year of employment. Application for renewal of credentials shall be completed every two years thereafter.

(3) Credentialing is completed by obtaining the credentialing packet from HQMC FAP (MFC-2), completing all requirements, and returning the packet. The Credential Review Board will determine whether the application for credentials is approved as requested, approved with modifications, or denied. The determination letter for credentialing will be sent to the Installation Commander and the FAPM.

(4) Copies of the entire credential application packet and the approval memorandum shall be kept in the ICF both at the installation and at HQMC.

(5) Credentialed providers must complete 15 hours of continuing education units that are relevant to child abuse and domestic abuse and an additional 17 hours of continuing education units within their discipline every 2 years.

f. Prevention and Education Specialists. All FAP personnel who provide prevention and education services have the following minimum qualifications:

(1) Education. A Bachelor's degree from an accredited university or college in any of the following disciplines:

(a) Social work.

(b) Psychology.

(c) Marriage, family, and child counseling.

(d) Counseling or behavioral science.

(e) Nursing.

(f) Education.

(g) Community health or public health.

(2) Experience. A minimum of two years of experience in a family and children's services public agency or family and children's services community organization, one year of which is in child abuse and domestic abuse.

(3) Supervision. Must be supervised by a Tier III credentialed provider.

g. Victim Advocates. The minimum qualifications for FAP VAs are as follows:

(1) Education. Bachelor's degree in one of the following fields:

(a) Social Work.

(b) Marriage and Family Therapy.

(c) Psychology.

(d) Counseling or Behavioral Science.

(e) Education.

(f) Community Health or Public Health.

(2) Experience. A minimum of two years experience in victim advocacy field working with victims of domestic abuse and sexual assault.

(3) Supervision. Must be supervised by a Tier III credentialed provider.

h. New Parent Support Program Home Visitor. The minimum qualifications for NPSP HVs include one of the following:

(1) Education

(a) A Master's degree in Social Work from a program accredited by the Council of Social Work Education.

(b) A Master's degree in Marriage and Family Therapy from a program approved by the Commission on Accreditation for Marriage and Family Therapy Education or an equivalent degree approved by a state regulatory board.

(c) A Registered Nurse with a Bachelor of Science degree from an accredited university or college in nursing.

(2) Licensure. All NPSP HVs with the above-mentioned educational background must possess a current, valid, unrestricted clinical state license or certification in their field of practice, at the independent provider level.

(3) Experience. Minimum of two years direct experience in child abuse and/or domestic violence, maternal, community and/or child health.

Chapter 11

Documentation and Records Management

1. Documentation of Reported Incidents, Assessments, and Treatment

a. Each FAP must ensure personally identifiable information (PII) collected in the course of FAP activities is safeguarded to prevent any unauthorized use or disclosure and that the collection, use, and disclosure of PII is in accordance with reference (h).

b. Before any collection of information from a service member or a family member, a Privacy Act Statement must be signed by the client, or annotated that the member refused to sign the statement. Any local forms that the clients are asked to complete should be coordinated with the installation Privacy Act officer before use.

c. Reports of Child Abuse and Unrestricted Reports of Domestic Abuse. For every new reported incident of child abuse and unrestricted report of domestic abuse, the FAP documents, at a minimum, must have an accurate accounting of all risk levels, actions taken, assessments conducted, and clinical services provided from the initial report of an incident to case closure in accordance with this Order.

d. Installation FAPs must maintain a log for documenting referrals. All referrals to FAP must be entered in the case log using the following guidelines:

(1) A case refers to a single victim who may be involved in one or multiple abuse incidents.

(2) If there are multiple victims, each counts as a separate case.

e. Documentation of Multiple Incidents. Multiple reported incidents of child abuse and unrestricted reports of domestic abuse involving the same service member and/or family members are documented separately within each person's FAP record.

f. Documenting Abuse by Photograph

(1) FAP personnel shall not collect or maintain pictures or other recorded media related to a child or domestic abuse incident. Per reference (b), law enforcement and military criminal investigative personnel are responsible for investigating reports of domestic violence and assembling

evidence indicating whether or not an act, attempted act, or threatened act of non-accidental physical force has occurred. Additionally, in connection with an incident of domestic abuse, at the victim's discretion/request, the HCP, if appropriately trained and/or supervised, shall conduct any forensic medical examination deemed appropriate which may including documentation of physical findings.

(2) For the purposes of IDC review, with the consent of the victim, the case manager may access the medical information that documents the provider's findings and conclusions of the victim's injuries and present that information at the IDC and/or invite medical personnel to the IDC review to present/discuss the injuries and impact.

(3) All records will be documented in SOAP note format:

(a) S: The situation will be documented according to the subjective report of the client.

(b) O: The clinician's observations shall include the mental status exam.

(c) A: Assessment will include clients' participation, and progress.

(d) P: The treatment plan shall include modalities, future appointments and if treatment was completed.

2. Maintenance, Storage, and Security of FAP and General Counseling Records

a. Maintenance

(1) FAP and General Counseling case files are maintained under the client's name and case number. Military sponsor names or other sponsor information is not used to identify files of clients who are family members. SSNs are not used to identify case files.

(2) Case numbers are maintained on other non-permanent records. Files within a family are cross-referenced by case number only. Military sponsors and commanders are not granted access to family members' files.

(3) Installation FAP staff will ensure the intake assessment and clinical notes are not duplicated and will not be placed in both the victim and alleged offender's case files.

(4) Cases that "did not meet criteria" may be referred for general counseling or other mental health services. In such cases, case records may be maintained as a general counseling (voluntary services) case.

(5) FAP files may be closed at the conclusion of treatment as determined by CCSM.

(6) FAP records identified for transfer will be sent to the gaining command FAPM via certified mail. The losing installation will send the original case files and retain a copy until it is determined the gaining command is in receipt of the files for continuity of care. Upon verification of receipt the duplicate record shall be destroyed per reference (h).

b. Storage

(1) Cases which were determined to have "met criteria" by the IDC are transferred to the National Personnel Records Center four years after the end of the calendar year in which the IDC determination was made and treatment has ended.

(2) General Counseling files and FAP cases which were determined as "did not meet criteria" by the IDC are closed, and after two years, saved electronically and maintained for 25 years after the end of the calendar year in which the IDC determination was made.

(3) During the period of retention, if there is a new report on the same family, the previous record may be used within 12 months to provide demographic and assessment information about the family so that a total reassessment may not be required.

c. Security. FAP and General Counseling records shall be maintained in accordance with reference (i) and under double lock and key (e.g., lockable door and lockable file cabinet).

3. FAP Restricted Reporting Records

a. A restricted report case number (RRCN) is assigned and a FAP Restricted Report Record is opened on all restricted reports of domestic abuse. The restricted report record should have "Restricted Report" clearly marked on the front jacket of the record and should be maintained in a separate area of the filing system from unrestricted FAP records.

b. If the victim later elects to convert the restricted report to an unrestricted report or if an exception applies, the restricted report is closed and maintained/archived as a FAP record. A traditional FAP record is opened and any documentation

the victim releases from the restricted report record is copied and placed in the FAP record. The Victim Restricted Preference Statement converting the restricted report to an unrestricted report shall be placed in the restricted report record and in the FAP record. The same applies to all documentation establishing that an exception to confidentiality applies.

4. Maintenance, Storage, and Security of NPSP Records

a. Maintenance. NPSP case records are kept under the client's case number and name. NPSP case records are kept in NPSP files, not in FAP files, if there is an open FAP case.

b. Storage. Files are closed, and after two years, saved electronically and maintained for 25 years after the end of the calendar year.

c. Security. NPSP case records are maintained in a secure limited-access area. NPSP staff shall take appropriate safeguards to protect client information from unauthorized disclosure.

5. Access to FAP and General Counseling Records and Information by Non-FAP Personnel

a. Clients. A client's request, including a parent or legal guardian of a child, for access to their record is handled per reference (h). Access includes the review of a record or obtaining a copy of the record or parts thereof. FAP staff shall coordinate such access with installation Privacy Officer.

b. Commanders. Commanders have an official need to know about FAP information pertaining to their service members. FAPMs shall provide information to the commander that is in the service member's FAP record only as it pertains to the actual alleged abuse or safety of involved parties or ability of the service member to be able to carry out their duties. Case files shall not be provided to or copied for commanders.

c. Other Officials. When disclosures are made to other officials in the performance of their duties who have an official need to know, FAP staff must ensure that the individual has an official need for the requested information prior to disclosure. Questions on release of information should be coordinated with the installation Privacy Officer.

d. FOIA Requests. All FOIA requests for records will be forwarded to the installation FOIA office.

e. Release of FAP and General Counseling Information to others not specifically noted above. Release of FAP/NPSP case file information to individuals not otherwise authorized access as noted in paragraphs 5a, 5b, and 5c of this chapter, generally requires the written and signed release of the individual of the case file record concerned. Questions on release under this paragraph should be directed to the installation Privacy Officer.

f. Disclosure Accounting. All records shall contain a Privacy Act Disclosure Accounting Form. The form is not required for "need to know" disclosures, e.g., as noted in paragraphs 5b and 5c of this chapter.

6. Central Registry

a. The Central Registry is the central management information system for identifying and recording information on child abuse and domestic abuse. This automated database consists of information on the sponsor, alleged victim, and alleged offender, and summary of each incident as well as administrative data from the alleged incident per reference (o).

b. Data is electronically submitted no more than 15 working days after the IDC has made an ISD.

(1) After two years, some information is purged from the Central Registry on incidents where the ISD was that the incident "does not meet criteria." This information includes personal identifiers of the sponsor, alleged offender, and victim. However, the remaining incident data will be maintained in the Central Registry for statistical purposes.

(2) Data contained in the Central Registry is used for:

(a) Internal management and program development.

(b) Evaluation and identification of protocols.

(c) Analyzing the scope of child abuse and domestic abuse prevalence rates and trends.

(d) Public, Congressional, and other governmental inquiries.

(e) Background checks related to applications to work with children in a DOD setting or regarding reports of child abuse and domestic abuse per reference (k).

c. Access to Records or Information Within the Central Registry

(1) Access is limited to those officials who have been properly screened and trained, have an official need to know, or as otherwise provided by the FOIA office. CMC (MFC-2) requires FAPMs to identify/re-identify authorized officials semi-annually.

(2) CMC (MFC-2) is the Privacy Act System Manager for the Marine Corps Central Registry. Requests for access to or disclosures from the Central Registry, other than FAP staff, shall be forwarded to CMC (MFC-2).

7. Archiving Process

a. The installation FAP representative submits an SF-135 (Records Transmittal and Receipt) form to the installation Command Designated Records Manager (CDRM). Those that do not have a CDRM should contact CMC Marine Corps, Administration and Resources, Records, Reports, and Directives Management Section, (ARDB) via e-mail at HQMCREC-MGR@USMC.MIL for further archiving instructions.

b. The Installation CDRM will review and upload the request into the CMC (ARDB) Sharepoint portal, or email the request (HQMCREC-MGR@USMC.MIL) along with the box inventories of records to be retained to the CMC (ARDB) Records Manager, who will review, sign, and forward the SF-135 to the National Personnel Records Center (NPRC) for approval.

c. Once approved for transfer by NPRC, CMC (ARDB) will notify the installation CDRM by providing a copy of the SF-135. It will be signed by the Marine Corps Records Manager, given an Accession number, and stamped "approved" by NPRC.

d. After receipt of the National Archives and Records Administration-approved SF-135 with Accession Number, FAP will forward all records included in the box inventory to the NPRC following the procedures developed by CMC (ARDB).

e. Once the NPRC is in receipt of the files and they are shelved, NPRC will send CMC (ARDB) a final copy of the SF-135 including an alpha-numeric location number indicating the location of the records boxes within NPRC.

f. CMC (ARDB) will forward the completed SF-135 to the CRDM who will return it to the installation. This document is necessary to confirm to CMC (MFC-2) the installation's archiving process and timeline.

APPENDIX A

DEFINITIONS

Alleged Abuser. An individual reported to the FAP for allegedly having committed child abuse or domestic abuse.

Child. An unmarried person under 18 years of age for whom a parent, guardian, foster parent, caregiver, employee of a residential facility, or any staff person providing out-of-home care is legally responsible. The term means a biological child, adopted child, stepchild, foster child, or ward. The term also includes a sponsor's family member (except the sponsor's spouse) of any age who is incapable of self-support because of a mental or physical incapacity, and for whom treatment in a DOD medical treatment program is authorized.

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

Domestic Abuse. Defined in reference (b).

Domestic Violence. Defined in reference (b).

Family Advocacy Committee. The policy-making, coordinating, recommending, and overseeing body for the installation FAP.

Family Advocacy Command Assistance Team. A multidisciplinary team composed of specially trained and experienced individuals who are on-call to provide advice and assistance on cases of child sexual abuse that involve DOD-sanctioned activities.

Family Advocacy Program. A program of coordinated efforts designed to prevent and intervene in cases of family violence, and to promote healthy family life through prevention, direct services (including identification and reporting, assessment, treatment, rehabilitation, and follow-up), administration, evaluation, and training.

Family Advocacy Program Manager. The individual designated by the installation commander or garrison commander in accordance with DOD Component implementing guidance to manage the installation FAP, supervise FAP staff, and coordinate all FAP activities with other activities.

Incident Determination Committee (IDC). A multidisciplinary team of designated individuals working at the installation level, tasked with the evaluation of reports of child abuse and domestic abuse to the FAP to determine whether they meet the relevant criteria for alleged child abuse and domestic abuse for entry into the Service FAP Central Registry of child abuse and domestic abuse reports. Formerly known as the Case Review Committee, or CRC.

Incident Status. The IDC determination of whether or not the reported incident meets the relevant criteria for alleged child abuse or domestic abuse for entry into the Service FAP central registry of child abuse and domestic abuse reports.

New Parent Support Program. Defined in Reference (s).

Out-of-Home Care. The responsibility of care for and supervision of a child in a setting outside the child's home by an individual placed in a caretaker role sanctioned by a Military Service or Defense Agency or authorized by the Service or Defense Agency as a provider of care. Examples include a child development center, school, recreation program, family child care, and child care activities that may be conducted as a part of a chaplain's program or as part of another morale, welfare, or recreation program.

Restricted Report. A report of an incident of domestic abuse by an adult victim who is eligible to receive military medical treatment, including a civilian or contractor who is eligible to receive military healthcare outside the continental United States on a reimbursable basis, to a domestic abuse victim advocate or healthcare provider without initiating the investigative process or notification to the victim's or alleged offender's commander.

Unrestricted Report. A report of an incident of domestic abuse by any person, including an adult victim, that uses current reporting channels, e.g. the chain of command, military or civilian law enforcement or criminal investigative organization, and the Family Advocacy Program for clinical intervention.

APPENDIX B

SAMPLE MEMORANDUM OF UNDERSTANDING

Work with SJA to draft - each state has different laws that apply; overseas Commands are subject to applicable treaties and Status of Forces Agreements

MEMORANDUM OF UNDERSTANDING

between and among

COMMANDING GENERAL (CG)

INSTALLATION (hereinafter "_____"),

COMMANDING OFFICER (CO)

NAVAL HOSPITAL
LOCATION (hereinafter "Hospital"),

SUPERVISORY SPECIAL AGENT

NAVAL CRIMINAL INVESTIGATIVE SERVICE
LOCATION (hereinafter "NCIS"),

DIRECTORS

COUNTY DEPARTMENT OF SOCIAL SERVICES
COUNTY, STATE (hereinafter "COUNTY/CITY CPS")

SECTION I--PURPOSE AND BACKGROUND

1. This Memorandum defines the working relationship between the *INSTALLATION* Family Advocacy Program (FAP) and (COUNTY/CITY CPS) in matters of domestic and/or child abuse. It provides procedures for the mutual reporting of known or suspected cases of domestic and/or child abuse involving service members or their families whether they occur on or off of *INSTALLATION* and cases occurring on *INSTALLATION* involving civilian employees and visitors. It also provides for maximum cooperation and support with the investigation, intervention, and treatment required of such cases.

2. The following laws and regulations safeguarding the well-being of endangered victims and/or children lay the foundation for the working relationship between parties to this Memorandum:

a. Federal Law

(1) Congress, through Section 1787 of Public Law 104-106

(Feb. 10, 1996), codified at 10 U.S.C. Sec. 1787, directed the Secretary of Defense to request States to provide for the reporting to the Secretary any report the State receives of known or suspected instances of child abuse in which the person having care of the child is a member of the armed forces or the spouse of the member.

(2) In the Victims of Child Abuse Act of 1990 (Section 211 of Public Law 101-647, codified at 42 U.S.C. Sec. 13001 et. seq.), Congress recognized a need for a multi-disciplinary approach to child abuse cases based on mutually agreed-upon procedures among community agencies and professionals involved in the intervention, prevention, prosecution, and investigation systems that best meet the needs of child victims and their non-offending family members. 42 U.S.C. Sec. 13031 mandates that covered professionals (i.e., healthcare workers, teachers, counselors, law enforcement) working on Federal land report suspected child abuse to designated agencies.

b. Military Directives

(1) Department of Defense Directive (DODD) 6400.6 - Family Advocacy Program (21 Aug 07), provides DOD policy on child abuse.

(2) Secretary of the Navy Instruction (SECNAVINST) 1752.3B, Family Advocacy Program (10 Nov 05), further implements DODD 6400.6.

(3) Marine Corps Order (MCO) 1754.11 - Marine Corps Family Advocacy and General Counseling Program, directs Installation Commanders to establish FAPs, develop MOUs with appropriate civilian officials, and institute procedures to report suspected child abuse through a Coordinated Community Response, which includes the local CPS.

(4) *Naval Hospital* _____ *Instruction (NAVHOS* ____ *INST)* _____ details the clinical and administrative management of alleged or suspected abuse, sexual assault cases at Naval Hospital _____.

c. State Law

NOTE: the following SAMPLE provisions must be tailored to the law of the state where the installation is located; consult with Staff Judge Advocate (SJA).

(1) The *STATE* Juvenile Code (*YEAR*, as amended), published in the *STATE STATUTES*, Sections _____ through _____ , establishes procedures for handling child abuse cases, including

reporting requirements, mandatory investigations, exchanges of information between investigating agencies, and subsequent action. Among those provisions are:

(a) Section _____ which allows the county Department of Social Services (CPS) to consult with local law enforcement agencies that assist in the investigation and evaluation of any report of abuse. Accordingly, the parties agree that (COUNTY/CITY CPS) is allowed to share case information with the Provost Marshal (PMO) and the Naval Criminal Investigative Service (NCIS).

(b) Section _____ which provides that when (COUNTY/CITY CPS) finds evidence a child may have been abused it shall report the findings to the appropriate law enforcement agency, which then, in turn, shall coordinate a criminal investigation with the protective services investigation being conducted by the county CPS. Accordingly, the parties agree:

NOTE for 1. and 2. below: Discuss with SJA whether applicable state law mandates that CPS report to the Installation or whether CPS has discretion - discuss distinctions between mandatory reporting to NCIS and voluntary reporting to PMO/FAPM.

1. (COUNTY/CITY CPS) *shall* report evidence of child abuse which occurs aboard exclusive jurisdiction areas of *INSTALLATION* to NCIS (which is the primary law enforcement agency responsible for investigation of child abuse cases in exclusive jurisdictional areas of *INSTALLATION*) per agreement with District Attorney Judicial District _____, and

2. (COUNTY/CITY CPS) *may* report appropriate cases occurring on or off *INSTALLATION* to PMO and/or the FAP Manager (FAPM) or his or her designated representative.

(c) Section _____which provides conditions under which any physician or administrator of a medical facility may retain physical custody of an abused child for further treatment or to ensure safety; and

(d) Section _____ provides that no privilege shall be grounds for any person or institution failing to report suspected child abuse, except when the knowledge or suspicion is gained by an attorney from that attorney's client during representation (attorney-client privilege). *(Note: Include any statutory provision concerning priest/penitent privilege in this context.)*

3. Cooperation and Assistance

a. The parties recognize that Federal law, *STATE* law, and

applicable military orders and directives place separate responsibilities upon State and local child protective agencies and upon the military Commands to investigate all reports of known or suspected child abuse.

b. The parties intend, through the working relationship established by this MOU, to maximize the cooperation and assistance between *INSTALLATION/HOSPITAL* and (COUNTY/CITY CPS) in their conduct of such separate investigations and determinations.

c. That cooperation should include to the maximum extent allowable under each parties' regulations, sharing: reports made of child abuse; information collected incident to investigation; any investigative report prepared; and, the respective determination, classification assigned, or remedial action taken as a result of such investigation.

d. The parties agree to protect the confidentiality of all shared information, reports, and records in accordance with applicable State and Federal laws and regulations or military directives.

e. The *INSTALLATION* Marine and Family Programs through FAP, is responsible for managing the non-criminal aspects of this agreement aboard *INSTALLATION*. FAP is responsible for managing abuse cases.

f. *INSTALLATION* agrees to invite and (COUNTY/CITY CPS) agrees to send a representative to attend child CCSM meetings to serve as a collaborative member of CCSM on child abuse issues.

g. (COUNTY/CITY CPS) representatives are allowed entry to the *INSTALLATION* via the Main Gate upon presentation of a (COUNTY/CITY CPS) personal identification badge in order to execute their duties as set forth in this Memorandum.

4. Definitions. The parties agree that the definitions of terms which apply to this MOU are those definitions set forth in Section _____ of the *STATE General Statutes*.

SECTION II—PROCEDURES

Tailor these SAMPLE procedures to follow FAP and Law Enforcement procedures at your installation.

1. Identification and Notification

a. By *INSTALLATION* and *HOSPITAL*:

(1) Cases of suspected/substantiated child abuse, wherein the caretaker or perpetrator is a member of the Armed Forces, or

a spouse of such member, when identified by military personnel, facilities, or activities, is immediately reported to the appropriate Provost Marshal's Office (PMO), unless that knowledge or suspicion is gained by an attorney through attorney privileged communications. *Discuss priest/penitent confidentiality with SJA; determine state law in this regard - see definition on confidentiality in chapter 9.*

(2) Upon receipt of such notification, the PMO immediately notifies the NCIS, the Family Advocacy Program Manager, (FAPM), or designated representative, and (COUNTY/CITY CPS).

(3) When reported assaults occur off *INSTALLATION*, PMO notifies NCIS.

(4) Upon receipt of such notification, the FAPM records the same and takes action in accordance with applicable military orders and directives. The FAPM continues to coordinate with (COUNTY/CITY CPS).

b. By (COUNTY/CITY CPS):

(1) (COUNTY/CITY CPS) reports to *INSTALLATION* NCIS on all cases of known or suspected child abuse occurring aboard *INSTALLATION.* In appropriate cases, (COUNTY/CITY CPS) may report cases of known or suspected child abuse occurring aboard *INSTALLATION* to PMO. In cases in which immediate FAP intervention is or may be required, NCIS shall notify the FAPM or his or her designated representative. By the next working day, NCIS shall notify the SJA and the FAPM if NCIS has not already done so.

(2) In appropriate cases, CPS *may* report to *INSTALLATION* PMO and FAPM or his or her designated representative on cases of known or suspected child abuse involving military service members or their family members which occur on or off *INSTALLATION.*

(3) In cooperation with IDC, (COUNTY/CITY CPS) provides appropriate protective and supportive services in cases involving *INSTALLATION* military personnel and their families in accordance with applicable State law and procedure.

2. Procedures When Immediate Removal of the Child is Necessary

a. When the victim is located aboard *INSTALLATION*:

(1) The CG, *INSTALLATION,* has authority to issue Child Removal Orders (CROs) directing a child be removed from any location aboard the *INSTALLATION* to a place of safety. The CRO

may be issued based upon a finding that there is substantial reason to believe an emergency situation exists and the child may be in imminent danger of serious mental, emotional, or physical harm. The CG, *INSTALLATION* hereby delegates authority to issue CROs to *other Commanders/PMO/NCIS*. Commanders are specifically authorized to issue Military Protective Orders (MPOs), DD Form 2873 and enforce Civilian Orders of Protection (Armed Forces Domestic Security Act, Public Law 107-311, Section 1561a) to ensure the safety and security of persons within their Commands, or to protect other individuals from persons within the Command.

(2) (COUNTY/CITY CPS):

(a) Immediately notifies PMO/NCIS, who accompanies (COUNTY/CITY CPS) to the child's location on *INSTALLATION;*

(b) Coordinates with PMO to assess the need for immediate removal. If the victim is presented for treatment at the Hospital, (COUNTY/CITY CPS) also coordinates with the attending physician at the Hospital;

(c) Arranges placement for the child when required

(d) Provides appropriate protective and supportive services to the family;

(e) Coordinates provision of services with the FAPM to include notification of the on-call clinician to provide immediate assessment and supportive services as clinically indicated.

(3) PMO:

(a) Coordinates with (COUNTY/CITY CPS) to assess the need for immediate removal;

(b) Accompanies (COUNTY/CITY CPS) to the child's location;

(c) Notifies the service member's CO, and, if necessary, takes the child into protective custody and transports the child to the designated shelter or foster home arranged by (COUNTY/CITY CPS); and

(d) Initiates investigation, coordinating with NCIS in appropriate cases.

b. When the victim is located off *INSTALLATION*:

(1) (COUNTY/CITY CPS) *may, in appropriate cases*, notify

PMO and keep the FAPM or his or her designated representative informed of the progress and completion of services

(2) The FAPM, when so informed by CPS,

(a) Records the report with a notation that conditions for immediate removal were required;

(b) Opens a case file and tracks the case until termination; and

(c) Notifies PMO and the service member's CO.

SECTION III--EFFECTIVE DATE, TERMINATION, AND AMENDMENT

1. Each of the signatories affixes the date of their signature. This Memorandum takes effect immediately upon the date of the last signature and supersedes prior Memoranda of Understanding between the parties with respect to addressing child abuse problems.

2. This Memorandum remains in full force and effect until specifically abrogated in writing by one of the parties. If any party unilaterally abrogates, in writing, less than the entire Memorandum, then all other parts of the Memorandum not specifically abrogated remain in effect. Furthermore, this Memorandum may be amended at any time by execution of a written amendment, signed by all of the parties. It is further understood the Memorandum will be amended to coincide with relevant changes in child welfare laws that would affect the Memorandum.

SIGNATORIES:
CG, INSTALLATION
CO, HOSPITAL
SUPERVISORY SPECIAL AGENT, NCIS
DIRECTOR, (COUNTY/CITY CPS)

APPENDIX C

RESPONDING TO INSTITUTIONAL CHILD SEXUAL ABUSE

1. Institutional child sexual abuse is addressed in reference (g). Cases of institutional child sexual abuse occurring in DOD-sanctioned activities are reported by telephone to CMC (MFC-2) within 24 hours of discovery. The telephonic report is followed by submission of an SIR within 72 hours of discovery. Cases are reported immediately to the installation FAPM and IDC for assistance and coordination. In cases where there are multiple victims (known or suspected), extensive community concerns, and/or other complex issues, assistance is requested promptly from CMC (MFC-2). IDC core members specifically trained to advise the command in child sexual abuse cases meet in an emergency session. Report Control Symbol MC-1754-01 is assigned to this reporting requirement.

2. The initial message to CMC (MFC-2) is initiated by the FAPM or designee and contains the following:

a. Date of alleged incident.

b. Date reported.

c. Date reported to CPS.

d. Installation location.

e. Facility where alleged abuse occurred.

f. Alleged offender's position within facility.

g. Alleged victim's name, age, DOB, and gender.

h. Agencies involved in the investigation.

i. Brief incident description.

j. Current case status.

k. FAP status: Pending/Met criteria/Did not meet criteria.

l. Police/NCIS Status: Pending or Closed.

m. Legal Status: Conviction or Sentence.

n. Military contact name and telephone number (DSN).

o. NCIS investigation case number and Abuse Report (Form 2486) case number.

3. Trained IDC members are activated in an emergency to investigate the allegation(s) of institutional child sexual abuse. The FAPM activates others as directed by the Installation Commander to complete and submit the incident report to CMC (MFC-2) within 24 hours. The team is comprised of individuals with the following qualifications or holding specific billets on the existing IDC:

a. Pediatrician or senior Medical Officer.

b. SJA.

c. NCIS Special Agent.

d. Provost Marshal.

e. Director of the "institution" where the alleged event occurred such as the CDC, FCC, MCCS activity, other agency, or sponsoring activity.

f. PAO.

g. FAPM.

4. The team is guided by provisions of reference (g) and is prepared to brief the Installation Commander within 36 hours following activation. The final recommendation of the briefing is whether the Marine Corps Regional Response Team and/or the DOD FACAT are needed.

5. In either case, weekly status reports of the investigation are submitted to CMC (MFC-2). Reports are coordinated with those of the FACAT.

6. A final report of investigative findings is sent to CMC (MFC-2) within 15 days of case determination, and should include the following:

a. Findings of fact.

b. Summary of actual and recommended legal action.

c. Lessons learned.

d. Recommendation for changes in policy and procedures.

e. Initiated corrective actions.

APPENDIX D

SERIOUS INCIDENT REPORT OF SERIOUS INJURY/FATALITY

1. Every case involving death or serious injury to a child or spouse known or suspected to be the result of abuse is reported to CMC (MFC-2) telephonically within 24 hours and in writing within 72 hours of discovery. All fatalities known or suspected to be the result of domestic abuse or child abuse are reported to the cognizant NCIS. Abuse and serious injury are defined in appendix E. Report Control Symbol MC-1754-01 is assigned to this reporting requirement.

2. A sample of the serious incident report (SIR) is found in Figure D-1.

3. In the case of fatalities, the electronic version of DD Form 2901, Child Abuse or Domestic Violence Related Fatality Initial Notification, must be completed in addition to the required SIR and forwarded to CMC (MFC-2) within the prescribed guidelines. DD Form 2901 can be located at the DOD Forms Management Program home page: www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm.

4. The FAPM ensures written follow-up every 30 days while the case is open and a closeout report is sent to CMC (MFC-2) within 30 days after investigations are completed and/or the IDC makes a determination. However, this report is not delayed pending completion of related disciplinary and administrative actions.

COMMAND LETTERHEAD
Address

IN REPLY REFER TO:
SSIC
Office Code
(date)

From: Name, Title, Installation
To: Commandant of the Marine Corps (MFC-2)

Subj: FAMILY ADVOCACY PROGRAM SERIOUS INCIDENT REPORT OF SERIOUS INJURY/FATALITY INVOLVING (RANK FIRST MI LASTNAME XXX XX FOUR/MOS ASSIGNED UNIT)

1. Date of alleged incident/death (DD MON YY)

2. Installation name/location

3. Nature of injury or cause of death (Refers to the medical description of injuries or condition).

4. Manner of injury or death. (Describe the way the offender caused the victim's death. This involves a different description than contained in paragraph 3. For example, paragraph 3 might be "asphyxiation" while paragraph 4 could be "manual strangulation").

5. Victim's name, date of birth, sex, and Service connection. If victim is active duty, give grade, rank, and branch of service. If victim is not active duty, give relationship to the sponsor and branch of service of sponsor.

6. Number of children in home

7. Number of adults in home

8. Type of victim. Indicate "spouse" or "child"

9. Agencies conducting the investigation: (select all that apply) FAP, CPS, PMO - including CID and NCIS, Civilian police, Special investigators, FBI, Medical

10. Brief incident description

11. Current case status

    a. FAP status: Met Criteria/Did Not Meet Criteria

    b. Police/NCIS Status:

    c. Legal Status:

12. Military POC and telephone number (DSN)

13. NCIS investigation case number and the Abuse Report (Form 2486) case number

14. Point of contact is name, title, phone number.

I. M. SIGNATURE

Figure E-1.--FAP Serious Incident Report of Serious Injury/Fatality

APPENDIX E

CRITERIA FOR IDC DETERMINATION OF REPORTS OF CHILD ABUSE AND DOMESTIC ABUSE

1. Child Physical Abuse. The non-accidental use of physical force on the part of a child's caregiver.

a. Child Physical Abuse Part A. Physical force includes, but is not limited to at least one of the following:

(1) Hitting with open hand or slapping, including spanking.

(2) Dropping.

(3) Pushing or shoving.

(4) Grabbing or yanking limbs or body.

(5) Poking.

(6) Hair-pulling.

(7) Scratching.

(8) Pinching.

(9) Restraining or squeezing.

(10) Shaking.

(11) Throwing.

(12) Biting.

(13) Kicking.

(14) Hitting with fist.

(15) Hitting with a stick, strap, belt, electrical cord, or other object.

(16) Scalding or burning.

(17) Poisoning.

(18) Stabbing.

(19) Applying force to throat.

(20) Strangling or cutting off air supply.

(21) Holding under water.

(22) Brandishing or using a weapon.

b. Child Physical Abuse Part B. Significant impact on the child involving ANY of the following:

(1) A more than inconsequential physical injury, involving any of the following:

(a) Any injury to the face or head.

(b) Any injury to a child under two years of age.

(c) A more-than-superficial bruise. The bruise was a color other than very light red or had a total area exceeding that of the victim's hand or was tender to a light touch.

(d) A more-than-superficial cut or scratch. The cut or scratch was bleeding and required pressure to stop the bleeding.

(e) Bleeding internally or from mouth or ears.

(f) A welt (a bump or ridge raised on the skin).

(g) Loss of consciousness.

(h) A burn.

(i) Loss of functioning, including but not limited to a sprain, broken bone, detached retina, or a loose or chipped tooth.

(j) Damage to an internal organ.

(k) Disfigurement, including but not limited to scarring.

(l) Swelling lasting at least 24 hours.

(m) Pain felt in the course of normal activities AND at least 24 hours after the physical injury was suffered. If the child is unable to report orally or in writing about pain or is inaccessible to clinical authorities for assessment of pain, the criterion of harm is met if the nature of the injury would typically result in such a level of pain.

(n) Death.

(2) Reasonable potential for more than inconsequential physical injury, given the:

(a) Inherent dangerousness of the act.

(b) Degree of force used.

(c) Physical environment in which the acts occurred.

(3) A more than inconsequential fear reaction: fear (verbalized or displayed) of bodily injury to self or others, AND at least one of the following signs of fear or anxiety lasting at least 48 hours:

(a) Persistent intrusive recollections of the incident, including recollections as evidenced in the child's play.

(b) Marked negative reactions to cues related to the incident, including the presence of the alleged offender, as evidenced by:

1. Avoidance of cues.

2. Subjective or overt distress to cues.

3. Physiological hyperarousal to cues.

(c) Acting or feeling as if incident is recurring.

(d) Marked symptoms of increased arousal, including any of the following:

1. Difficulty falling or staying asleep.

2. Irritability or outbursts of anger.

3. Difficulty concentrating.

4. Hypervigilance (i.e., acting overly sensitive to sounds and sights in the environment; scanning the environment expecting danger; feeling keyed up and on edge).

(e) Exaggerated startle response.

c. Part C: Exclusion From Child Physical Abuse Part A. Any non-accidental act of physical force shall NOT be considered to meet the criteria for Part A if it is determined to be:

(1) An act committed to protect the caregiver from imminent physical harm. The act must include ALL of the following:

(a) The act occurred while the child was in the act of using physical force. "In the act" begins with the initiation of motoric behavior that typically would result in an act of physical force, such as charging at the caregiver to hit him or her, and ends when the use of force is no longer imminent.

(b) The sole function of the act was to stop the child's use of physical force, and did not include punishment for the child's use of physical force.

(c) The act used only that force that was minimally sufficient to stop the child's use of physical force.

(2) An act committed during developmentally appropriate physical play with the child, including, but not limited to, horseplay, wrestling, and tackle football.

(3) An act committed to protect the child or another person from imminent physical harm, including, but not limited to, grabbing the child to prevent the child from being hit by a car, taking a weapon from a suicidal child, or physically intervening to prevent the child from inflicting injury on another person. However, this does not include non-accidental use of physical force as punishment for the child's behavior that may have subjected the child or another person to the risk of imminent harm.

2. Child Sexual Abuse. Sexual activity by a caregiver with a child for the purpose of sexual gratification of the child, the alleged offender, or any other person.

a. Child Sexual Abuse Part A

(1) Sexual Exploitation Without Direct Contact. Forcing, tricking, enticing, threatening, or pressuring a child to participate in an act for the sexual gratification of the child, the alleged offender, or any other person without direct physical contact between the child and the alleged offender. Sexual gratification means providing sexual arousal or pleasure or appealing to prurient interest but does NOT require overt evidence of arousal such as an erection, vaginal lubrication,

ejaculation, or orgasm. Sexual exploitation acts include, but are not limited to:

(a) Exposing the child's genitals or anus or, if the child is a female, the child's breasts.

(b) Exposing the alleged offender's genitals or anus or, if the alleged offender is a female, the alleged offender's breasts, to the child.

(c) Having the child masturbate or watch any other person masturbate.

(d) Having the child participate in sexual activity with a third person, including child prostitution.

(e) Having the child pose, undress, or perform in a sexual fashion, including posing or performing for child pornography.

(f) Exposing the child to child pornography, adult pornography, or a live sexual performance.

(g) Engaging in voyeurism ("peeping") or other prurient watching of a child's genitals or anus or, if the child is a female, the child's breasts without the child's knowledge.

(2) Rape or Intercourse. The caregiver's use of force, emotional manipulation, trickery, threatening, or taking advantage of the child's youth or naïveté to engage in penetration of the vagina, however slight:

(a) By the penis; or

(b) By a hand or finger or any object with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

(3) Sodomy. The caregiver's engaging in any of the following:

(a) Placing the alleged offender's sexual organ in the mouth or anus of a child, however slight the penetration; or

(b) Taking into the alleged offender's mouth or anus the sexual organ of a child, however slight the penetration.

(4) Molestation. Physical contact of a sexual nature not involving rape, intercourse, or sodomy between the child and the caregiver, including, but not limited to any of the following:

(a) The fondling or stroking of the genitals or buttocks, directly or through clothing, with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

(b) The fondling or stroking of a female's breast, directly or through clothing, with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

(c) The attempted penile penetration of the vagina, anus, or mouth.

(d) The attempted penetration of the vagina, with a hand or finger or any object with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

b. Child Sexual Abuse Part B. Any act of child sexual abuse that meets the criteria of Part A shall be considered to have a significant impact on the child, which is the criterion for part B. No voting is required for Part B.

c. Part C: Exclusion From Child Sexual Abuse. There are NO exclusions from any act of child sexual abuse. No voting is required for Part C.

3. Child Emotional Abuse. A non-accidental act or acts, including the following and any other act not listed of similar severity, but excluding an act that meets the criteria of child physical abuse or child sexual abuse:

a. Child Emotional Abuse Part A

(1) Berating, disparaging, degrading, scapegoating, or humiliating the child, or other similar behavior directed toward the child.

(2) Threatening the child, including but not limited to indicating or implying future physical abuse, abandonment, or sexual abuse.

(3) Harming or indicating that the caregiver will harm a person or thing that the child cares about, such as:

(a) A loved one, including but not limited to a relative or friend of the child.

(b) A pet.

(c) Real or tangible property.

(4) Abandoning or indicating that the caregiver will abandon a person or thing that the child cares about, such as:

(a) A loved one, including but not limited to a relative or friend of the child.

(b) A pet.

(c) Real or tangible property.

(5) Restricting the child's movement by:

(a) Fastening the child's arms or legs together,

(b) Binding the child to a chair, bed, or other object, or

(c) Confining a child to an enclosed area, such as a closet.

(6) Coercing the child to inflict pain on himself or herself, including, but not limited to:

(a) Ordering the child to kneel on split peas, rice, or similar substance for long periods.

(b) Ordering the child to ingest a highly spiced food, spice, or herb.

(7) Disciplining the child through non-physical means or with the non-accidental use of force that does not meet the criteria of child physical abuse, when such discipline is excessive because there is disproportion between the:

(a) Frequency of punishment and the infrequency of the child's bad behavior.

(b) Severity of punishment and the undesirability of the child's bad behavior.

(c) Duration of punishment and the undesirability of the child's bad behavior.

b. Child Emotional Abuse Part B. Significant impact on the child involving ANY of the following:

(1) Psychological harm, including either:

(a) More than inconsequential fear reaction.

(b) Significant psychological distress related to the act, including one or more psychiatric disorders at or near diagnostic thresholds as defined by the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.

(2) Reasonable potential for psychological harm, including either when:

(a) The act or pattern of acts creates reasonable potential for the development of a psychiatric disorder, at or near diagnostic threshold, related to or exacerbated by the act(s) when taken into consideration with the child's level of functioning and any risk and resilience factors present; or

(b) The act, or pattern of acts, carries a reasonable potential for significant disruption of the child's physical, psychological, cognitive, or social development by substantially worsening the child's developmental level and trajectory that was evident before the alleged emotional abuse.

(3) Stress-related somatic symptoms related to or exacerbated by the act or pattern of acts significantly interfere with normal functioning, including aches and pains, migraines, gastrointestinal problems, or other stress-related physical ailments.

c. Part C: Exclusion From Child Emotional Abuse. The following shall NOT be considered to meet the criteria for Part A:

(1) Any generally accepted care giving practice such as:

(a) Confining a small child in a child car seat or safety harness, or

(b) Swaddling an infant.

(2) Any generally accepted disciplinary practice proportionate to the seriousness of the child's behavior that involves:

(a) Restriction of a child's normal privileges (e.g., "grounding" a child), or

(b) Restricting a child to his or her room for a period of time.

4. Child Neglect. The negligent treatment of a child through egregious acts or omissions below the lower bounds of normal care giving, which shows a striking disregard for the child's well-being, under circumstances indicating the child's welfare has been harmed or threatened by the deprivation of age-appropriate care. Defiance of base guidance may be cause for referral to FAP for services, but it is not necessarily neglectful unless the alleged act or omission meets the criteria for Part A and Part B.

a. Child Neglect Part A. Any of the following:

(1) Abandonment. This includes the absence of the caregiver with no intent to return or the absence of the caregiver from the home for more than 24 hours without having arranged for an appropriate surrogate caregiver. Any act of child abandonment that meets the criteria of Part A child neglect shall be considered to have a significant impact on the child, which is the criterion for Part B. No voting is required for Part B for abandonment.

(2) Lack of Supervision. Egregious absence or inattention, taking into account the child's age and level of functioning.

(3) Exposure to Physical Hazards. Inattention to the child's safety by exposing the child to physical dangers or home hazards including, but not limited to:

(a) Exposed electrical wiring.

(b) Broken glass.

(c) Non-secured, loaded firearms in the home.

(d) Illegal drugs in home.

(e) Dangerous or unhygienic pet.

(f) Asking the child to perform dangerous activities.

(g) Driving a vehicle while intoxicated, with the child in the vehicle.

(h) Hazardous chemicals.

(i) Unhygienic living conditions dangerous to health.

(j) Caregivers known to be abusive.

(k) An act of domestic violence close enough to the child to have created a risk of injury to the child.

(4) Educational Neglect. When education is compulsory by law, any of the following:

(a) Knowingly allowing the child to have extended or frequent absences from school.

(b) Neglecting to enroll the child in appropriate home schooling or public or private education.

(c) Preventing the child from attending school for other than justifiable reasons.

(5) Neglect of healthcare. Refusal or failure to provide appropriate healthcare, including but not limited to failure to obtain appropriate professionally indicated medical, mental health, or dental services, procedures, or medications, although the caregiver was financially able to do so or was offered other means to do so. It includes withholding of medically indicated treatment for a child with life-threatening conditions.

(6) Deprivation of Necessities. This is defined as the failure to provide age-appropriate nourishment, shelter, and clothing to the child. It includes non-organic failure to thrive as determined by a competent medical authority.

b. Child Neglect Part B. Significant impact on the child involving ANY of the following:

(1) More-than-inconsequential physical injury including heat exhaustion or heat stroke.

(2) Reasonable potential for more than inconsequential physical injury given the:

(a) Act(s) or omission(s); and

(b) The child's physical environment.

(3) Psychological harm, as set forth in paragraph 3b(1) of this appendix.

(4) Reasonable potential for psychological harm.

(5) Stress-related somatic symptoms.

c. Part C: Exclusion From Child Neglect. The following shall NOT be considered to meet the relevant criteria for Part A:

(1) Unattended Older Child in a Vehicle. A caregiver's leaving a child age 10 or older unattended in a vehicle for a brief period of time in a safe area DOES NOT meet the Part A criterion for lack of supervision.

(2) Unforeseen Lack of Supervision or Exposure to Physical Hazards. When lack of supervision or exposure to physical hazards occurs, but a person who is not the caregiver is directly responsible for such lack of supervision or exposure to physical hazards, such lack of supervision or exposure to physical hazards does not meet the Part A criterion IF the IDC concludes that a reasonably competent caregiver would not have foreseen such lack of supervision or exposure to physical hazards by such other person.

(3) First Time Exclusion. The Part A criteria for lack of supervision or exposure to physical hazards are not met if ALL of the following criteria are met:

(a) The impact on the child meets the criteria for potential harm, but NOT for actual harm.

(b) The caregiver has no other significant risk factors for neglect (e.g., low self-esteem, high impulsivity, lack of social support, high daily stress, substance abuse diagnosis).

(c) Two-thirds of the voting members determine the neglect to have barely met criteria.

(d) There has been no previous incident of problematic care giving, as evidenced by both of the following:

1. The caregiver has not come to the attention of any community helper (including, but not limited to, teachers, security forces, medical professionals, civilian authorities) for potential child abuse or extreme parenting practices; AND

2. The caregiver has not been reported to the FAP or a civilian CPS agency previously for allegations of child abuse or child neglect.

5. Intimate Partner Physical Abuse. The non-accidental use of physical force against a current or former intimate partner.

a. Intimate Partner Physical Abuse Part A. Such physical force includes but is not limited to at least one of the acts set forth in paragraph 1a of this appendix.

b. Intimate Partner Physical Abuse Part B. Significant impact on the intimate partner involving ANY of the following:

(1) Any physical injury, including, but not limited to:

(a) Pain that lasts at least four hours.

(b) A bruise.

(c) A cut.

(d) A sprain.

(e) A broken bone.

(f) Loss of consciousness.

(g) Death.

(2) Reasonable potential for more than inconsequential physical injury given:

(a) The inherent dangerousness of the act.

(b) The degree of force used.

(c) The physical environment in which the acts occurred.

(3) More than inconsequential fear reaction as set forth in paragraph 1b(3) of this appendix but excluding "intrusive recollections as evidenced in the child's play."

c. Part C: Exclusion From Intimate Partner Physical Abuse. Any non-accidental use of physical force act that meets any of the following situations shall NOT be considered to meet the criterion for Part A. These exclusions do not include subsequent non-accidental use of physical force against the intimate partner that was not protective.

(1) The act was committed to protect the alleged offender from imminent physical harm from the intimate partner who was in the act of using physical force. The act must include ALL of the following:

(a) The act occurred while the intimate partner was in the act of using physical force. "In the act" begins with the initiation of motoric behavior that typically would result in an act of physical force, such as charging at the alleged offender to hit him or her, and ends when the use of force is no longer imminent.

(b) The sole function of the act was to stop the intimate partner's use of physical force.

(c) The act used only that force that was minimally sufficient to stop the intimate partner's use of physical force.

(2) The act was committed to protect the alleged offender from imminent physical harm from the intimate partner who had previously threatened the alleged offender with more than inconsequential physical injury. This requires that:

(a) The act followed the intimate partner's verbal or non-verbal threat to imminently inflict more than inconsequential physical injury on the alleged offender; AND

(b) The IDC determined that there was at least one previous incident of the intimate partner inflicting more than inconsequential physical injury on the alleged offender. "More than inconsequential physical injury" shall have the meaning set forth in paragraph 1b(1) of this appendix but excluding "any injury to a child under two years of age."

(3) The act was committed to protect the intimate partner or another person from imminent physical harm, including, but not limited to:

(a) Grabbing or pushing the intimate partner to prevent him or her from being hit by a vehicle.

(b) Taking a weapon away from a suicidal intimate partner.

(c) Stopping the intimate partner from inflicting physical abuse on a child as set forth in paragraph 1a of this appendix.

(4) The act was committed during physical play with the intimate partner, including, but not limited to, horseplay, wrestling, and tackle football.

6. Intimate Partner Sexual Abuse. A sexual act with the intimate partner without the consent of the intimate partner or physical contact of a sexual nature against the expressed wishes

of the intimate partner. Corroboration of the report of the intimate partner is NOT required to meet the Part A criteria for intimate partner sexual abuse. A sexual act is:

a. Contact between the penis and the vulva, or the penis and the anus, involving penetration, however slight;

b. Contact between the mouth and the penis, vulva, or anus; or

c. Penetration of the anal or genital opening by a hand, finger, or other object.

d. Intimate Partner Sexual Abuse Part A. Any of the following:

(1) The use of physical force to compel the intimate partner to engage in a sex act against his or her will, whether or not the sex act is completed.

(2) The use of a physically aggressive act in paragraph 1a of this appendix or use of one's body, size, or strength, or an emotionally aggressive act in paragraph 7a of this appendix, to coerce the intimate partner to engage in a sex act, whether or not the sex act is completed.

(3) An attempted or completed sex act involving a intimate partner who is unable to provide consent. The intimate partner is unable to understand the nature or conditions of the act, to decline participation, or to communicate unwillingness to engage in the sexual act because of illness, disability, being asleep, being under the influence of alcohol or other drugs, or other reasons.

(4) Physical contact of a sexual nature, including but not limited to, kissing, groping, rubbing, or fondling, directly or through clothing, of the intimate partner that does not meet the criteria of paragraphs 6d(1) through 6d(3) of this appendix but is against the expressed wishes of the intimate partner.

e. Intimate Partner Sexual Abuse Part B. Any act that meets the criteria for Part A intimate partner sexual abuse shall be considered to have a significant impact on the intimate partner, which is the criterion for part B. No voting is required for Part B for intimate partner sexual abuse.

f. Part C: Exclusion From Intimate Partner Sexual Abuse. There are NO exclusions from any act of spouse sexual abuse or from any act of intimate partner sexual abuse that meets the criteria for Part A.

7. Intimate Partner Emotional Abuse. A non-accidental act or acts, excluding physical abuse or sexual abuse, or threat adversely affecting the psychological well-being of a current or former intimate partner.

a. Intimate Partner Emotional Abuse Part A. Including, but not limited to any one or more of the following:

(1) Interrogating the intimate partner.

(2) Berating, disparaging, or humiliating the intimate partner or using other similar behavior against the intimate partner.

(3) Isolating the intimate partner from his or her family, friends, or social support resources.

(4) Interfering with the intimate partner's adaptation to American culture or the military subculture.

(5) Restricting the intimate partner's access to or use of economic resources despite an obviously grave economic situation, when such restriction does not reasonably obstruct the intimate partner from recklessly incurring debts for which the alleged offender would be responsible for repayment.

(6) Restricting the intimate partner's access to or use of appropriate military services and benefits, including, but not limited to, taking away the intimate partner's military identification card.

(7) Obstructing the intimate partner from obtaining medical, mental health, or dental services.

(8) Restricting the intimate partner's ability to come and go freely when such restriction is not intended to prevent the intimate partner from committing:

(a) An act or acts injurious to the intimate partner.

(b) An act or acts that may injure another person.

(9) Trying to make the intimate partner believe that he or she is mentally ill, and/or trying to make others think that the intimate partner is mentally ill.

(10) Threatening to harm the intimate partner directly or indirectly, including, but not limited to, by threatening to:

(a) Inflict physical abuse or sexual abuse on the intimate partner.

(b) Harm the intimate partner's children, pets, or people that the intimate partner cares about.

(c) Damage or destroy the intimate partner's property.

(11) Harming the intimate partner's children, pets or property.

(12) Stalking the intimate partner.

(13) Obstructing the intimate partner's access to protective assistance, including but not limited to assistance from:

(a) A military domestic violence VA or the FAP.

(b) The military command.

(c) A military or civilian law enforcement agency.

(d) An attorney.

(e) A civilian court of competent jurisdiction.

(f) A civilian domestic violence program of shelter, support, or other assistance.

b. Intimate Partner Emotional Abuse Part B. Significant impact on the intimate partner involving ANY of the following:

(1) Psychological harm, including ANY of the following:

(a) More than inconsequential fear reaction (fear, verbalized or displayed) as set forth in paragraph 1b(3) of this appendix, but excluding "intrusive recollections as evidenced in the child's play;"

(b) Significant psychological distress as set forth in paragraph 3b(1)(b) of this appendix;

1. Fear of an emotionally abusive act that significantly interferes with the intimate partner's ability to carry out any of five major life activities: employment, education, religious faith, obtaining necessary medical or mental health services or following prescribed treatment, or contact with family or friends;

2. Stress-related somatic symptoms as set forth in paragraph 3b(3) of this appendix.

(2) Part C: Exclusion From Intimate Partner Emotional Abuse. There are NO exclusions from any act of intimate partner emotional abuse that meets the criteria for Part A.

8. Neglect of Spouse. A type of domestic abuse in which the alleged offender withholds necessary care or assistance for his or her current spouse who is incapable of self-care physically, psychologically, or culturally, although the caregiver is financially able to do so or has been offered other means to do so.

a. Neglect of Spouse Part A. The IDC must determine that ALL of the following conditions are present:

(1) The alleged offender withholds, or withholds the spouse's access to, any of the following:

(a) Appropriate, medically indicated healthcare, including but not limited to appropriate medical, mental health, or dental care;

(b) Appropriate nourishment, shelter, clothing, or hygiene; or

(c) Care-giving for more than 24 hours without having arranged for an appropriate surrogate caregiver.

(2) The alleged offender is able to provide care, or access to care, specified in paragraph 4h(1)(a) of this appendix or has been offered assistance to do so.

(3) The spouse is incapable of self-care due to substantial limitations in one or more of the following areas:

(a) Physical, including but not limited to quadriplegia,

(b) Psychological or intellectual, including but not limited to vegetative depression, very low intelligence, or psychosis, or

(c) Cultural, including but not limited to the inability to communicate in English or the inability to manage activities of rudimentary daily living in American culture.

b. Neglect of Spouse Part B. Deprivation-related significant impact involves either of the following:

(1) More-than-inconsequential physical injury, as set forth in paragraph 1b(1) of this appendix, but excluding "any injury to a child under two years of age" AND including heat exhaustion or heat stroke.

(2) Reasonable potential for more than inconsequential physical injury, given:

(a) The reason(s) the spouse is incapable of self-care;

(b) The care required for the spouse's condition(s); and

(c) The more-than-inconsequential injury that the spouse could suffer if appropriate access to care is withheld.

c. Part C: Exclusion from Neglect of Spouse. There are NO exclusions from any act of spouse neglect that meet the criteriafor Part A.

APPENDIX F

MILITARY PROTECTIVE ORDERS (MPOs) AND CHILD REMOVAL ORDERS (CROs)

1. Commanders are responsible for the security and safety of service members under their Command, as well as other individuals within areas for which the Commander is responsible. The Commander has the inherent authority to take reasonable actions commensurate with that responsibility, and is prepared to act decisively in cases involving alleged child abuse and domestic abuse. This is especially true overseas and in 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. Commanders are authorized to issue MPOs (DD Form 2873) and CROs, and to enforce Civilian Orders of Protection Armed Forces Domestic Security Act to ensure safety and security of persons within their Commands, or to protect other individuals from persons within the Command. Commanders are referred to herein as issuing authorities. As directed in reference (b) commanding officers shall issue MPOs when necessary safeguard victims, quell disturbances, and maintain good order and discipline, and the MPO form, DD form 2873, shall be used when issuing protective orders. The electronic version of this form can be located at the DOD Forms Management Program home page at www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm. Distribution of MPO copies is specified on DD Form 2873. The format, found in Figure F-1, for the CRO is suggested, not required, since similar actions could be taken without specific authorization. The original CRO is given to the individual who was custodian of the child(ren) with copies to others who have custodial interest in the child(ren). A copy of each MPO and CRO issued is given to PMO and the FAPM.

3. MPOs are directed to service members and may be broad in scope. 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 debarment orders, employer directives, and housing area directives.

4. MPOs and CROs are based upon a balancing of interests. The greater the crisis and need to protect, the greater the need to move quickly and to focus on safety of the person(s) requiring protection. As the crisis abates and long-term solutions are considered and put into effect, the need for a MPO or CRO diminishes.

6. MPOs and CROs are administrative in nature, and are not to be confused with actions of pre-mast and pre-trial restraint, which can be taken under the UCMJ, reference (j). Use of an MPO does not preclude simultaneous or subsequent action under reference (j).

7. MPOs directed to military personnel may include, but are not limited to:

a. Direction to refrain from contacting, harassing, or touching certain named persons.

b. Direction to remain away from certain specified areas, such as the home, schools, and CDCs.

c. Direction to do, or refrain from doing, certain acts or activities.

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

9. Issuing authorities should seek the advice and assistance of local FAP team members since family violence ignores traditional professional borders. Healthcare professionals, social workers, law enforcement personnel, and attorneys play a significant role. Early intervention and cooperation are essential to ensure maximum success.

10. An order designed to protect one individual by limiting the activity of another are not always in writing. For the purpose of this Order, MPOs and CROs shall be provided, in writing, to the designated person.

COMMAND LETTERHEAD
Address

IN REPLY REFER TO:
SSIC
Office Code
(Date)

From: Billet, Command
To: Marine
Via:

Subj: MILITARY CHILD REMOVAL ORDER IN THE CASE OF

Ref: (a) SECNAVINST 1752.3A w/Ch-1
(b) MCO 1754.XX

1. You are hereby directed to remove son(s)/daughter(s) of (and),_from (the family home at/other location). Unless otherwise directed by me or my designee, the above child(ren) will be returned to the home not later than _____.

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

3. You are directed to ensure 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:

5. This Order remains in effect until , unless sooner canceled by me, or higher authority.

I. M. MARINE

Copy to:
PMO
FAPM

Figure F-1.--Sample Military Child Removal Order