



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

BUMEDINST 6320.70
BUMED-32
1 Jun 1999

BUMED INSTRUCTION 6320.70

From: Chief, Bureau of Medicine and Surgery
To: All Ships and Stations Having Medical Department Personnel

Subj: FAMILY ADVOCACY PROGRAM

Ref: (a) DoD Directive 6400.1 (NOTAL)
(b) SECNAVINST 1752.3A
(c) OPNAVINST 1752.2A
(d) MCO P1752.3B
(e) BUMEDINST 6320.72
(f) BUMEDINST 7050.1
(g) Joint Commission on Accreditation of Healthcare Organizations Comprehensive Standards (JCAHO)

Encl: (1) Definitions
(2) Overseas MTFs and Protection of Victims of Child Abuse/Neglect
(3) Screening for Domestic Violence in MTFs
(4) Guidelines on Child Abuse/Neglect for MTF/DTFs
(5) Guidelines on Child Sexual Abuse for MTF/DTFs
(6) Procedures for Photographing Victims
(7) FAP Case Review Committee's Chairs and MTF Staff Members
(8) Memorandum of Understanding with Local Agencies
(9) Supplemental Care Guidance for FAP Active Duty Clients
(10) FAP Training Requirements for MTF/DTFs

1. Purpose. To establish guidance for involvement in the Family Advocacy Program (FAP) for naval medical treatment facilities (MTF) and dental treatment facilities (DTF).

2. Cancellation. NAVMEDCOMINST 6320.22.

3. Discussion. The FAP is a multi-disciplinary, community coordinated program designed to respond to problems of spouse and child abuse/neglect within the military community. Naval MTFs and DTFs play a critical role in medical and dental interventions and reporting aspects of the FAP. Cooperation with military and civilian agencies that respond to child and spouse abuse is essential for the program to be effective.

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5. Policy

a. This instruction implements the policies set forth in references (a) through (d) and is in consonance with references (e) and (f).

b. Spouse and child abuse has a negative effect upon military readiness, effectiveness, good order, and discipline. All military personnel and units shall undertake a cooperative effort to reduce and eliminate child and spouse abuse at every level of the command. MTFs and DTFs shall ensure compliance with this policy through implementation of this instruction.

6. Action

a. Chief, Bureau of Medicine and Surgery (BUMED) shall:

(1) Provide resources, professional services, and technical aid to support the health care requirements of naval FAPs per references (a) through (d).

(2) Appoint a Medical Service Corps social worker as the Family Advocacy Program liaison at BUMED to coordinate MTF and DTF participation in the FAP.

b. The FAP Liaison shall:

(1) Coordinate with Family Support Branch, Navy Personnel Command; Family Programs Branch, Headquarters, U.S. Marine Corps; Assistant Secretary of the Navy, Office of Family Policy and Support; Department of Defense (DoD), and other Federal agencies as necessary.

(2) Provide program guidance to naval medical and dental commands.

(3) Serve as a member of the DoD Family Advocacy Committee and DoD subcommittees as appropriate.

(4) Assist with FAP training oversight and assistance visits to MTFs and DTFs as necessary.

(5) Serve as a member of the Navy Headquarters Review Team, the Child Sexual Abuse Response Team, and other Navy teams and committees as appropriate.

c. Commanding Officers and Officers in Charge of MTFs shall:

(1) Ensure safety of the victim of family abuse/neglect is given the highest priority. Temporary admission of a victim to the MTF, enclosure (2), for protection against further abuse is authorized in those situations where there is no reasonable alternative. In the absence of State law, the admission may be up to 48 hours for a minor without parental consent.

(2) Ensure reporting of all known or suspected incidents of spouse or child abuse or neglect to the family advocacy representative (FAR) or family advocacy program manager (FAPM) at the Family Service Center (FSC), Family Advocacy Department or Center, and to appropriate civilian authorities per references (a) through (d). Enclosure (4) of reference (c) has additional guidance regarding reporting of spouse abuse.

(3) Ensure medical assessment, evaluation, and treatment is completed in child and spouse abuse incidents when injury occurs, to include photographing of injuries as appropriate. Follow guidelines in enclosures (3) through (6). Information obtained from the medical assessment, evaluation, treatment, and historical review of medical records will be made available to the FAR and Case Review Committee (CRC).

(4) Publish an MTF instruction in coordination with the installation commander that provides specific guidance for FAP involvement at the MTF. This instruction must include consideration of applicable installation orders and local and State laws concerning spouse and child abuse/neglect as well as guidelines or protocols for the identification, medical crisis intervention, and referral of incidents of child abuse/neglect and spouse abuse per references (a) through (d).

(5) Appoint (at Navy installations) in coordination with the installation commander, a privileged member of the MTF staff as chair and other MTF staff as members for each CRC. The Navy CRC chair shall represent the MTF on the installation's Family Advocacy Committee (FAC), per reference (c) and enclosure (7). Marine Corps (MC) installation commanders appoint all members of the MC FAC with the family advocacy program officer (FAPO) as the designated CRC chair, per reference (d). Designate clinically privileged members of the MTF staff, including at least one physician with experience in the medical assessment and treatment of child sexual abuse victims, to serve on the Regional Child Sexual Abuse Response Team as needed.

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(6) In coordination with the installation commander or designee, establish memoranda of understanding (MOU) as indicated per reference (c) and enclosure (8).

(7) Budget supplemental care funding for active duty victims and offenders when MTF care is not available; reference (a) and enclosure (9) apply.

(8) Ensure education and training are provided to all medical personnel concerning family advocacy issues and procedures, per reference (c) and enclosure (10).

(9) Ensure criteria are developed and used by MTF staff to identify possible victims of abuse and neglect per reference (g).

(10) Include family advocacy in health promotion programs.

d. Commanding Officers of DTFs shall:

(1) Ensure safety of victims of abuse/neglect is given the highest priority.

(2) Refer all known and suspected incidents of child abuse/neglect and spouse abuse to the FAR/FAPM, per references (a) through (d).

(3) Publish a DTF FAP instruction in coordination with the supporting MTF. This instruction must include procedures to ensure the immediate safety, dental assessment, treatment, and photographing of persons suspected of being victims of child abuse/neglect and spouse abuse, per enclosures (3) through (6).

(4) Educate and train all DTF personnel concerning family advocacy issues and procedures, per reference (c) and enclosure (10).

(5) Provide consultation to the CRCs as needed.


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Available:
<http://navymedicine.med.navy.mil/instructions/external/external.htm>

DEFINITIONS

The definitions used in this instruction correspond to references (a) through (e) and are intended solely for the administration of the FAP.

1. Case. A case refers to a single victim who may be involved in one or multiple abuse incidents. Individual cases of members of the same family shall be linked in some manner for cross-referencing purposes.

2. Case Review Committee (CRC). The multi-disciplinary team responsible for reviewing and approving incident assessments, determining the status of a case, and monitoring case progress. The CRC acts as an advisory body for the (FAC).

3. Case Status. The status of the case at the time of the report. Possible determinations include substantiated, unsubstantiated, and suspected as follows:

a. Substantiated. A case that has been investigated and the preponderance of available information indicates abuse has occurred. This means the information that supports the occurrence of abuse is of greater weight, or more convincing than the information that indicates the abuse and/or neglect did not occur. (This includes cases where abuse is substantiated, but the offender is unknown.)

b. Unsubstantiated. A case that has been investigated and the available information is insufficient to support the allegation of child abuse and/or spouse abuse.

(1) Unsubstantiated, Did not Occur. A case is ruled unsubstantiated, did not occur, that has been investigated and the allegation of abuse and/or neglect is unsupported. The family needs no family advocacy services.

(2) Unsubstantiated, Unresolved. A case is ruled unsubstantiated, unresolved, that has been investigated and the available information is insufficient to support the allegation of abuse and/or neglect. Referral to family support services may occur.

c. Suspected. A case determination is pending further investigation. Duration for a case to be "suspected" and under investigation should not exceed 60 days from the first report of abuse or neglect.

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4. Child. The term "child" shall include the natural (birth) child, adopted (legally finalized) child, stepchild, foster child, or ward who is a dependent of a military member and is under the age of 18. The term shall also include an individual of any age who is incapable of self-support due to mental or physical incapacity and for whom treatment in a military medical or dental treatment facility (MTF or DTF) has been authorized.

5. Child Abuse/Neglect. The physical injury, sexual abuse, emotional abuse, deprivation of necessities, or threat of other abuse of a child by a parent, guardian, employee of a residential facility, or any person providing out-of-home care who is responsible for the child's welfare. The term encompasses both acts and omissions on the part of the responsible person. This term includes offenders whose relationship is outside the family and includes, but is not limited to, individuals known to the child and living or visiting in the same residence who are unrelated to the victim by blood or marriage, and individuals unknown to the victim. Specific types of abuse/neglect are:

a. Physical Abuse. Includes, but is not limited to, acts resulting in death, brain damage or skull fracture, subdural hemorrhage or hematoma; dislocation or sprain, internal injury; poisoning, burning, scalding, severe cut or laceration, or other physical injury that seriously impairs the health or physical well-being of the child victim; or injury that includes minor bruises, welts, cuts, twisting, or shaking that does not constitute a substantial risk to the life or well-being of the victim.

b. Sexual Abuse. Actions including but not limited to, the employment, use, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct). This includes, but is not limited to rape, molestation, prostitution, or other sexual activity between the offender or a third party and a child when the offender is in a position of power over the child. Sexual abuse also includes exploitation, to include forcing or allowing a child to look at the offender's genitals, forcing or allowing a child to observe an offender's or anyone else's masturbation activities, exposing of a child's genitals for sexual gratification of the offender, talking to a child in a sexually explicit manner, surreptitious viewing of a child while undressed for the offender's sexual gratification, or involving a child in sexual activity such as pornography or prostitution in which the offender does not have direct physical contact with the child.

c. Emotional Abuse. Actions including, but not limited to, active, intentional berating, disparaging, or other behavior towards the victim that adversely affects the psychological well-being of the victim.

d. Neglect. Actions or omissions by a parent or guardian or caretaker that include but are not limited to deliberate or negligent withholding or deprivation of necessities (nourishment, shelter, clothing, and health care), lack of adequate supervision, emotional or educational neglect, and abandonment.

6. Clinical Privileging. The process whereby a health care practitioner is granted the permission and responsibility to independently provide specific medical or dental care within the scope of his or her license, certification, or registration. Clinical privileges define the scope and limit of practice for individual practitioners.

7. Family Advocacy Committee (FAC). The policy making, coordinating, recommending, and overseeing body for the installation FAP. Generally, membership includes representatives from victim and witness services, family support programs, MTF or DTF, legal staff, chaplains, youth and child care services, shelters, installation and tenant commands.

8. Family Advocacy Program (FAP). A program designed to address prevention, identification, evaluation, rehabilitation, education, counseling, follow-up, and reporting of family violence. FAP consists of coordinated efforts designed to prevent and intervene in cases of family distress and to promote healthy family life.

9. Family Advocacy Program Manager (FAPM). A term used by the Marine Corps to identify the person, usually a social worker, eligible for independent provider status, who is responsible for implementing and managing the intervention/followup aspects of the installation's FAP.

10. Family Advocacy Representative (FAR). A term used by the Navy to identify a person, usually a credentialed social worker or other clinical counselor, eligible for independent provider status, who is responsible for implementing and managing the intervention and rehabilitation aspects of the installation's FAP.

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11. Major Physical Injury. This includes brain damage, skull fracture, subdural hemorrhage or hematoma, bone fracture, dislocations, sprain, internal injury, poisoning, burn, scald, severe cut, laceration, bruise, welt, or any combination thereof that constitutes a substantial risk to the life or well-being of the victim.

12. Offender. Any person who allegedly caused the abuse of a child or spouse, or whose act, or failure to act, substantially impaired the health or well-being of the abuse victim.

13. Spouse. A partner in a lawful marriage where one or both of the partners are employed by, or are military members in, the Department of Defense (DoD). A married person under 18 years of age shall be included in this category.

14. Spouse Abuse. Spouse abuse includes, but is not limited to, assault, battery, physical injury, sexual assault, threat to injure or kill, any act of force, violence, emotional abuse, undue physical or psychological trauma, fear of physical injury, intentional destruction of property, psychological abuse, and stalking.

15. Victim. An individual who is the subject of abuse, or whose welfare is harmed or threatened by acts of omission or commission by another individual or individuals.

OVERSEAS MTFs and PROTECTION OF VICTIMS OF CHILD ABUSE/NEGLECT

1. Child abuse cases in overseas settings present a number of difficult dilemmas for the MTF. Close coordination is required among the commanding officer of the MTF, the installation commander, military police authorities, the FAR/FAPM and civilian authorities because of the increased distance from close friends and family support networks and the unavailability or unreliability of local government social service agencies. Enclosure (11) of reference (c) must be followed to ensure proper and responsible actions are taken to protect children from child neglect or abuse.

2. The health care provider who initially identifies a case of child abuse or neglect has a pivotal role in the recommendation to the installation commander regarding removal of a child from parental control. The provider is often the person most directly involved with the parents in the emergent situation. Experience has shown these situations are best handled when the provider is able to give the parents an empathetic response and support while a decision regarding removal of the child is made. The provider should explain the following issues to the parents:

a. What the medical concerns are, the child has injuries or a condition which is either not explained by the history given, or suggests the child needs protection.

b. There is reason to be concerned for the child's safety and a report to the installation commanding officer, to the FAR or FAPM, and to base security or to the provost marshal is required.

3. In most cases parents will cooperate with military interventions tailored to protect children from a dysfunctional family setting. But, in those cases where parents are not available or cooperative, naval authorities have the responsibility to act in the best interest of a child when necessary. Emergency and life saving medical care can be provided to a child without the consent of either parent. Involvement of a parent and/or sponsor throughout the assessment and treatment process should always be sought. But, if both parents are unavailable, uncooperative, or refuse consent to required medical care, the commanding officer of the MTF may authorize care and treatment including admission to the MTF following consultation with the installation commander. See enclosure (11) of reference (c) for further guidance.

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SCREENING FOR DOMESTIC VIOLENCE IN MTFs

1. The U.S. Surgeon General has cited domestic violence (spouse abuse) as one of the major health problems facing American families today. The American Medical Association (AMA) has stated domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. Because some women may not initially recognize themselves as "battered," the health care provider should routinely ask all women direct, specific questions about abuse. Such questions may be included in the social history, past history, review of symptoms, or history of present illness.

2. Although women may not bring up the subject of abuse on their own, many will discuss it when asked simple, direct questions, in a non-judgmental way and in a confidential setting. The patient should be interviewed alone, without her partner present. The provider should make an opening supportive statement, such as: "Because abuse and violence are so common in women's lives, I've begun to ask about it routinely." Even if the patient does not respond at the time, the fact the provider is concerned and believes battering is a possibility will make an impression. The provider's concern about abuse validates her feelings and reinforces her capacity to seek help when she feels ready and able to do so.

3. Routine questions about violence not only identify women who are currently being abused but also serve to assess the safety of women who have been battered in the past and to heighten the awareness of those who have not been in abusive relationships. Routine assessment is particularly important for women who have left a violent relationship. Leaving an abusive partner or finalizing a divorce may increase her risk for abuse. Information about naval FAPs or civilian agencies that deal with domestic abuse should be available in all MTFs.

4. When a victim (male or female) of alleged spouse abuse comes voluntarily to an MTF seeking counseling and there are no current injuries requiring medical attention, and the spouse is responsive and capable of responding to renewed threats of abuse, the provider is not required to report the incident if, in the provider's professional opinion, the victim's safety is not an immediate issue and the spouse does not want the incident reported. The provider, however, should encourage the spouse to

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report the incident to the proper family advocacy or law enforcement officials. This applies only to MTFs at Navy installations. See enclosure (4) of reference (c) for further guidance.

5. Marine Corps guidelines call for the reporting of all alleged incidents of spouse abuse, per reference (d).

6. Questions about domestic violence should be asked in the provider's own words and in a non-judgmental way. Here are recommended questions:

a. Are you in a relationship in which you have been recently hurt or threatened by your partner or have you ever been in such a relationship?

b. Are you (or have you ever been) in a relationship in which you felt you were badly treated? In what ways?

c. Has your partner ever destroyed things you cared about?

d. Has your partner ever threatened or abused your children?

e. Has your partner ever forced you to have sex in ways you didn't want to? Have you been forced to engage in sex that makes you uncomfortable?

f. We all fight at home. What happens when you and your partner fight or disagree?

g. Are you ever afraid of your partner?

h. Has your partner ever prevented you from leaving the house, seeing your friends, taking a job, or continuing your education?

i. You mentioned your partner uses drugs/alcohol. How does that affect you? Is your partner ever physically or verbally abusive?

j. Are there guns in your home? Has your partner ever threatened to use them while angry or at any other time?

7. If a positive response is received, the provider should consult with or report to the FAR or FAPM for guidance and assistance in getting the victim help.

GUIDELINES ON CHILD ABUSE/NEGLECT FOR MTF/DTFs

1. Health care providers are in a unique position to detect the injuries and behavioral problems resulting from child abuse and neglect. State law and Navy regulations require physicians and other professionals providing services to children to report suspected incidents of child abuse and neglect.

2. Children who are abused or neglected must be identified for their own protection. Our current understanding of child abuse as a symptom of family dysfunction and a problem with complex, variable origins suggests no one person or profession can be solely responsible for the management of these cases. The FAP includes a multi-disciplinary Case Review Committee (CRC) that includes representatives from medical, mental health, social services, investigative, legal, and law enforcement to decide whether child abuse or neglect has occurred and to recommend followup and treatment for the child and/or family involved. Enclosure (7) of reference (c) and reference (d) apply.

3. Health care providers in all practice settings will see abused children and should be able to:

a. Identify the signs and symptoms of abuse and neglect.

b. Provide medical or dental evaluation and treatment for injuries or conditions resulting from abuse and/or neglect.

c. Take emergency measures needed to protect the child from further injury. A child at risk can either be hospitalized or placed in emergency foster care or safe home with the aid of the FAP and/or use of a military protective order and the State's child protective services.

d. Provide an accurate and complete medical or dental evaluation and record.

e. Remain objective and professional toward child and caretakers.

f. When appropriate, attempt to establish or maintain a therapeutic alliance with the family.

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g. Attempt to secure medical or dental evaluation of other children present in the household.

h. Report all cases of suspected child abuse and/or neglect per State and military requirements for the naval FAPs.

i. Be willing and available to give evidence in court.

4. The above issues should be covered in any training program for health care staff.

GUIDELINES ON CHILD SEXUAL ABUSE FOR MTF/DTFs

1. Child sexual abuse can be defined as the engagement of a child in sexual activities for which the child is developmentally unprepared and cannot give informed consent. Sexual abuse need not involve sexual intercourse. Often physical force is not used; rather, the offender uses gradual seduction techniques. The sexual activities may include genital or anal contact by or to the child or non-touching abuses, such as exhibitionism, voyeurism, or using the child in the production of pornography. Sexual abuse may result in anal-genital injury or be accompanied by other signs of physical abuse, such as bruises, or by neglect, such as poor hygiene. Survivors of child sexual abuse often experience long term adverse effects on their psychological and social well-being and may be more likely to be victimized later in life as well. See enclosure (1), paragraph 5b.

2. The health care provider should focus on assessment of the immediate safety and long-term best interests of the child.

3. Sexually abused children will be seen in all practice settings. To protect these children from further harm the health care provider should:

a. Identify the signs and symptoms of child sexual abuse.

b. Provide medical or dental evaluation and treatment of injuries or conditions resulting from sexual abuse.

c. Take emergency measures needed to protect the child from further harm. Children sexually abused or at risk can be hospitalized or placed in emergency foster care or safe home with the help of the FAP and/or the jurisdiction's child protective services. (May consider recommending the offender's command issue military protection order.)

d. Provide an accurate and thorough medical evaluation and record.

e. Remain objective and professional toward the child and caretakers.

f. When appropriate, attempt to establish or maintain a therapeutic alliance with the family.

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g. Attempt to secure medical evaluation of other children present in the household.

h. Report all cases of suspected child sexual abuse per enclosure (8) of reference (c), reference (d), and with all State requirements.

i. Be willing and available to give evidence in court.

4. In any clinical setting where children are cared for, a plan for the identification and management of such cases, including physical abuse and neglect, must exist. Protocols are required for facilities accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO). The American Academy of Pediatrics (AAP), the American Medical Association (AMA) and the American Dental Association (ADA) have published guidelines for the evaluation of sexual abuse in children, as well as sexual assault in adolescents.

5. The above issues should be covered in any training program for health care staff, per enclosure (10).

6. The special needs of sexually abused children generally require training well beyond that provided in a general residency or other medical provider curriculum. The health care provider's attention should focus on potential pediatric referral or consultation in determining how best to assure skillful intervention without obstructing the collection of essential evidence.

7. Navy FAPs offer interventions for military and family members who are involved in suspected cases of child sexual assault. The FAP's multi-disciplinary CRC includes representatives from medical, mental health, social services, investigations, and legal to decide whether child sexual abuse has occurred. The Navy Personnel Command Child Sexual Abuse Management Section (PERS 661) works with local CRCs and the State's child protective services to make decisions for treatment and followup with these families, per enclosure (8) of reference (c).

PROCEDURES FOR PHOTOGRAPHING VICTIMS

1. Color photographs should be taken after examination has determined injuries or conditions, alleged or suspected, are the result of spouse abuse or child abuse/neglect.
2. The health care provider should take the following action:
 - a. Notify the MTF photographer.
 - b. Complete the appropriate local MTF form for requesting photography.
 - c. Obtain a private setting for taking photographs, away from spouse, parents, and others so there is no further trauma for the victim.
 - d. In cases of spouse abuse, permission of the alleged victim must be obtained before photographing injuries.
 - e. In child maltreatment cases obtain the signature of the parent or guardian on the consent for photographic services form. If a parent or guardian is not available, or refuses to sign, the reason the form was not signed should be noted and the photographs taken. (Naval authorities have the inherent authority and responsibility to act in the best interest of a child when necessary as in the case of maltreatment of a child.)
 - f. Ensure entry is made in the alleged victim's medical or dental record that states the photographs were requested and identify who made the request.
 - g. When possible, have photographs taken before medical or dental treatment.
3. Contusions may become more apparent following the initial examination, so the medical or dental practitioner may initiate a second request for photographs when the injuries are predicted to be more visible. It is extremely important a set of photographs be taken initially to establish the baseline that may later prove essential for evidentiary purposes. The color of the contusions at the time of the initial assessment determines the need for further photographs.

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<u>Age of the contusion since trauma</u>	<u>Color or condition</u>
0-2 days	Swollen, tender
0-5 days	Red, blue, purple
5-7 days	Green
7-10 days	Yellow
10-14 days or longer	Brown
2-4 weeks	Cleared

4. Guidance for the photographer:

a. Ensure necessary form has been properly completed.

b. Sensitive handling of the patient is secondary only to the delivery of prompt medical or dental care. Explain to the patient what is being done before the photographs are taken.

c. Studio photography is most desirable; however, the impact that movement to the studio may have on the patient should always be a prime consideration. It is very important to take the photographs in a private setting.

5. Procedures to be followed:

a. A card with the patient's name, their own social security number, the current date, time, and the name of the MTF or DTF should be displayed in the lower left section of each photograph. Close ups should include scales for size (use a ruler or stick on centimeter scale). Without this information the photographs have no evidentiary value.

b. Use color negative film, (photograph bite marks in black and white if possible as well as in color). If available, infrared film should be used in situations where dark skin coloring makes contusions difficult to detect. Do not use digital electronic cameras because the images can be manipulated.

c. Photograph from different angles including full body and close up.

d. Hold up a coin, ruler, or other object to illustrate the size of an injury.

e. Include the person's face in at least one photograph.

f. Take at least two photographs of every major trauma area.

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g. Orientation photographs should have a visible body landmark that clearly shows the location of the injury. More than one photograph may be required to show the landmark and still obtain a clear close up of the injured area.

h. An 18 per cent gray card for verification of correct color and the signed copy of the permission form should be visible in at least one photograph.

6. Photographs involving FAP cases are to be released by the photographer to the FAR or FAPM when they become available. The FAR or FAPM will sign a receipt for and become custodian of all developed prints and negatives involving FAP cases per instructions from Navy Criminal Investigative Service or Marine Corps Criminal Investigative Division.

FAP CASE REVIEW COMMITTEE'S CHAIRS AND MTF STAFF MEMBERS

1. Case Review Committees (CRCs) will exist for child and spouse abuse, and in some areas for child sexual abuse. These committees can be combined in those areas that do not have sufficient cases for separate committees. Enclosure (7) of reference (c), and reference (d) apply.
2. The commanding officer of the MTF, in conjunction with the installation commanding officer, will appoint a clinically privileged member of the MTF staff to chair each Navy CRC and recommend one chair (alternate) to represent the MTF as co-chair of the area FAC. The commanding officer of the MTF will appoint, in writing, other permanent members (alternates) of the MTF staff as appropriate and noted in enclosure (7) of reference (c).
3. MTF commanding officers on Marine Corps installations will appoint, in writing, a representative to the CRC to be chaired by the family advocacy program manager (FAPM). The commanding officer of the MTF will appoint, in writing, a practitioner to the Marine Corps' spouse abuse CRC and a pediatrician (when available) to Marine Corps' child abuse CRC, as described in reference (d).
4. In all substantiated cases a one line entry must be recorded in the medical records related to the case. The entry will be on the problem summary list, which is normally located on the left side of the outpatient record, and will read as follows: "FAP case substantiated this date." When the FAP case is closed an entry will be made on the problem summary list as follows: "FAP case closed this date." Family advocacy or medical records personnel may perform this function.
5. A designated MTF permanent member of the CRC will ensure that pertinent medical records are available for review by the CRC to assist with case status determinations.

MEMORANDUM OF UNDERSTANDING WITH LOCAL AGENCIES

1. A memorandum of understanding (MOU) with local military and civilian agencies should be developed which outlines responsibilities for coordinated community responses in the operation of the FAP. The MOU should clearly delineate roles and responsibilities for the care of family violence victims in crisis situations both during and after hours. Consideration should be given to the role of the FAP, child protective services, local community shelters, investigations, and base security so the MTF or DTF can provide care, safety planning, and referral to appropriate resources, per references (c) and (d).

2. The MOU should be constructed to address the concerns of all agencies involved. (See reference (f) for general guidelines.) The following is a partial list of areas for inclusion:

a. Subject. The agencies involved and any references they want to include.

b. Purpose. To provide services or to have an agreement for each to do specific things.

c. Background. Reason this agreement is needed - how it came to be.

d. Definition of terms. For clarity and to prevent misunderstanding in the future.

e. Responsibilities. What each agency involved agrees to do.

f. Authority. When there are instructions, directives, or legalities directing the agreement.

g. Procedures. Specific steps each agency will take to carry out their part in the agreement.

h. Time. Duration of the agreement and when it will be reviewed for renewal.

i. Signatures. All parties must have the MOU signed by the highest authority involved (CO, Responsible Line Commander (RLC), etc.). Once signed, all parties should have a copy.

SUPPLEMENTAL CARE GUIDANCE FOR FAP ACTIVE DUTY CLIENTS

1. Reference (a) directs active duty victims or offenders who require specialized rehabilitative education and counseling, unavailable through military providers, be referred to civilian service providers.

2. Active duty offenders of child sexual abuse/incest should be referred to civilian professional therapy only on a case by case basis. Alleged child sexual abuse offenders in cases that are eligible for supplemental care funds must be assessed and/or treated at an appropriately accredited sexual offender program per enclosure (8) of reference (c). When any request or claim for treatment for an active duty offender comes to the attention of Medical/Dental Affairs, the member's commanding officer and the FAR or FAPM will be contacted to determine if the member is a part of the FAP, as stated in references (c) and (d).

3. Active duty victims or offenders should be treated using the staff of the local FAP, FSC, FAC, or MTF before expending funds for civilian medical or professional care, per reference (e), provided the MTF staff have the requisite training and experience to do this specialized work. Special requirements exist for assessing and treating sex offenders.

FAP TRAINING REQUIREMENTS FOR MTF/DTFs

1. Training is an essential component of the FAP. All medical and dental personnel should be familiar with the operation of the FAP and must be properly prepared to meet the challenge that FAP cases present. All privileged providers, emergency room, primary care, and mental health nurses and corpsmen, must receive training to include identification, diagnosis, and disposition of spouse and child maltreatment victims. Training of key responders should occur on a regular, yearly basis, to involve new staff members as soon as possible. At a minimum all staff must receive training as they report to a new command, covering the areas outlined in paragraph 3 below.

2. Case Review Committee (CRC) chairs and staff members from medical facilities require an intensive knowledge of child and spouse maltreatment. The commanding officer of the MTF in coordination with the installation commanding officer and the Family Service Center's family advocacy officer (FAO) must ensure, at a minimum, 16 hours of child and spouse abuse training within 6 months of appointment to the CRC. The members must also receive 24 hours of FAP related training in each subsequent year. Enclosure (7) of reference (c) applies.

3. Training for CRC and key responders noted above is a responsibility of NAVPERS and must be ensured by the family advocacy officer, the FAP regional coordinator and other FAP personnel in cooperation with the education and training department of the MTF. Enclosure (12) of reference (c) applies. Education and training departments at MTFs will be responsible for notification of trainees, location, and documentation of required training in staff training records. NAVPERS FAP personnel are responsible for providing the training. Training must have a multi-disciplinary focus to include specific crisis intervention and referral protocols for cases of child and spouse abuse. Topics to be included in FAP protocols and training are:

- a. Safety planning for spouse and child victims of abuse and neglect.
- b. Screening procedures for child and spouse abuse.
- c. Sensitive and protective patient interviewing techniques.
- d. Military and civilian reporting requirements.
- e. Provision of basic family violence information.
- f. Underlying causes, patterns, and dynamics of family violence and abuse.
- g. Emotional and mental health needs of victims of abuse.

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- h. Proper collection and transfer of evidence.
- i. Referral and/or provision for victim advocacy services.
- j. Specialized family violence discharge planning.
- k. Use of the Navy risk assessment model.