

14 MARCH 2001

Medical Services

FAMILY ADVOCACY PROGRAM (FAP)



COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

NOTICE: This publication is available digitally on the AFDPO WWW site at:
<http://afpubs.hq.af.mil>

OPR: 22 MG/SGOMHS (Glyneise Canady)
Supersedes MAFBI 40-301, 12 July 1997

Certified by: 22 MDG/CC (Col Judith Varnau)
Pages: 18
Distribution: F

This instruction implements AFD 40-3, policy and procedures at McConnell AFB to minimize the negative impact of and to prevent, where possible, children and families having exceptional medical or educational needs. This instruction applies in whole or in part to all military assigned or attached to McConnell AFB, to include the Kansas Air National Guard. Civilian personnel assigned or attached to McConnell AFB are strongly encouraged to comply with this instruction.

The mission of the Family Advocacy Program (FAP) is to support Air Force readiness. The goal is to promote family functioning by enhancing the health, welfare, and morale of the Air Force family. This instruction directs collection and maintenance of information protected by the Privacy of Act 1974. Authorized by 10 U. S. C. 8013 and 10 U.S.C. Chapter 55. Privacy Act Statement required by AFI 37-131, is annotated on DD Form 2005, Privacy Act Statement - Health care Records.

SUMMARY OF REVISIONS

This document has been revised to reflect local organization names, phone numbers, and Family Advocacy Standards changes. See new changes: (references: **4.4.3**. Children Family Services, **4.5.5.3.4**. No Record Open or, 5.1.1.5.6. **5.6.1.-5.6.4**. Security Force, 8, A1.10.A.1.46. change to acronym DoD to DOD, and A1.27.).

1. References. AFI 40-301, Family Advocacy Program. (All applicable references are listed in this instruction.)

2. Services. All eligible military families living in the civilian community, those families living on the installation and eligible civilians shall be recipients of FAP services.

3. Explanation of Terms and Indicators of Child Abuse & Neglect. Refer to **Attachment 1** and **Attachment 2**.

4. Assigned Responsibilities: Organizational structure of the McConnell AFB FAP.

4.1. The Installation Commander: The installation commander may delegate to the 22 Support Group Commander or Support Group Deputy Commander.

4.1.1. Responsible for implementation and management of the base FAP.

4.1.2. Family Advocacy Committee (FAC).

4.2. Family Advocacy Committee (FAC): The FAC has a policy making and resource management function. The members of the FAC will include: 22 SPTG/CC or 22 SPTG/DC; DBMS or 22 MDG/SGH (Chairperson); Family Advocacy Officer (FAO); Family Advocacy Outreach Manager (FAOM); Family Advocacy Treatment Manager (FATM); Family Advocacy Nurse (FAN); Family Support Center Director; Staff Judge Advocate (SJA) or designee; Chief of Military Personnel Flight or designee; and a representative from Security Forces Squadron, Air Force Office of Special Investigation (AFOSI), Chaplain, Substance Abuse, the Director of the Child Development Center, and Youth Programs. The FAC may invite representatives from the civilian child protection agencies to attend meetings. The FAC may add other members at the discretion of the chairperson. The FAC meets at least once every three months or at the call of the chairperson. This committee sets policy and procedures for establishing and operating the FAP based on this instruction and on the FAP Standards. Advocates establishing and improving services that promote healthy families. Solicits the resources needed to successfully run the FAP. Coordinates activities of different organizations that contribute to the FAP and identifies resource and service delivery problems. Reviews available data on families to identify at-risk groups requiring prevention services and to detect trends. Uses findings to ensure that responsive programs are implemented. Monitors training programs for FAP personnel. Establishes a cooperative working relationship with local community agency personnel. Develops and maintains a directory of community resources. Establishes a FAP management team, High Risk for Violence Team (HRVRT), and a Child Sexual Maltreatment Response Team (CSMRT).

4.3. 22 MDG/CC:

4.3.1. Is responsible for management and monitoring the installation FAP.

4.3.2. Serves as chairperson of the installation FA. The 22 MDG/CC may delegate this responsibility to the Chief of Medical Staff (SGH).

4.3.3. DBMS or SGH: Assumes responsibility of these area staffing and training of Family Advocacy Program activity.

4.3.4. Appoints a clinical social worker to serve as the Exceptional Family Member Program Officer and as the Family Advocacy Officer.

4.4. Family Advocacy Officer (FAO):

4.4.1. Chairs the Family Maltreatment Case Management Team (FMCMT) and ensures timely evaluation of all referrals to FAP.

4.4.2. Notifies the servicing AFOSI unit and the service member's commander of all suspected incidents of family maltreatment.

4.4.3. Notifies the local civilian Children Family Service (CFS) of all child abuse incidents.

4.4.4. Ensures that FAP activities comply with federal, state, and local laws.

4.4.5. Maintains case records according to FAP Standards.

- 4.4.6. Directly supervises the activities of the Family Advocacy staff.
- 4.4.7. Obtains legal guidance from the SJA in situations that might have legal ramifications, such as advising clients of their rights.
- 4.5. The FMCMT clinically manages the assessment of and interventions with families having allegations of maltreatment. Administrative, legal, and disciplinary issues will not be addressed at the FMCMT, except as they pertain to safety issues for clients.
 - 4.5.1. The FMCMT will be a multidisciplinary team appointed by the FAC Chairperson in writing. The FAO will chair the FMCMT.
 - 4.5.2. Membership will include the following: FATM, FAN, Chief of Pediatrics or designee, OSI representative, SJA, SFSI, CFS representative, Family Support Center Director, Staff Chaplain, Youth Flight or Child Development Center Director and others as needed on a case-by-case basis.
 - 4.5.3. Squadron commanders and first sergeants will be invited to the FMCMT as a guest to participate only in discussions concerning assigned members of their units.
 - 4.5.4. The FAP staff will obtain and document consent from adult victims to share with FMCMT information of a historical or contextual nature that is not directly relevant to the incident status determination or the intervention planning process.
 - 4.5.5. FMCMT will:
 - 4.5.5.1. Only discuss information pertinent to maltreatment issues.
 - 4.5.5.2. Review and concur/non concur on the non-opening of “no record opened” (NRO) cases.
 - 4.5.5.3. Make incident status determinations on each incident using the following categories:
 - 4.5.5.3.1. Substantiated
 - 4.5.5.3.2. Unsubstantiated – Did Not Occur
 - 4.5.5.3.3. Unsubstantiated – Unresolved
 - 4.5.5.3.4. No Record Open - NRO
 - 4.5.6. Ensure unit commanders are informed of the findings, recommendations for intervention, and participation in treatment.
 - 4.5.7. Review each open, substantiated incident at least quarterly, with the exception of child sexual maltreatment incidents, which are reviewed monthly. FMCMT will make decisions on transfer and closure cases.
 - 4.5.7.1. Ensure involved adult family members receive notification of FMCMT incident status determination and changes in treatment recommendations.
 - 4.5.7.2. Develop, review, and approve intervention plans, including treatment modalities, for substantiated incidents.
 - 4.5.7.3. When making an incident status determination in spouse maltreatment cases, the FMCMT will include, but is not limited to the following contextual factors.
 - 4.5.7.3.1. Victim’s level of fear.

- 4.5.7.3.2. Pattern of abuse.
 - 4.5.7.3.3. Who initiated the violence?
 - 4.5.7.3.4. Whether the victim was protecting self, child, or other household members.
 - 4.5.7.3.5. Severity of incident, to include injuries.
- 4.5.8. FMCMT minutes will reflect team discussions and decisions. The minutes will refer to clients by incident number only.
- 4.5.9. Meets at the call of the chairperson, but at least monthly.
- 4.6. Child Sexual Maltreatment Response Team (CSMRT). The team will be appointed in writing by FAC to manage the initial response to all high profile child sexual maltreatment allegations. The primary responsibility of the CSMRT will be to develop and implement the initial management of each referral. The goal of the team is to minimize the trauma to the victim and family. The team will be notified on all child sexual cases and activated immediately in high profile cases.
- 4.6.1. The composition of the CSMRT will include FAO, OSI, SJA, and CFS. The CSMRT will meet semi-annually to clarify roles and responsibilities for the initial response to child sexual maltreatment allegations.
 - 4.6.2. In cases of child maltreatment, the CSMRT will initiate the initial investigation, biopsychosocial assessment, and intervention plan for the alleged offender, including the initial risk assessment and safety plan.
 - 4.6.3. CSMRT will:
 - 4.6.3.1. Review the allegations.
 - 4.6.3.2. Coordinate a course of action.
 - 4.6.3.3. Ensure victim safety and prevent revictimization.
 - 4.6.3.4. Attend to the well being of the victim, the victim's family and the alleged offender, ensuring suicidal/homicidal risk is evaluated.
 - 4.6.3.5. Ensure the number of investigative interviews and medical examinations are minimized to reduce the potential emotional trauma of the investigative process.
- 4.7. High Risk for Violence Response Team (HRVRT) established by the FAC to manage potentially dangerous situations involving FAP clients. The goal of HRVRT is to use a coordinated community response to decrease the risk of violence. Potentially dangerous situations include threat to seriously harm family members or FAP staff.
- 4.7.1. The composition of the HRVRT will include the FAO (HRVRT Chairperson), FATM, Squadron Commander, SFS Operational Fight Commander, JA, Mental Health Provider, OSI representative, and representatives from other agencies as appropriate.
 - 4.7.2. Upon notification of suspicion of potential threat of harm by an individual, the FAO will activate the HRVRT. The HRVRT will assess the level of danger then develop and implement a course of action to manage the risk of violence.
 - 4.7.3. The FAO will involve the threatened individuals in the safety planning process.

4.7.4. The FAO will report the HRVRT finding, plans, and activities to the FAC Chairperson and the FMCMT.

4.8. Exceptional Family Member Program (EFMP). The FAC will establish a multidisciplinary Exceptional Family Member Program (EFMP) Team, which will serve as resource and specialty consultants to the Exceptional Family Member Program Officer (EFMPO) and will have input on local policy and procedures when, called upon to do so.

4.8.1. The EFMPO will coordinate the activity of the EFMP.

4.8.2. Composition will include the EFMPO, medical, educational, and military or civilian support personnel directly involved with families.

4.8.3. Procedures:

4.8.3.1. Will meet as needed. No periodic case review required.

4.8.3.2. Team functions as an ad hoc working group that meets at the call of the EFMPO to review EFMP issues, procedures or cases requiring multidisciplinary consultation.

5. Procedures:

5.1. Who, When, and How to Report: Kansas Law (K. S. A. 38-1522) requires that any licensed physician, resident or intern examining, attending, or treating a child; any law enforcement officer, registered nurse, visiting nurse, school teacher, psychologist or social worker acting in their official capacity; or any other person knowing or having reasonable suspicion that a child is an abused or neglected child, report the matter by telephone immediately, or as soon as practically possible. Additionally, McConnell Air Force Base not only requires compliance with the Kansas Law, but also requires any active duty military member (strongly encourages civilian employees), knowing or having reasonable suspicion that a spouse or another legal dependent of an active duty member is an abused or neglected person, immediately report such maltreatment, as directed herein. On McConnell Air Force Base, per the memorandum of understanding (MOU) with Kansas Social and Rehabilitation Services (SRS), the FAO or designee shall be the initial point of contact and coordinator of all maltreatment allegations (759-5768) during duty hours. For those emergency cases requiring immediate law enforcement or medical involvement, or for those cases occurring after duty hours, the Law Enforcement Desk (759-3976) is the point of contact. The FAO or their designee will serve as the liaison with the Kansas SRS and CFS worker and will process family maltreatment incidents according to existing Air Force instruction, guidelines, and the MOU. Family maltreatment issues occurring after duty hours or off base shall be referred to the CFS (1-800-922-5330). The referring person will notify the FAO the next day. If the child or spouse abuse incident is in progress, dial 911 or the Law Enforcement Desk (759-3976). The FAO will be notified of all child or spouse abuse incidents reported to 911 or the law enforcement desk.

5.1.1. Procedures for Emergency Removal of Children. When action needs to be taken to intervene in securing a child's safety, removal of the offender should be considered first. However, when this is not possible, or if there are reasonable grounds to believe that child's surroundings could contribute to further injury, illness or danger, a Security Forces officer may take the child into protective custody until appropriate authorities arrive to transport the child to a shelter or foster care. Such action will be immediately coordinated with the FAO during duty hours (759-5768). After duty hours, the Protection Reporting Center Hot-Line (1-800-922-5330), SJA, AFOSI, and the sponsor's commander will be immediately notified.

5.1.2. Interviewing Guidelines. It is the spirit and intent of this instruction to prevent and, when necessary, provide intervention to eliminate domestic maltreatment. In an effort to achieve such a goal, the following guidelines will be the focus for how a child, spouse, and other victims shall be interviewed by base agencies having jurisdiction and where appropriate, their civilian counterparts:

5.1.2.1. Avoid the necessity of subjecting the victim to multiple interviews. The FAP and AFOSI (when allegations of a criminal nature are reasonably suspected) will coordinate the needed interviews.

5.1.2.2. All information collected from the victims shall be accomplished in such a manner that will foster the victim's right to privacy and maintain the victim's dignity.

5.1.2.3. All interviews of the victims, especially children, shall be conducted in an environment that is sensitive to dealing with the trauma of maltreatment and not in the presence of the alleged offender.

5.2. Evaluation of Risk: The following general areas should be assessed to evaluate the risk to maltreatment victims:

5.2.1. Extent of injuries, objects used in the abuse, accessibility of weapons to the offender or victim, threats of violence made, drugs or alcohol involvement, offender or caretaker demonstration of bizarre behavior, victims concern or fear of anticipated recurrence, cooperation from all parties being interviewed, previous history of family maltreatment and dysfunction, interaction between family members and collateral contacts dictated by the situation.

5.2.2. When action needs to be taken to intervene in an unsafe situation, removal of the offender should be considered first. This avoids re-victimizing the injured person and may enhance the offender's awareness that there are consequences to negative behavior.

5.2.3. Remember spouse abuse victims are adults and have choices to make about their shelter arrangements. All referring base and civilian agencies should not attempt to force spouse abuse victims to choose a specific option, but should definitely provide guidance and support commensurate with the situation.

5.2.4. In doing the assessment and determining risk, recantation by the victim shall be considered a fact and part of the information on the case. It shall not, in and of itself, be used to conclude the incident did not occur.

5.3. Information Needed. Those making reports are asked to provide the following information, if known:

5.3.1. Name and age of victim.

5.3.2. Victim's sponsor's unit and rank.

5.3.3. Location of victim (address of place where abuse or neglect is occurring or has occurred.)

5.3.4. Name of offender.

5.3.5. Description of abuse or neglect (physical, lack of parental supervision, sexual molestation, unsanitary home, etc.)

5.3.6. When the abuse or neglect occurred.

5.3.7. Reporting person's name, address and phone number (optional, if not a mandated report, see para 5.1.).

5.4. Action taken by base FAO:

5.4.1. Non emergency Situations. Review facts in the incident and decide if abuse or neglect is reasonably suspected. If it is a reasonably suspected abuse or neglect incident, the sponsor's commander or first sergeant, and the appropriate civilian and base agencies will be briefed on the incident, and given a recommendation for further action.

5.4.2. Reports appearing to reasonably suggest a sexual or physical assault should be immediately coordinated with AFOSI by the FAO. If appropriate, in the judgment of the detachment commander, AFOSI will open a criminal investigation. Once a criminal investigation is opened, AFOSI assumes investigative jurisdiction and updates the FAO frequently. AFOSI will immediately confer with the FAO to assure the welfare of the spouse or child involved.

5.4.3. The agency or therapist providing treatment to active duty members will be asked to send a statement to the FAO documenting progress with treatment objectives; however, active duty members are responsible for obtaining documentation from the provider and giving it to the FAO at least monthly.

5.5. Action by Unit Commander:

5.5.1. It is the aim of the FAP to consult with the unit commander or their designee in an effort to formulate an effective treatment program that addresses identified family dynamics. This will be arranged through the FAO.

5.5.2. Unit commanders will be notified as soon as possible when the FAP is involved with an active duty member of a family member. This allows the commander or first sergeant to contribute to the case management process and facilitates the active duty member's compliance with the management plan. Commanders will be updated on any change in case status, case management plan, civilian court and civilian agency involvement, and subsequent incidents or increased risk to family members.

5.5.3. Many families will comply with the prescribed plans; however, some families may be hostile and resistant to change. For these families, the interpersonal and clinical skills of the FAO or the FATM are required to establish a working alliance and promote client cooperation. If a family is extremely resistant to a particular intervention plan, alternatives may be explored. The continued safety of all family members is a primary concern. If the assistance of the unit commander has been requested and concerns still remain, the FMCMT will review the situation and reassess the intervention plan. The FMCMT may request the assistance of the FAC and the group commander or the equivalent level in implementing the plan.

5.6. Action by the Security Forces Squadron (SFS).

5.6.1. Security Forces may be called to investigate child neglect cases or stabilize an abuse or negligent situation. During duty hours, all actions will be reported to the FAO, preferably prior to the Security Force patrol being dispatched to the scene. In incidents suggesting a physical or sexual assault of a child, or the aggravated assault of a spouse, AFOSI will be immediately notified. If indicated, the alert photographer will be requested to take appropriate photographs. If the member's unit commander or first sergeant is present, the FAO will consult them to determine appropriate action to restore stability to the family situation. After duty hour incidents will be the

responsibility of the active duty member's commander or their designee to determine the appropriate course of action.

5.6.2. If either victim or perpetrator becomes violent or life threatening in any way, the SF on the scene will take what action is reasonably needed to establish a conflict-free environment to preserve law and order.

5.6.3. The Law Enforcement Desk or designated SF section will ensure that a copy of the blotter and incident reports are available to review and, if needed, photo copies provided to the FAO or their designee the next duty day.

5.6.4. 22 SFS/CC will ensure squadron personnel are properly trained to handle domestic violence, including spouse and child abuse. Commanders are encouraged to call on helping agencies specializing in the treatment and prevention of family violence to assist in the training. Coordination with the FAO is needed.

5.7. Action by the SJA.

5.7.1. In all cases of reasonable suspected child and spouse abuse or neglect, conformity with applicable laws will be monitored during the investigation to include all others pertinent to the incident.

5.7.2. In the event of prosecution of the offender by civilian or military court, SJA will confer with the convening authority to determine whether or not the case will be processed through civilian or military court. In these cases, every effort will be made to provide the greatest benefit to all involved. In the event of legal action, it should be oriented toward correcting unlawful behavior and preventing its recurrence. Preservation of the family should be the goal, but not at the sacrifice of the well being of the victim, other family members involved, or the community.

5.7.3. Makes sure FAP activities comply with applicable federal, state and local laws.

5.8. Action by Medical Group. If needed, the Medical Group will provide medical transportation in the event a victim must be moved to another medical facility to obtain needed medical care. This will be done with the approval of the Medical Group commander or administrator.

6. Exceptional Family Member Program (EFMP): The EFMP is a component of the FAP and designed to help military members who have dependents (spouses, children, or other dependent family members) require exceptional medical or special educational services. This can include a variety of physiological, psychological or social conditions of a chronic nature that have been diagnosed and require specialized care. In addition, children in special education at school or who have other specialized educational or related needs (i.e., speech, physical, occupational therapy, audiology, and ophthalmology), and other needs as indicated by an Individualized Education Program (IEP) are potentially eligible for this program.

6.1. Many military members are under the misconception that enrollment in any Air Force program may be detrimental to their military careers. This, along with fact that some services are only available in the civilian community, has resulted in many of them seeking services from outside of the military system. They have a right to do this and often are even encouraged to do so. However, the result has been that many that should be enrolled in EFMP are not aware of the program.

6.2. Enrollment in EFMP is required in order to guarantee the needed care will be available at a new location. Without the EFMP, military children and family members could experience unneeded family disruption and financial burdens.

6.3. The EFMP officer is the action officer for this program. All EFMP concerns should be addressed through the EFMP Officer (759-5768), 22 MDOS/SGOHF, McConnell AFB KS.

6.4. All medical providers (both civilian and military) having knowledge of the following will immediately contact the EFMP officer:

6.4.1. Physiological, psychological, or social condition of a chronic nature that has been medically diagnosed and that requires medical management by a subspecialty (not simple consultation).

6.4.2. Medically related services that are listed in an Individualized Education Plan (IEP) and are necessary for the student to benefit from the educational curriculum (i.e., occupational therapy, physical therapy, audiology, speech therapy, psychiatric diagnosis etc).

6.4.3. Services that are strictly educational and are identified in the IEP.

7. Operating Instructions (OIS). Each organization listed herein, and other organizations that can reasonably expect to have contact with family maltreatment or EFMP dynamics, shall establish a written outlining implementation of the FAP as it pertains to each organization's respective functions. Such OIs will be forwarded to the FAO for coordination with the FAO.

8. Conclusion. Nothing contained herein shall be constructed to take precedence over the FAP standards as determined by the DOD Family Advocacy Program Manager, Office of the Surgeon General.

FREDERICK F. ROGGERO, Colonel, USAF
Commander

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

AFPD 40-3, *Family Advocacy Program*

AFI 33-131, *Air Force Privacy Act Program*

AFI 40-301, *Family Advocacy Program*

Abbreviations and Acronyms

AFOSI—Air Force Office of Special Investigation

CFS—Children Family Service

CSMRT—Child Sexual Maltreatment Response Team

EFMP—Exceptional Family Member Program

EFMPO—Exceptional Family Member Program Officer

FAC—Family Advocacy Committee

FAN—Family Advocacy Nurse

FAO—Family Advocacy Officer

FAOM—Family Advocacy Nurse (FAN)

FAP—Family Advocacy Program

FATM—Family Advocacy Treatment Manager

FMCMT—Family Maltreatment Case Management Team

HRVRT—High Risk for Violence Team

NRO—No Record Open

OI's—Operating Instructions

SFS—Security Forces Squadron

SJA—Staff Judge Advocate

Attachment 2

EXPLANATION OF TERMS

A2.1. ABUSE: Non accidental physical injury or emotional disturbance as evidenced by, but not limited to, scratches, lacerations, skin bruising, bleeding, malnutrition, sexual maltreatment or abuse, burns, bone fractures, subdural hematoma, soft tissue swelling, and unexplained death; or where the history given concerning such condition, or where circumstances indicate that the condition may not be the result or product of an accidental occurrence.

A2.2. ABANDONMENT: The caregiver is absent and does not intend to return or is away from home for an extended period without having arranged for an appropriate surrogate caregiver.

A2.3. CHILD EMOTIONAL MALTREATMENT: Emotional abuse usually involves a pattern of active, intentional berating, disparaging, or other abusive behavior toward the victim, such as violent acts that may not cause observable injury. Emotional neglect involves passive or passive-aggressive inattention to the victim's emotional needs, nurturing, or psychological well being.

A2.4. CHILD MALTREATMENT: The physical injury, sexual maltreatment, emotional maltreatment, deprivation of necessities, or other maltreatment of a child under the age of 18 years or an individual of any age who is incapable of self-support due a mental or physical incapacity. The term encompasses acts and omissions on the part of a person responsible for the child's welfare i.e., parent, guardian, employee of a residential facility, or any person providing out-of-home care. The definition also includes incidents of sexual maltreatment when the alleged offender is in a position of power over the child.

A2.5. CHILD NEGLECT: Neglect of a child involving one or more of the following: Deprivation Of Necessities, Non-Organic Failure To Thrive, Lack Of Supervision, Educational Neglect, Abandonment, Medical Neglect, And Spouse Maltreatment

A2.6. CHILD PHYSICAL MALTREATMENT: Physical acts against a child that caused major or minor physical injury to the victim. Major injuries/acts include brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, shaking or twisting of infants and young children, dislocations or sprains, internal injuries, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts; or other physical injury that seriously impairs the health or physical well-being of the child victim. Minor injuries/acts include minor cuts, bruises or welts; other shaking or twisting incidents that do not result in significant injury. An injury does not have to be visible for physical maltreatment to be present.

A2.7. CHILD SEXUAL MALTREATMENT: The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct), or the rape, molestation, prostitution, or other such forms of sexual exploitation of children, or incest with children. All sexual activity between an offender and a child, when the offender is in a position of power over the child, is considered sexual maltreatment. Sexual maltreatment specifically includes the following: Exploitation, Rape/Intercourse, Molestation, Other Sexual Maltreatment, Child Sexual Maltreatment In Dod-Sanctioned Activities (Formerly Termed "Out-Of-Home") and Emotional Maltreatment.

A2.8. CHILD SEXUAL MALTREATMENT IN DOD-SANCTIONED ACTIVITIES (FORMERLY-TERMED “OUT-OF-HOME”): Any child sexual maltreatment occurring during DOD sanctioned activity in any location where the military service has sanctioned or authorized care of children by individuals other than their legal guardians. Examples include: CDCs, Department of Defense Education agency (DODEA) schools, buses, recreation facilities, Licensed Home Day Care Facilities, DOD sponsored Boy/Girl Scout functions, or locations where Red Cross trained baby-sitting occurs.

A2.9. DEPRIVATION OF NECESSITIES: Failure to provide appropriate nourishment, appropriate shelter and/or clothing.

A2.10. EDUCATIONAL NEGLECT: Knowingly allowing the child to have extended or frequent absence from school, neglecting to enroll a child in school, or preventing the child from attending school for other than justified reasons. Exception exists when a child of sufficient legal age has decided to terminate school attendance. Home schooling must have evidence of a designed curriculum and method to measure outcome in a home environment.

A2.11. EMOTIONAL MALTREATMENT: Acts or a pattern of acts, omissions or a pattern of omissions, or passive or passive-aggressive inattention to a child’s emotional needs resulting in an adverse affect upon the child’s psychological well-being. Maltreatment includes intentional berating, disparaging or other verbally abusive behavior toward the child, and violent acts that may not cause observable injury. An emotionally maltreated child manifests low self-esteem, chronic fear or anxiety, conduct disorders, affective disorders or other cognitive or mental impairment.

A2.12. EXPLOITATION: The victim is made to participate in the sexual gratification of another person without direct physical contact between them. Exploitation includes forcing or encouraging a child to do any of the following: expose the child's genitals or (if female) breasts, to look at another individual’s genitals or (if female) breasts, to observe another’s masturbatory activities, to view pornographic photographs or read pornographic literature, to hear sexually explicit speech, or to participate in sexual activity with another person, such as in pornography of prostitution, in which the alleged offender does not have direct physical contact with the child.

A2.13. LACK OF SUPERVISION: Characterized by the absence or inattention of the parent, guardian, foster parent or other caretaker that results in injury to the child being unable to care for himself or herself, or an injury or serious threat of injury to another person because the child’s behavior was not properly monitored.

A2.14. MALTREATMENT PREVENTION: Efforts to prevent child and spouse maltreatment; and to build resilience at the individual, unit, base, and community levels.

A2.14.1. PRIMARY PREVENTION: Programs and services available to all members of the community on a voluntary basis that promote healthy family and community functioning.

A2.14.2. SECONDARY PREVENTION: Voluntary programs and services that target the reduction of identified risk factors and the strengthening of protective factors on the individual, unit, base, and community levels.

A2.14.3. TERTIARY PREVENTION: Therapeutic interventions provided after an incident has occurred with the goal to prevent subsequent incidents.

A2.15. MCFAPM OR MAJCOM PROGRAM MANAGER: Major Command Family Advocacy Program Manager.

A2.16. MEDICAL NEGLECT: A type of child neglect in which a parent or guardian refuses or fails to provide appropriate, medically necessary health care (medical, mental health, dental) for the child although the parent is financially able to do so or was offered other means to do so.

A2.17. MOLESTATION: Fondling or stroking of breasts or genitals, oral sex, or attempted penetration of the child's vagina, labia, or rectum.

A2.18. NEGLECT: Failure to provide needed age-appropriate care.

A2.19. NEW PARENT SUPPORT PROGRAM (NPSP): A home-based family maltreatment prevention program for families at risk with infants and toddlers managed by the assigned Family Advocacy Nurse. (See Standard P-10).

A2.20. NO RECORD OPENED (NRO): A FAP record not opened due to lack of reasonable suspicion, ineligibility for FAP services, or jurisdictional ineligibility. Formally known as NRA or no record activated.

A2.21. NON-ORGANIC FAILURE TO THRIVE: Failure of adequate growth in infants and young children, usually below the third percentile in height and weight, when no organic basis for this deviance is found. Such children often show concurrent symptoms such as excessive irritability, apathy, vomiting, decreased food intake, diarrhea, and distortions in social responses. Multiple factors may be present, such as individual child or parent difficulties, parent-child relationship problems, and/or a difficult social environment. Organic causes for failure to thrive must be ruled out by competent medical authority before non-organic failure to thrive can be substantiated.

A2.22. OCONUS: Outside the Continental United States

A2.23. OFFENDER: Any person who causes the maltreatment of a child while in a caretaker role, or the maltreatment of their spouse, or whose act, or failure to act, substantially impaired the health or wellbeing of the victim. Exception exists in cases of child sexual maltreatment, when the alleged offender may not be in a caretaker role but was in a position of power over the victim.

A2.24. ON-BASE AGENCIES: Any facility or service available on-base to assist military families, such as the Medical Treatment Facility, Chapel, Air Force Aid Society, Personal Affairs, Social Actions, Family Support Center, American Red Cross, the Child Development Center, Security Forces, and Air Force Office of Special Investigations.

A2.25. OPENED FAP RECORD: An FAP program records opened IAW FAP Standard M-4

A2.26. OTHER SEXUAL MALTREATMENT: All other types of child sexual abuse or maltreatment not mentioned above.

A2.27. OUTREACH: To extend outward to develop formal and informal networks that facilitate community cohesion and services. Includes neighborhood-based activities to bring services and information to people in their homes, at work, and other usual environments.

A2.28. OUTREACH PREVENTION LOG (OPL): **Centralized tool used by the FAP prevention team to document primary and secondary prevention activities, community organization initiatives, prevention-focused task forces, working groups, team meetings, and annual training.**

A2.29. POSITION OF POWER: Person has power over another person due to physical size, age threats with the ability to carry out a threat, etc. The position of power may occur in a single incident or be a feature of an ongoing relationship.

A2.30. PREVENTION: To avoid or inhibit negative outcomes through activities that increase education and awareness, build community cohesion and conducive culture changes, inoculate at-risk groups, and enhance autonomy or effective decision-making. Prevention includes establishing those conditions in society that enhance opportunities for individuals, families and communities to achieve positive fulfillment.

A2.31. PREVENTION ACTIVITY FOLDER: The prevention activity folder is NOT a medical record and is maintained IAW Standard P-13. Mechanism used to document secondary prevention services that require bio-psycho-social assessments and intervention plans tailored to the need of an at-risk family.

A2.32. PREVENTION SERVICES ACTION PLAN (PSAP): A “blueprint” for a prevention activity which includes implementation procedures, goals and objectives, outlines, resources required, key contacts, and evaluation.

A2.33. PROTECTION: Offering a form of safeguarding the victim or potential victim from physical, emotional, and sexual maltreatment, or neglect.

A2.34. PROTECTIVE FACTORS: Elements that promote positive behavior, health, and well-being and system success. Protective factors include positive social orientation, resilient temperament, positive community norms and laws, and the psychological sense of connection to one’s community.

A2.35. PROPERTY VIOLENCE: Property damage that occurs as a means to scare or intimidate. It includes, but is not limited to, the breaking of property, putting a fist or foot through a wall or door, throwing food, breaking dishes, and damaging automobiles. Injury of pets is included in this category.

A2.36. PSYCHOLOGICAL VIOLENCE INVOLVES ONE OR MORE OF THE FOLLOWING BEHAVIORS: Explicit or implicit threats of violence, extreme controlling types of behavior, extreme jealousy, mental degradation (name calling, etc.) and isolating behavior.

A2.37. "Q CODE": An assignment limitation code that indicate an Air Force member has a family member with an exceptional condition which needs to be considered in the assignment process. Initiated by the local EFMP staff, the code is put into the system by local MPF staff. Q-coded personnel always require verification of availability of services at the gaining location during the reassignment process. The Q-code remains in effect as long as the exceptional need exists and the family is eligible for care.

A2.38. RAPE/INTERCOURSE: Sexual intercourse between an offender, male or female, and a child, male or female, that involves the penetration of the child's vagina labia or rectum, however slight, by means of physical force. The penetration may result from emotionally manipulating the child or by taking advantage of a child's naiveté rather than physical force.

A2.39. RISK: The potential for harm of the victim or potential victim of abuse; imminent, threatened or otherwise, without regard to whether maltreatment allegations are or can be substantiated.

A2.40. RISK ASSESSMENT: A clearly-defined process that uses interviews, observations, and evidence to develop an accurate, reliable, understanding (and written description) of whether or not the victim is safe and unlikely to be harmed by the offender(s) in the near future. The risk assessment cannot definitively predict behavior, but can reduce errors in judgment and may be studied over time to lend more accuracy to predictions. Risk assessment will identify strengths as well as problems and limitations.

A2.41. RISK FACTORS: Elements that increase the likelihood of an event or problem. Community risk factors can include availability of drugs, availability of firearms, community disorganization, or low neighborhood attachment.

A2.42. SECONDARY PREVENTION PROVIDERS: Any FAP staff providing prevention services, on a voluntary basis, to individuals, families, and groups with identified risk factors for family maltreatment.

A2.43. SPOUSE: A married individual who is married and i.e., either (1) a service member, (2) employed by DOD and eligible for care through DOD medical treatment programs, or (3) a civilian who is eligible for care through DOD medical treatment programs because of marriage to a service member, or to an employee of DOD who is eligible for care through DOD medical treatment programs. This includes a married individual who is under 18 years of age.

A2.44. SPOUSE EMOTIONAL MALTREATMENT: Acts or threats that adversely affect the psychological well-being of a spouse, including those intended to intimidate, coerce, or terrorize the spouse. Such acts and threats include those likely to result in physical injury, property damage or loss, or economic injury. Arguments alone are not sufficient to substantiate emotional maltreatment.

A2.45. SPOUSE PHYSICAL MALTREATMENT: Use of physical force that causes physical injury to the spouse. Violence is generally used to intimidate, control, or force a spouse to do something against his or her will. This may include grabbing, pushing, holding, slapping, choking, punching, sitting or standing on, kicking, hitting with objects, and assaults with knives, firearms, or other weapons.

A2.46. SPOUSE SEXUAL MALTREATMENT: The use of physical violence, intimidation, or the explicit or implicit threat of future violence by a spouse to coerce the other spouse to engage in any sexual activity. Sexual intercourse between an alleged offender and a spouse that involves the penetration of the vagina or rectum, however slight, by means of physical force. Sexual abuse of a spouse specifically includes "Rape/Intercourse." It also includes coercing the spouse to participate in sexual activity with another person, as in pornography or prostitution.

A2.47. SUBSEQUENT INCIDENT: Another maltreatment incident has occurred to a victim by the same offender in an existing, open case.

A2.48. SUBSTANTIATED: Determination made by the FMCMT when a preponderance of information exists to support an allegation of family maltreatment

A2.49. UNSUBSTANTIATED DID NOT OCCUR: Determination made by the FMCMT when information does not exist to support an allegation of maltreatment.

A2.50. UNSUBSTANTIATED-UNRESOLVED: Determination made by the FMCMT when information exists to support an allegation of maltreatment but the information is not sufficient to substantiate an incident.

A2.51. VICTIM: An individual who is the subject of maltreatment.

Attachment 3**POTENTIAL INDICATORS OF CHILD ABUSE AND NEGLECT****A3.1. PHYSICAL ABUSE:**

BRUISES AND WELTS: On the face, lips, and mouth or large area of the torso, in different areas in different stages of healing; in unusual pattern; reflective of the instrument used to inflict them.

BURNS: From cigarettes or cigars; immersion in a hot liquid; rope burns on the arms, legs or neck; patterned burns that show the shape of the object used to inflict them (iron or grill).

FRACTURES: In various stages of healing; multiple fractures; ANY fracture in a child under two years old.

LACERATIONS AND ABRASIONS: To the mouth, lips gums, eyes or external genitalia; human bite marks on any part of the body.

A3.2. NEGLECT:

Consistently dirty, unwashed, hungry or inappropriately dressed.

Without supervision for extended periods of time or when engaged in dangerous activities.

Constantly tired or listless.

Has unattended physical problems or lack routine medical care.

Is exploited, overworked or kept from attending school.

Has been abandoned.

A3.3. SEXUAL:

Has torn, stained or bloody underclothing.

Experiences pain or itching in the genital area.

Has bruises or bleeding in the external area of the genital, vagina or anal area.

Has a venereal disease.

Has swollen or red cervix or vulva.

Fondling

A3.4. EMOTIONAL: Emotional maltreatment includes: belittling, ridiculing, constant teasing, unfair treatment, excessive demands, verbal attacks and inadequate nurturance.

A3.5. CHILD'S BEHAVIOR

A3.5.1. PHYSICAL ABUSE: Wary of physical contact with adults; apprehensive when other children cry; has extremes in behavior; or seems frightened of parents and reports injury by parents.

A3.5.2. NEGLECT/EMOTIONAL: Engages in delinquent acts of vandalism, drinking, drug use or prostitution. Beggars or steals food. Rarely attended school.

A3.5.3. SEXUAL: Withdrawn or engaged in fantasy or infantile behavior; has poor peer relationships; unwilling to engage in physical activities; runaway or delinquent acts; or states he or she has been sexually assaulted by a parent or other caretaker.

ALL CASES OF ABUSE WILL BE REPORTED TO THE MCCONNELL FAMILY ADVOCACY OFFICE AT 759-5768 DURING DUTY HOURS. AFTER DUTY HOURS, REPORTS CAN BE MADE TO THE ON-CALL MENTAL HEALTH PROVIDER AT 759-5025, OR TO THE LAW ENFORCEMENT DESK AT 759-3976.