

who are the subjects of the report from different Military Services or DoD Components;

(ii) Significant issues in responding to the allegations have arisen between the Military Services or DoD Components and other Federal agencies or civilian authorities; or

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

(3) The DASD(MC&FP) shall configure the FACAT based on the information and recommendations of the requestor, the installation FAPM, and the FAPD of the DoD Component.

(4) The DASD(MC&FP) shall:

(i) Request the FAPDs to identify several individuals from the FACAT roster who are available for deployment.

(ii) Request, through the appropriate channels of the DoD Component, that the individuals' supervisors release them from normal duty positions to serve on temporary duty with the deploying FACAT.

(5) The DASD(MC&FP) shall provide fund citations to the FACAT members for their travel orders and per diem and shall provide information regarding travel arrangements. The FACAT members shall be responsible for preparing travel orders and making travel arrangements.

(6) FACAT members who are subject to DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)" (see <http://www.dtic.mil/whs/directives/corres/pdf/602513p.pdf>) shall be responsible for arranging temporary clinical privileges in accordance with DoD 6025.13-R, "Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation" (see <http://www.dtic.mil/whs/directives/corres/pdf/602513r.pdf>) at the installation to which they shall be deployed.

(e) *FACAT tasks.* The FACAT shall meet with the installation's commanding officer, the MCIO, or designated response team to assess the current situation and assist in coordinating the installation's response to the incidents. Depending on the com-

position of the team, such tasks may include:

(1) Investigating the allegations.

(2) Conducting medical and mental health assessment of the victims and their families.

(3) 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.

(4) Coordinating with local officials to manage public affairs tasks.

(f) *Reports of FACAT activities.* The FACAT chief shall prepare three types of reports:

(1) Daily briefs for the installation commander or designee.

(2) Periodic updates to the FAPD of the DoD Component and to the DASD(MC&FP).

(3) An after-action brief for the installation commander briefed at the completion of the deployment and transmitted to the DASD(MC&FP) and the FAPD of the DoD Component.

PART 61—FAMILY ADVOCACY PROGRAM (FAP)

Subpart A—Family Advocacy Program (FAP)

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Subpart A—Family Advocacy Program (FAP)

AUTHORITY: 5 U.S.C. 552a; 10 U.S.C. 1058(b), 1783, 1787, and 1794; Public Law 103–337, Section 534(d)(2).

SOURCE: 80 FR 11780, Mar. 4, 2015, unless otherwise noted.

§ 61.1 Purpose.

This part is composed of several subparts, each containing its own purpose. This subpart establishes policy and assigns responsibilities for addressing child abuse and domestic abuse through the FAP.

§ 61.2 Applicability.

This subpart applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense (referred to collectively in this subpart as the “DoD Components”).

§ 61.3 Definitions.

Unless otherwise noted, these terms and their definitions are for the purposes of this subpart.

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.

DoD-sanctioned activity. A DoD-sanctioned activity is defined as a U.S. Government activity or a nongovernmental activity authorized by appropriate DoD officials to perform child care or supervisory functions on DoD controlled property. The care and supervision of children may be either its primary mission or incidental in carrying out another mission (e.g., medical care). Examples include Child Development Centers, Department of Defense Dependents Schools, or Youth Activities, School Age/Latch Key Programs, Family Day Care providers, 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.

Domestic abuse. Domestic violence or a pattern of behavior resulting in emotional/psychological abuse, economic control, and/or interference with personal liberty that is directed toward a person who is:

- (1) A current or former spouse.
- (2) A person with whom the abuser shares a child in common; or
- (3) A current or former intimate partner with whom the abuser shares or has shared a common domicile.

Domestic violence. An offense under the United States Code, the Uniform Code of Military Justice (UCMJ), or State law involving the use, attempted use, or threatened use of force or violence against a person, or a violation of a lawful order issued for the protection of a person who is:

- (1) A current or former spouse.
- (2) A person with whom the abuser shares a child in common; or
- (3) A current or former intimate partner with whom the abuser shares or has shared a common domicile.

Family Advocacy Command Assistance Team (FACAT). 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 committee (FAC). The policy-making, coordinating, recommending, and overseeing body for the installation FAP.

FAP. A program designed to address prevention, identification, evaluation, treatment, rehabilitation, follow-up, and reporting of family violence. FAPs consist of coordinated efforts designed to prevent and intervene in cases of family distress, and to promote healthy family life.

Family Advocacy Program Manager (FAPM). An individual designated by a Secretary of a Military Department or the head of another DoD Component to manage, monitor, and coordinate the FAP at the headquarters level.

Incident determination committee (IDC). A multidisciplinary team of designated individuals working at the installation level, tasked with determining whether a report of domestic abuse or child abuse meets the relevant DoD criteria for entry into the Service FAP Central Registry as child abuse and domestic abuse incident. Formerly known as the Case Review Committee.

Incident status determination. 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 (NPSP). A standardized secondary prevention program under the FAP that delivers intensive, voluntary, strengths based home visitation services designed specifically for expectant parents and parents of children from birth to 3 years of age to reduce the risk of child abuse and neglect.

Restricted reporting. A process allowing an adult victim of domestic abuse, who is eligible to receive military medical treatment, including civilians and contractors who are eligible to receive military healthcare outside the Continental United States on a reimbursable basis, the option of reporting an incident of domestic abuse to a specified individual without initiating the investigative process or notification to the victim's or alleged offender's commander.

Unrestricted reporting. A process allowing a victim of domestic abuse to report an incident using current reporting channels, *e.g.* chain of command, law enforcement or criminal investigative organization, and FAP for clinical intervention.

§ 61.4 Policy.

It is DoD policy to:

(a) Promote public awareness and prevention of child abuse and domestic abuse.

(b) Provide adult victims of domestic abuse with the option of making restricted reports to domestic abuse victim advocates and to healthcare providers in accordance with DoD Instruction 6400.06, "Domestic Abuse Involving DoD Military and Certain Affiliated Personnel" (available at <http://www.dtic.mil/whs/directives/corres/pdf/640006p.pdf>).

(c) Promote early identification; reporting options; and coordinated, comprehensive intervention, assessment, and support to:

(1) Victims of suspected child abuse, including victims of extra-familial child abuse.

(2) Victims of domestic abuse.

(d) Provide assessment, rehabilitation, and treatment, including comprehensive abuser intervention.

(e) Provide appropriate resource and referral information to persons who are not covered by this subpart, who are victims of alleged child abuse or domestic abuse.

(f) Cooperate with responsible federal and civilian authorities and organizations in efforts to address the problems to which this subpart applies.

(g) Ensure that 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 release of PII is in compliance with 5 U.S.C. 552a.

(h) Develop program standards (PSs) and critical procedures for the FAP that reflect a coordinated community risk management approach to child abuse and domestic abuse.

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(i) Provide appropriate individualized and rehabilitative treatment that supplements administrative or disciplinary action, as appropriate, to persons reported to FAP as domestic abusers.

(j) Maintain a central child abuse and domestic abuse database to:

(1) Analyze the scope of child abuse and domestic abuse, types of abuse, and information about victims and alleged abusers to identify emerging trends, and develop changes in policy to address child abuse and domestic abuse.

(2) Support the requirements of DoD Instruction 1402.5, “Criminal History Background Checks on Individuals in Child Care Services” (available at <http://www.dtic.mil/whs/directives/corres/pdf/140205p.pdf>).

(3) Support the response to public, congressional, and other government inquiries.

(4) Support budget requirements for child abuse and domestic abuse program funding.

§ 61.5 Responsibilities.

(a) The Under Secretary of Defense for Personnel and Readiness (USD(P&R)) will:

(1) Collaborate with the DoD Component heads to establish programs and guidance to implement the FAP elements and procedures in § 61.6 of this subpart.

(2) Program, budget, and allocate funds and other resources for FAP, and ensure that such funds are only used to implement the policies described in § 61.6 of this subpart.

(b) Under the authority, direction, and control of the USD(P&R), the Assistant Secretary of Defense for Readiness and Force Management (ASD(R&FM)) or designee will review FAP instructions and policies prior to USD(P&R) signature.

(c) Under the authority, direction, and control of the USD(P&R) through the ASD(R&FM), the Deputy Assistant Secretary of Defense for Military Community and Family Policy (DASD(MC&FP)) will:

(1) Develop DoD-wide FAP policy, coordinate the management of FAP with other programs serving military families, collaborate with federal and State agencies addressing FAP issues, and serve on intra-governmental advisory

committees that address FAP-related issues.

(2) Ensure that the information included in notifications of extra-familial child sexual abuse in DoD-sanctioned activities is retained for 1 month from the date of the initial report to determine whether a request for a FACAT in accordance with DoD Instruction 6400.03, “Family Advocacy Command Assistance Team” (available at <http://www.dtic.mil/whs/directives/corres/pdf/640003p.pdf>) may be forthcoming.

(3) Monitor and evaluate compliance with this subpart.

(4) Review annual summaries of accreditation/inspection reviews submitted by the Military Departments.

(5) Convene an annual DoD Accreditation/Inspection Review Summit to review and respond to the findings and recommendations of the Military Departments’ accreditation/inspection reviews.

(d) The Secretaries of the Military Departments will:

(1) Establish DoD Component policy and guidance on the development of FAPs, including case management and monitoring of the FAP consistent with 10 U.S.C. 1058(b), this subpart, and published FAP guidance, including DoD Instruction 6400.06 and DoD 6400.1–M, “Family Advocacy Program Standards and Self-Assessment Tool” (available at <http://www.dtic.mil/whs/directives/corres/pdf/640001m.pdf>).

(2) Designate a FAPM to manage the FAP. The FAPM will have, at a minimum:

(i) A masters or doctoral level degree in the behavioral sciences from an accredited U.S. university or college.

(ii) The highest licensure in good standing by a State regulatory board in either social work, psychology, or marriage and family therapy that authorizes independent clinical practice.

(iii) 5 years of post-license experience in child abuse and domestic abuse.

(iv) 3 years of experience supervising licensed clinicians in a clinical program.

(3) Coordinate efforts and resources among all activities serving families to promote the optimal delivery of services and awareness of FAP services.

(4) Establish standardized criteria, consistent with DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)" (available at <http://www.dtic.mil/whs/directives/corres/pdf/602513p.pdf>) and DoD 6025.13-R, "Military Health System (MHS) Clinical Quality Assurance (CQA) Program" (available at <http://www.dtic.mil/whs/directives/corres/pdf/602513r.pdf>), for selecting and certifying FAP healthcare and social service personnel who provide clinical services to individuals and families. Such staff will be designated as healthcare providers who may receive restricted reports from victims of domestic abuse as set forth in DoD Instruction 6400.06.

(5) Establish a process for an annual summary of installation accreditation/inspection reviews of installation FAP.

(6) Ensure that installation commanders or Service-equivalent senior commanders or their designees:

(i) Appoint persons at the installation level to manage and implement the local FAPs, establish local FACs, and appoint the members of IDCs in accordance with DoD 6400.1-M and supporting guidance issued by the USD(P&R).

(ii) Ensure that the installation FAP meets the standards in DoD 6400.1-M.

(iii) Ensure that the installation FAP immediately reports allegations of a crime to the appropriate law enforcement authority.

(7) Notify the DASD(MC&FP) of any cases of extra-familial child sexual abuse in a DoD-sanctioned activity within 72 hours in accordance with the procedures in §61.6 of this subpart.

(8) Submit accurate quarterly child abuse and domestic abuse incident data from the DoD Component FAP central registry of child abuse and domestic abuse incidents to the Director of the Defense Manpower Data Center in accordance with DoD 6400.1-M-1, "Manual for Child Maltreatment and Domestic Abuse Incident Reporting System" (available at <http://www.dtic.mil/whs/directives/corres/pdf/640001m1.pdf>).

(9) Submit reports of DoD-related fatalities known or suspected to have resulted from an act of domestic abuse; child abuse; or suicide related to an act

of domestic abuse or child abuse on DD Form 2901, "Child Abuse or Domestic Violence Related Fatality Notification," by fax to the number provided on the form in accordance with DoD Instruction 6400.06 or by other method as directed by the DASD(MC&FP). The DD Form 2901 can be found at <http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm>.

(10) Ensure that fatalities known or suspected to have resulted from acts of child abuse or domestic violence are reviewed annually in accordance with DoD Instruction 6400.06.

(11) Ensure the annual summary of accreditation/inspection reviews of installation FAPs are forwarded to OSD FAP as directed by DASD(MC&FP).

(12) Provide essential data and program information to the USD(P&R) to enable the monitoring and evaluation of compliance with this subpart in accordance with DoD 6400.1-M-1.

(13) Ensure that PII collected in the course of FAP activities is safeguarded to prevent any unauthorized use or disclosure and that the collection, use, and release of PII is in compliance with 5 U.S.C. 552a, also known as "The Privacy Act of 1974," as implemented in the DoD by 32 CFR part 310).

§61.6 Procedures.

(a) *FAP Elements.* FAP requires prevention, education, and training efforts to make all personnel aware of the scope of child abuse and domestic abuse problems and to facilitate cooperative efforts. The FAP will include:

(1) *Prevention.* Efforts to prevent child abuse and domestic abuse, including public awareness, information and education about the problem in general, and the NPSP, in accordance with DoD Instruction 6400.05, specifically directed toward potential victims, offenders, non-offending family members, and mandated reporters of child abuse and neglect.

(2) *Direct Services.* Identification, treatment, counseling, rehabilitation, follow-up, and other services, directed toward the victims, their families, perpetrators of abuse, and their families. These services will be supplemented locally by:

(i) A multidisciplinary IDC established to assess incidents of alleged

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abuse and make incident status determinations.

(ii) A clinical case staff meeting (CCSM) to make recommendations for treatment and case management.

(3) *Administration.* All services, logistical support, and equipment necessary to ensure the effective and efficient operation of the FAP, including:

(i) Developing local memorandums of understanding with civilian authorities for reporting cases, providing services, and defining responsibilities when responding to child abuse and domestic abuse.

(ii) Use of personal service contracts to accomplish program goals.

(iii) Preparation of reports, consisting of incidence data.

(4) *Evaluation.* Needs assessments, program evaluation, research, and similar activities to support the FAP.

(5) *Training.* All educational measures, services, supplies, or equipment used to prepare or maintain the skills of personnel working in the FAP.

(b) *Responding to FAP Incidents.* The USD(P&R) or designee will establish procedures for:

(1) Reporting and responding to suspected child abuse consistent with 10 U.S.C. 1787 and 1794, 42 U.S.C. 13031, and 28 CFR part 81.

(2) Providing victim advocacy services to victims of domestic abuse consistent with DoD Instruction 6400.06 and section 534(d)(2) of Public Law 103–337, “National Defense Authorization Act for Fiscal Year 1995.”

(3) Responding to restricted and unrestricted reports of domestic abuse consistent with DoD Instruction 6400.06 and 10 U.S.C. 1058(b).

(4) Collection of FAP data into a central registry and analysis of such data in accordance with DoD 6400.1–M–1.

(5) Coordinating a comprehensive DoD response, including the FACAT, to allegations of extra-familial child sexual abuse in a DoD-sanctioned activity in accordance with DoD Instruction 6400.03 and 10 U.S.C. 1794.

(c) *Notification of Extra-Familial Child Sexual Abuse in DoD-Sanctioned Activities.* The names of the victim(s) and alleged abuser(s) will not be included in the notification. Notification will include:

(1) Name of the installation.

(2) Type of child care setting.

(3) Number of children alleged to be victims.

(4) Estimated number of potential child victims.

(5) Whether an installation response team is being convened to address the investigative, medical, and public affairs issues that may be encountered.

(6) Whether a request for the DASD(MC&FP) to deploy a FACAT in accordance with DoD Instruction 6400.03 is being considered.

Subpart B—FAP Standards

AUTHORITY: 5 U.S.C. 552a, 10 U.S.C. chapter 47, 42 U.S.C. 13031.

§61.7 Purpose.

(a) This part is composed of several subparts, each containing its own purpose. The purpose of the overall part is to implement policy, assign responsibilities, and provide procedures for addressing child abuse and domestic abuse in military communities.

(b) This subpart prescribes uniform program standards (PSs) for all installation FAPs.

§61.8 Applicability.

This subpart applies to OSD, the Military Departments, the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the DoD (referred to collectively in this subpart as the “DoD Components”).

§61.9 Definitions.

Unless otherwise noted, the following terms and their definitions are for the purposes of this subpart.

Alleged abuser. Defined in subpart A of this part.

Case. One or more reported incidents of suspected child abuse or domestic abuse pertaining to the same victim.

Clinical case staff meeting (CCSM). An installation FAP meeting of clinical service providers to assist the coordinated delivery of supportive services and clinical treatment in child abuse

and domestic abuse cases, as appropriate. They provide: clinical consultation directed to ongoing safety planning for the victim; the planning and delivery of supportive services, and clinical treatment, as appropriate, for the victim; the planning and delivery of rehabilitative treatment for the alleged abuser; and case management, including risk assessment and ongoing safety monitoring.

Child. Defined in subpart A of this part.

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.

Clinical case management. The FAP process of providing or coordinating the provision of clinical services, as appropriate, to the victim, alleged abuser, and family member in each FAP child abuse and domestic abuse incident from entry into until exit from the FAP system. It includes identifying risk factors; safety planning; conducting and monitoring clinical case assessments; presentation to the Incident Determination Committee (IDC); developing and implementing treatment plans and services; completion and maintenance of forms, reports, and records; communication and coordination with relevant agencies and professionals on the case; case review and advocacy; case counseling with the individual victim, alleged abuser, and family member, as appropriate; other direct services to the victim, alleged abuser, and family members, as appropriate; and case transfer or closing.

Clinical intervention. A continuous risk management process that includes identifying risk factors, safety planning, initial clinical assessment, formulation of a clinical treatment plan, clinical treatment based on assessing readiness for and motivating behav-

ioral change and life skills development, periodic assessment of behavior in the treatment setting, and monitoring behavior and periodic assessment of outside-of-treatment settings.

Domestic abuse. Domestic violence or a pattern of behavior resulting in emotional/psychological abuse, economic control, and/or interference with personal liberty that is directed toward a person who is:

(1) A current or former spouse.

(2) A person with whom the abuser shares a child in common; or

(3) A current or former intimate partner with whom the abuser shares or has shared a common domicile.

Domestic violence. An offense under the United States Code, the Uniform Code of Military Justice (UCMJ), or State law involving the use, attempted use, or threatened use of force or violence against a person, or a violation of a lawful order issued for the protection of a person who is:

(1) A current or former spouse.

(2) A person with whom the abuser shares a child in common; or

(3) A current or former intimate partner with whom the abuser shares or has shared a common domicile.

Family Advocacy Committee (FAC). Defined in subpart A of this part.

Family Advocacy Command Assistance Team (FACAT). Defined in subpart A of this part.

Family Advocacy Program (FAP). Defined in subpart A of this part.

High risk for violence. A level of risk describing families or individuals experiencing severe abuse or the potential for severe abuse, or offenders engaging in high risk behaviors such as making threats to cause grievous bodily harm, preventing victim access to communication devices, stalking, etc. Such cases require coordinated community safety planning that actively involves installation law enforcement, command, legal, and FAP.

Home visitation. A strategy for delivering services to parents in their homes to improve child and family functioning.

Home visitor. A person who provides FAP services to promote child and family functioning to parents in their homes.

IDC. Defined in subpart A of this part.

Installation. Any more or less permanent post, camp, station, base for the support or carrying on of military activities.

Installation Family Advocacy Program Manager (FAPM). The individual at the installation level designated by the installation commander in accordance with Service FAP headquarters implementing guidance to manage the FAP, supervise FAP staff, and coordinate all FAP activities. If the Service FAP headquarters implementing guidance assigns the responsibilities of the local FAPM between two individuals, the FAPM is the individual who has been assigned the responsibility for implementing the specific procedure.

NPSP. A standardized secondary prevention program under the FAP that delivers intensive, voluntary, strengths based home visitation services designed specifically for expectant parents and parents of children from birth to 3 years of age to reduce the risk of child abuse and neglect.

Non-DoD eligible extrafamilial caregiver. A caregiver who is not sponsored or sanctioned by the DoD. It includes nannies, temporary babysitters certified by the Red Cross, and temporary babysitters in the home, and other non-DoD eligible family members who provide care for or supervision of children.

Non-medical counseling. Short term, non-therapeutic counseling that is not appropriate for individuals needing clinical therapy. Non-medical counseling is supportive in nature and addresses general conditions of living, life skills, improving relationships at home and at work, stress management, adjustment issues (such as those related to returning from a deployment), marital problems, parenting, and grief and loss. This definition is not intended to limit the authority of the Military Departments to grant privileges to clinical providers modifying this scope of care consistent with current Military Department policy.

Out-of-home care. The responsibility of care for and/or 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 De-

fense Agency or authorized by the Service or Defense Agency as a provider of care, such as care in a child development center, school, recreation program, or family child care, part.

Primary managing authority (PMA). The installation FAP that has primary authority and responsibility for the management and incident status determination of reports of child abuse and unrestricted reports of domestic abuse.

Restricted reporting. Defined in subpart A of this part.

Risk management. The process of identifying risk factors associated with increased risk for child abuse or domestic abuse, and controlling those factors that can be controlled through collaborative partnerships with key military personnel and civilian agencies, including the active duty member's commander, law enforcement personnel, child protective services, and victim advocates. It includes the development and implementation of an intervention plan when significant risk of lethality or serious injury is present to reduce the likelihood of future incidents and to increase the victim's safety, continuous assessment of risk factors associated with the abuse, and prompt updating of the victim's safety plan, as needed.

Safety planning. A process whereby a victim advocate, working with a domestic abuse victim, creates a plan, tailored to that victim's needs, concerns, and situation, that will help increase the victim's safety and help the victim to prepare for, and potentially avoid, future violence.

Service FAP headquarters. The office designated by the Secretary of the Military Department to develop and issue Service FAP implementing guidance in accordance with DoD policy, manage the Service-level FAP, and provide oversight for Service FAP functions.

Unrestricted reporting. Defined in subpart A of this part.

Victim. A child or current or former spouse or intimate partner who is the subject of an alleged incident of child maltreatment or domestic abuse because he/she was allegedly maltreated by the alleged abuser.

Victim advocate. An employee of the Department of Defense, a civilian

working under contract for the Department of Defense, or a civilian providing services by means of a formal memorandum of understanding between a military installation and a local victim advocacy service agency, whose role is to provide safety planning services and comprehensive assistance and liaison to and for victims of domestic abuse, and to educate personnel on the installation regarding the most effective responses to domestic abuse on behalf of victims and at-risk family members. The advocate may also be a volunteer military member, a volunteer civilian employee of the Military Department, or staff assigned as collateral duty.

§61.10 Policy.

According to subpart A of this part, it is DoD policy to:

(a) Promote early identification; reporting; and coordinated, comprehensive intervention, assessment, and support to victims of child abuse and domestic abuse.

(b) Ensure that 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 release of PII is in compliance with 5 U.S.C. 552a.

§61.11 Responsibilities.

(a) Under the authority, direction, and control of the USD(P&R) through the Assistant Secretary of Defense for Readiness and Force Management, the Deputy Assistant Secretary of Defense for Military Community and Family Policy (DASD(MC&FP)):

(1) Monitors compliance with this subpart.

(2) Collaborates with the Secretaries of the Military Departments to develop policies and procedures for monitoring compliance with the PSs in §61.12 of this subpart.

(3) Convenes an annual DoD Accreditation and Inspection Summit to review and respond to the findings and recommendations of the Military Departments' accreditation or inspection results.

(b) The Secretaries of the Military Departments:

(1) Develop Service-wide FAP policy, supplementary standards, and instruc-

tions to provide for unique requirements within their respective installation FAPs to implement the PSs in this subpart as appropriate.

(2) Require all installation personnel with responsibilities in this subpart receive appropriate training to implement the PSs in §61.12 of this subpart.

(3) Conduct accreditation and inspection reviews outlined in §61.12 of this subpart.

§61.12 Procedures.

(a) *Purposes of the standards*—(1) *Quality Assurance (QA) to address child abuse and domestic abuse.* The FAP PSs provide DoD and Service FAP headquarters QA guidelines for installation FAP-sponsored prevention and clinical intervention programs. Therefore, the PSs presented in this section and cross referenced in the Index of FAP Topics in the Appendix to §61.12 represent the minimal necessary elements for effectively dealing with child abuse and domestic abuse in installation programs in the military community.

(2) *Minimum requirements for oversight, management, logistical support, procedures, and personnel requirements.* The PSs set forth minimum requirements for oversight, management, logistical support, procedures, and personnel requirements necessary to ensure all military personnel and their family members receive family advocacy services from the installation FAPs equal in quality to the best programs available to their civilian peers.

(3) *Measuring quality and effectiveness.* The PSs provide a basis for measuring the quality and effectiveness of each installation FAP and for systematically projecting fiscal and personnel resources needed to support worldwide DoD FAP efforts.

(b) *Installation response to child abuse and domestic abuse*—(1) *FAC*—(i) *PS 1: Establishment of the FAC.* The installation commander must establish an installation FAC and appoint a FAC chairperson in accordance with subpart A of this part and Service FAP headquarters implementing policies and guidance to serve as the policy-making, coordinating, and advisory body to address child abuse and domestic abuse at the installation.

(ii) *PS 2: Coordinated community response and risk management plan.* The FAC must develop and approve an annual plan for the coordinated community response and risk management of child abuse and domestic abuse, with specific objectives, strategies, and measurable outcomes.

The plan is based on a review of:

(A) The most recent installation needs assessment.

(B) Research-supported protective factors that promote and sustain healthy family relationships.

(C) Risk factors for child abuse and domestic abuse.

(D) The most recent prevention strategy to include primary, secondary, and tertiary interventions.

(E) Trends in the installation's risk management approach to high risk for violence, child abuse, and domestic abuse.

(F) The most recent accreditation review or DoD Component Inspector General inspection of the installation agencies represented on the FAC.

(G) The evaluation of the installation's coordinated community response to child abuse and domestic abuse.

(iii) *PS 3: Monitoring coordinated community response and risk management plan.* The FAC monitors the implementation of the coordinated community response and risk management plan. Such monitoring includes a review of:

(A) The development, signing, and implementation of formal memorandums of understanding (MOUs) among military activities and between military activities and civilian authorities and agencies to address child abuse and domestic abuse.

(B) Steps taken to address problems identified in the most recent accreditation review of the FAP and evaluation of the installation's coordinated community response and risk management approach.

(C) FAP recommended criteria to identify populations at higher risk to commit or experience child abuse and domestic abuse, the special needs of such populations, and appropriate actions to address those needs.

(D) Effectiveness of the installation coordinated community response and risk management approach in respond-

ing to high risk for violence, child abuse, and domestic abuse incidents.

(E) Implementation of the installation prevention strategy to include primary, secondary, and tertiary interventions.

(F) The annual report of fatality reviews that Service FAP headquarters fatality review teams conduct. The FAC should also review the Service FAP headquarters' recommended changes for the coordinated community response and risk management approach. The coordinated community response will focus on strengthening protective factors that promote and sustain healthy family relationships and reduce the risk factors for future child abuse and domestic abuse-related fatalities.

(2) *Coordinated Community Response—*

(i) *PS 4: Roles, functions, and responsibilities.* The FAC must ensure that all installation agencies involved with the coordinated community response to child abuse and domestic abuse comply with the defined roles, functions, and responsibilities in DoD Instruction 6400.06 and the Service FAP headquarters implementing policies and guidance.

(ii) *PS 5: MOUs.* The FAC must verify that:

(A) Formal MOUs are established as appropriate with counterparts in the local civilian community to improve coordination on: Child abuse and domestic abuse investigations; emergency removal of children from homes; fatalities; arrests; prosecutions; and orders of protection involving military personnel.

(B) Installation agencies established MOUs setting forth the respective roles and functions of the installation and the appropriate federal, State, local, or foreign agencies or organizations (in accordance with status-of-forces agreements (SOFAs)) that provide:

(1) Child welfare services, including foster care, to ensure ongoing and active collaborative case management between the respective courts, child protective services, foster care agencies, and FAP.

(2) Medical examination and treatment.

(3) Mental health examination and treatment.

(4) Domestic abuse victim advocacy.
 (5) Related social services, including State home visitation programs when appropriate.

(6) Safety shelter.

(iii) *PS 6: Collaboration between military installations.* The installation commander must require that installation agencies have collaborated with counterpart agencies on military installations in geographical proximity and on joint bases to ensure coordination and collaboration in providing child abuse and domestic abuse services to military families. Collaboration includes developing MOUs, as appropriate.

(iv) *PS 7: Domestic abuse victim advocacy services.* The installation FAC must establish 24 hour access to domestic abuse victim advocacy services through personal or telephone contact in accordance with DoD Instruction 6400.06 and Service FAP headquarters implementing policy and guidance for restricted reports of domestic abuse and the domestic abuse victim advocate services.

(v) *PS 8: Domestic abuse victim advocate personnel requirements.* The installation commander must require that qualified personnel provide domestic abuse victim advocacy services in accordance with DoD Instruction 6400.06 and Service FAP headquarters implementing policy and guidance.

(A) Such personnel may include federal employees, civilians working under contract for the DoD, civilians providing services through a formal MOU between the installation and a local civilian victim advocacy service agency, volunteers, or a combination of such personnel.

(B) All domestic abuse victim advocates are supervised in accordance with Service FAP headquarters policies.

(vi) *PS 9: 24-hour emergency response plan.* An installation 24-hour emergency response plan to child abuse and domestic abuse incidents must be established in accordance with DoD Instruction 6400.06 and the Service FAP headquarters implementing policies and guidance.

(vii) *PS 10: FAP Communication with military law enforcement.* The FAP and military law enforcement reciprocally provide to one another:

(A) Within 24 hours, FAP will communicate all reports of child abuse involving military personnel or their family members to the appropriate civilian child protective services agency or law enforcement agency in accordance with subpart A of this part, 42 U.S.C. 13031, and 28 CFR 81.2.

(B) Within 24 hours, FAP will communicate all unrestricted reports of domestic abuse involving military personnel and their current or former spouses or their current or former intimate partners to the appropriate civilian law enforcement agency in accordance with subpart A of this part, 42 U.S.C. 13031, and 28 CFR 81.2.

(viii) *PS 11: Protection of children.* The installation FAC in accordance with Service FAP headquarters implementing policies and guidance must set forth the procedures and criteria for:

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

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

(C) Ongoing collaborative case management between FAP, relevant courts, and child welfare agencies when military children are placed in civilian foster care.

(D) Notification of the affected Service member's command when a dependent child has been taken into custody or foster care by local or State courts, or child welfare or protection agencies.

(3) *Risk Management—(i) PS 12: PMA.* When an installation FAP receives a report of a case of child abuse or domestic abuse in which the victim is at a different location than the abuser, PMA for the case must be:

(A) In child abuse cases:

(1) The sponsor's installation when the alleged abuser is the sponsor; a non-sponsor DoD-eligible family member; or a non-sponsor, status unknown.

(2) The alleged abuser's installation when the alleged abuser is a non-sponsor active duty Service member; a non-sponsor, DoD-eligible extrafamilial

caregiver; or a DoD-sponsored out-of-home care provider.

(3) The victim's installation when the alleged abuser is a non-DoD-eligible extrafamilial caregiver.

(B) In domestic abuse cases:

(1) The alleged abuser's installation when both the alleged abuser and the victim are active duty Service members.

(2) The alleged abuser's installation when the alleged abuser is the only sponsor.

(3) The victim's installation when the victim is the only sponsor.

(4) The installation FAP who received the initial referral when both parties are alleged abusers in bi-directional domestic abuse involving dual military spouses or intimate partners.

(ii) *PS 13: Risk management approach*—

(A) All installation agencies involved with the installation's coordinated community risk management approach to child abuse and domestic abuse must comply with their defined roles, functions, and responsibilities in accordance with 42 U.S.C. 13031 and 28 CFR 81.2 and Service FAP headquarters implementing policies and guidance.

(B) When victim(s) and abuser(s) are assigned to different servicing FAPs or are from different Services, the PMA is assigned according to PS 12 (paragraph (b)(3)(i) of this section), and both servicing FAP offices and Services are kept informed of the status of the case, regardless of who has PMA.

(iii) *PS 14: Risk assessments*. FAP conducts risk assessments of alleged abusers, victims, and other family members to assess the risk of re-abuse, and communicate any increased levels of risk to appropriate agencies for action, as appropriate. Risk assessments are conducted:

(A) At least quarterly on all open FAP cases.

(B) Monthly on FAP cases assessed as high risk and those involving court involved children placed in out-of-home care, child sexual abuse, and chronic child neglect.

(C) Within 30 days of any change since the last risk assessment that presents increased risk to the victim or warrants additional safety planning.

(iv) *PS 15: Disclosure of information in risk assessments*. Protected information

collected during FAP referrals, intake, and risk assessments is only disclosed in accordance with DoD 6025.18-R, "DoD Health Information Privacy Regulation" (available at <http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf>) when applicable, 32 CFR part 310, and the Service FAP headquarters implementing policies and guidance.

(v) *PS 16: Risk management and deployment*. Procedures are established to manage child abuse and domestic abuse incidents that occur during the deployment cycle of a Service member, in accordance with subpart A of this part and DoD Instruction 6400.06, and Service FAP headquarters implementing policies and guidance, so that when an alleged abuser Service member in an active child abuse or domestic abuse case is deployed:

(A) The forward command notifies the home station command when the deployed Service member will return to the home station command.

(B) The home station command implements procedures to reduce the risk of subsequent child abuse and domestic abuse during the reintegration of the Service member into the FAP case management process.

(4) *IDC*—(i) *PS 17: IDC established*. An installation IDC must be established to review reports of child abuse and unrestricted reports of domestic abuse.

(ii) *PS 18: IDC operations*. The IDC reviews reports of child abuse and unrestricted reports of domestic abuse to determine whether the reports meet the criteria for entry into the Service FAP headquarters central registry of child abuse and domestic abuse incidents in accordance with subpart A of this part and Service FAP headquarters implementing policies and guidance.

(iii) *PS 19: Responsibility for training FAC and IDC members*. All FAC and IDC members must receive:

(A) Training on their roles and responsibilities before assuming their positions on their respective teams.

(B) Periodic information and training on DoD policies and Service FAP headquarters policies and guidance.

(iv) *PS 20: IDC QA*. An IDC QA process must be established for monitoring

and QA review of IDC decisions in accordance with Service FAP headquarters implementing policy and guidance.

(c) *Organization and management of the FAP*—(1) *General organization of the FAP*—(i) *PS 21: Establishment of the FAP*. The installation commander must establish a FAP to address child abuse and domestic abuse in accordance with DoD policy and Service FAP headquarters implementing policies and guidance.

(ii) *PS 22: Operations policy*. The installation FAC must ensure coordination among the following key agencies interacting with the FAP in accordance with subpart A of this part and Service FAP headquarters implementing policies and guidance:

- (A) Family center(s).
- (B) Substance abuse program(s).
- (C) Sexual assault and prevention response programs.
- (D) Child and youth program(s).
- (E) Program(s) that serve families with special needs.
- (F) Medical treatment facility, including:
 - (1) Mental health and behavioral health personnel.
 - (2) Social services personnel.
 - (3) Dental personnel.
 - (G) Law enforcement.
 - (H) Criminal investigative organization detachment.
 - (I) Staff judge advocate or servicing legal office.
 - (J) Chaplain(s).
 - (K) Department of Defense Education Activity (DoDEA) school personnel.
 - (L) Military housing personnel.
 - (M) Transportation office personnel.

(iii) *PS 23: Appointment of an installation FAPM*. The installation commander must appoint in writing an installation FAPM to implement and manage the FAP. The FAPM must direct the development, oversight, coordination, administration, and evaluation of the installation FAP in accordance with subpart A of this part and Service FAP headquarters implementing policy and guidance.

(iv) *PS 24: Funding*. Funds received for child abuse and domestic abuse prevention and treatment activities must be programmed and allocated in accordance with the DoD and Service

FAP headquarters implementing policies and guidance, and the plan developed under PS 3, described in paragraph (b)(1)(ii) of this section.

(A) Funds that OSD provides for the FAP must be used in direct support of the prevention and intervention for domestic abuse and child maltreatment; including management, staffing, domestic abuse victim advocate services, public awareness, prevention, training, intensive risk-focused secondary prevention services, intervention, record keeping, and evaluation as set forth in this subpart.

(B) Funds that OSD provides for the NPSP must be used only for secondary prevention activities to support the screening, assessment, and provision of home visitation services to prevent child abuse and neglect in vulnerable families in accordance with DoD Instruction 6400.05.

(v) *PS 25: Other resources*. FAP services must be housed and equipped in a manner suitable to the delivery of services, including but not limited to:

- (A) Adequate telephones.
- (B) Office automation equipment.
- (C) Handicap accessible.
- (D) Access to emergency transport.
- (E) Private offices and rooms available for interviewing and counseling victims, alleged abusers, and other family members in a safe and confidential setting.
- (F) Appropriate equipment for 24/7 accessibility.

(2) *FAP personnel*—(i) *PS 26: Personnel requirements*. The installation commander is responsible for ensuring there are a sufficient number of qualified FAP personnel in accordance with subpart A of this part, DoD Instruction 6400.06, and DoD Instruction 6400.05, and Service FAP headquarters implementing policy and guidance. FAP personnel may consist of military personnel on active duty, employees of the federal civil service, contractors, volunteers, or a combination of such personnel.

(ii) *PS 27: Criminal history record check*. All FAP personnel whose duties involve services to children require a criminal history record check in accordance with DoD Instruction 1402.5, "Criminal History Background Checks on Individuals in Child Care Services"

(available at <http://www.dtic.mil/whs/directives/corres/pdf/140205p.pdf>).

(iii) *PS 28: Clinical staff qualifications.* All FAP personnel who conduct clinical assessment of or provide clinical treatment to victims of child abuse or domestic abuse, alleged abusers, or their family members must have all of the following minimum qualifications:

(A) A Master in Social Work, Master of Science, Master of Arts, or doctoral-level degree in human service or mental health from an accredited university or college.

(B) The highest licensure in a State or clinical licensure in good standing in a State that authorizes independent clinical practice.

(C) Two years of experience working in the field of child abuse and domestic abuse.

(D) Clinical privileges or credentialing in accordance with Service FAP headquarters policies.

(iv) *PS 29: Prevention and Education Staff Qualifications.* All FAP personnel who provide prevention and education services must have the following minimum qualifications:

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

- (1) Social work.
- (2) Psychology.
- (3) Marriage, family, and child counseling.
- (4) Counseling or behavioral science.
- (5) Nursing.
- (6) Education.
- (7) Community health or public health.

(B) Two years of experience in a family and children's services public agency or family and children's services community organization, 1 year of which is in prevention, intervention, or treatment of child abuse and domestic abuse.

(C) Supervision by a qualified staff person in accordance with the Service FAP headquarters policies.

(v) *PS 30: Victim advocate staff qualifications.* All FAP personnel who provide victim advocacy services must have these minimum qualifications:

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

- (1) Social work.

(2) Psychology.

(3) Marriage, family, and child counseling.

(4) Counseling or behavioral science.

(5) Criminal justice.

(B) Two years of experience in assisting and providing advocacy services to victims of domestic abuse or sexual assault.

(C) Supervision by a Master's level social worker.

(vi) *PS 31: NPSP staff qualifications.* All FAP personnel who provide services in the NPSP must have qualifications in accordance with DoD Instruction 6400.05.

(3) *Safety and home visits*—(i) *PS 32: Internal and external duress system established.* The installation FAPM must establish a system to identify and manage potentially violent clients and to promote the safety and reduce the risk of harm to staff working with clients and to others inside the office and when conducting official business outside the office.

(ii) *PS 33: Protection of home visitors.* The installation FAPM must:

(A) Issue written FAP procedures to ensure minimal risk and maximize personal safety when FAP or NPSP staff perform home visits.

(B) Require that all FAP and NPSP personnel who conduct home visits are trained in FAP procedures to ensure minimal risk and maximize personal safety before conducting a home visit.

(iii) *PS 34: Home visitors' reporting of known or suspected child abuse and domestic abuse.* All FAP and NPSP personnel who conduct home visits are to report all known or suspected child abuse in accordance with subpart A of this part and 42 U.S.C. 13031, and domestic abuse in accordance with DoD Instruction 6400.06 and the Service FAP headquarters implementing policy and guidance.

(4) *Management information system*—(i) *PS 35: Management information system policy.* The installation FAPM must establish procedures for the collection, use, analysis, reporting, and distributing of FAP information in accordance with subpart A of this part, DoD 6025.18-R, 32 CFR part 310, DoD 6400.1-M-1 and Service FAP headquarters implementing policy. These procedures ensure:

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(A) Accurate and comparable statistics needed for planning, implementing, assessing, and evaluating the installation coordinated community response to child abuse and domestic abuse.

(B) Identifying unmet needs or gaps in services.

(C) Determining installation FAP resource needs and budget.

(D) Developing installation FAP guidance.

(E) Administering the installation FAP.

(F) Evaluating installation FAP activities.

(ii) *PS 36: Reporting of statistics.* The FAP reports statistics annually to the Service FAP headquarters in accordance with subpart A of this part and the Service FAP headquarters implementing policies and guidance, including the accurate and timely reporting of:

(A) *FAP metrics*—(1) The number of new commanders at the installation whom the Service FAP headquarters determined must receive the FAP briefing, and the number of new commanders who received the FAP briefing within 90 days of taking command.

(2) The number of senior noncommissioned officers (NCOs) in pay grades E-7 and higher whom the Service FAP headquarters determined must receive the FAP briefing annually, and the number of senior NCOs who received the FAP briefing within the year.

(B) *NPSP metric*—(1) The number of high risk families who began receiving NPSP intensive services (two contacts per month) for at least 6 months in the previous fiscal year.

(2) The number of these families with no reports of child maltreatment incidents that met criteria for abuse for entry into the central registry (formerly, “substantiated reports”) within 12 months after their NPSP services ended, in accordance with DoD Instruction 6400.05.

(C) *Domestic abuse treatment metric*—(1) The number of allegedly abusive spouses in incidents that met FAP criteria for domestic abuse who began receiving and successfully completed FAP clinical treatment services during the previous fiscal year.

(2) The number of these spouses who were not reported as allegedly abusive in any domestic abuse incidents that met FAP criteria within 12 months after FAP clinical services ended.

(D) *Domestic abuse victim advocacy metrics.* The number of domestic abuse victims:

(1) Who receive domestic abuse victim advocacy services, and of those, the respective totals of domestic abuse victims who receive such services from domestic abuse victim advocates or from FAP clinical staff.

(2) Who initially make restricted reports to domestic abuse victim advocates and the total of domestic abuse victims who initially make restricted reports to FAP clinical staff, and of each of those, the total of domestic abuse victims who report being sexually assaulted.

(3) Whose initially restricted reports to domestic abuse victim advocates became unrestricted reports, and the total of domestic abuse victims whose initially restricted reports to FAP clinical staff became unrestricted reports.

(4) Initially making unrestricted reports to domestic abuse victim advocates and making unrestricted reports to FAP clinical staff and, of each of those, the total of domestic abuse victims who report being sexually assaulted.

(d) *Public awareness, prevention, NPSP, and training*—(1) *Public awareness activities*—(i) *PS 37: Implementation of public awareness activities in the coordinated community response and risk management plan.* The FAP public awareness activities highlight community strengths; promote FAP core concepts and messages; advertise specific services; use appropriate available techniques to reach out to the military community, especially to military families who reside outside of the military installation; and are customized to the local population and its needs.

(ii) *PS 38: Collaboration to increase public awareness of child abuse and domestic abuse.* The FAP partners and collaborates with other military and civilian organizations to conduct public awareness activities.

(iii) *PS 39: Components of public awareness activities.* The installation public

awareness activities promote community awareness of:

(A) Protective factors that promote and sustain healthy parent/child relationships.

(1) The importance of nurturing and attachment in the development of young children.

(2) Infant, childhood, and teen development.

(3) Programs, strategies, and opportunities to build parental resilience.

(4) Opportunities for social connections and mutual support.

(5) Programs and strategies to facilitate children's social and emotional development.

(6) Information about access to community resources in times of need.

(B) The dynamics of risk factors for different types of child abuse and domestic abuse, including information for teenage family members on teen dating violence.

(C) Developmentally appropriate supervision of children.

(D) Creating safe sleep environments for infants.

(E) How incidents of suspected child abuse should be reported in accordance with subpart A of this part, 42 U.S.C. 13031, 28 CFR 81.2, and DoD Instruction 6400.03, "Family Advocacy Command Assistance Team" (available at <http://www.dtic.mil/whs/directives/corres/pdf/640003p.pdf>) and the Service FAP headquarters implementing policy and guidance.

(F) The availability of domestic abuse victim advocates.

(G) Hotlines and crisis lines that provide 24/7 support to families in crisis.

(H) How victims of domestic abuse may make restricted reports of incidents of domestic abuse in accordance with DoD Instruction 6400.06.

(I) The availability of FAP clinical assessment and treatment.

(J) The availability of NPSP home visitation services.

(K) The availability of transitional compensation for victims of child abuse and domestic abuse in accordance with DoD Instruction 1342.24, "Transitional Compensation for Abused Dependents" (available at <http://www.dtic.mil/whs/directives/corres/pdf/134224p.pdf>) and Service FAP head-

quarters implementing policy and guidance.

(2) *Prevention activities*—(i) *PS 40: Implementation of prevention activities in the coordinated community response and risk management plan.* The FAP implements coordinated child abuse and domestic abuse primary and secondary prevention activities identified in the annual plan.

(ii) *PS 41: Collaboration for prevention of child abuse and domestic abuse.* The FAP collaborates with other military and civilian organizations to implement primary and secondary child abuse and domestic abuse prevention programs and services that are available on a voluntary basis to all persons eligible for services in a military medical treatment facility.

(iii) *PS 42: Primary prevention activities.* Primary prevention activities include, but are not limited to:

(A) Information, classes, and non-medical counseling as defined in §61.3 to assist Service members and their family members in strengthening their interpersonal relationships and marriages, in building their parenting skills, and in adapting successfully to military life.

(B) Proactive outreach to identify and engage families during pre-deployment, deployment, and reintegration to decrease the negative effects of deployment and other military operations on parenting and family dynamics.

(C) Family strengthening programs and activities that facilitate social connections and mutual support, link families to services and opportunities for growth, promote children's social and emotional development, promote safe, stable, and nurturing relationships, and encourage parental involvement.

(iv) *PS 43: Identification of populations for secondary prevention activities.* The FAP identifies populations at higher risk for child abuse or domestic abuse from a review of:

(A) Relevant research findings.

(B) One or more relevant needs assessments in the locality.

(C) Data from unit deployments and returns from deployment.

(D) Data of expectant parents and parents of children 3 years of age or younger.

(E) Lessons learned from Service FAP headquarters and local fatality reviews.

(F) Feedback from the FAC, the IDC, and the command.

(v) *PS 44: Secondary prevention activities.* The FAP implements secondary prevention activities that are results-oriented and evidence-supported, stress the positive benefits of seeking help, promote available resources to build and sustain protective factors for healthy family relationships, and reduce risk factors for child abuse or domestic abuse. Such activities include, but are not limited to:

(A) Educational classes and counseling to assist Service members and their family members with troubled interpersonal relationships and marriages in improving their interpersonal relationships and marriages.

(B) The NPSP, in accordance with DoD Instruction 6400.05 and Service FAP headquarters implementing policy and guidance.

(C) Educational classes and counseling to help improve the parenting skills of Service members and their family members who experience parenting problems.

(D) Health care screening for domestic abuse.

(E) Referrals to essential services, supports, and resources when needed.

(3) *NPSP—(i) PS 45: Referrals to NPSP.* The installation FAPM ensures that expectant parents and parents with children ages 0–3 years may self-refer to the NPSP or be encouraged to participate by a health care provider, the commander of an active duty Service member who is a parent or expectant parent, staff of a family support program, or community professionals.

(ii) *PS 46: Informed Consent for NPSP.* The FAPM ensures that parents who ask to participate in the NPSP are provided informed consent in accordance with subpart A of this part and DoD Instruction 6400.05 and Service FAP headquarters implementing policy and guidance to be:

(A) Voluntarily screened for factors that may place them at risk for child abuse and domestic abuse.

(B) Further assessed using standardized and more in-depth measurements if the screening indicates potential for risk.

(C) Receive home visits and additional NPSP services as appropriate.

(D) Assessed for risk on a continuing basis.

(iii) *PS 47: Eligibility for NPSP.* Pending funding and staffing capabilities, the installation FAPM ensures that qualified NPSP personnel offer intensive home visiting services on a voluntary basis to expectant parents and parents with children ages 0–3 years who:

(A) Are eligible to receive services in a military medical treatment facility.

(B) Have been assessed by NPSP staff as:

(1) At-risk for child abuse or domestic abuse.

(2) Displaying some indicators of high risk for child abuse or domestic abuse, but whose overall assessment does not place them in the at-risk category.

(3) Having been reported to FAP for an incident of abuse of a child age 0–3 years in their care who have previously received NPSP services.

(iv) *PS 48: Review of NPSP screening.* Results of NPSP screening are reviewed within 3 business days of completion. If the screening indicates potential for risk, parents are invited to participate in further assessment by a NPSP home visitor using standardized and more in-depth measurements.

(v) *PS 49: NPSP services.* The NPSP offers expectant parents and parents with children ages 0–3, who are eligible for the NPSP, access to intensive home visiting services that:

(A) Are sensitive to cultural attitudes and practices, to include the need for interpreter or translation services.

(B) Are based on a comprehensive assessment of research-based protective and risk factors.

(C) Emphasize developmentally appropriate parenting skills that build on the strengths of the parent(s).

(D) Support the dual roles of the parent(s) as Service member(s) and parent(s).

(E) Promote the involvement of both parents when applicable.

(F) Decrease any negative effects of deployment and other military operations on parenting.

(G) Provide education to parent(s) on how to adapt to parenthood, children's developmental milestones, age-appropriate expectations for their child's development, parent-child communication skills, parenting skills, and effective discipline techniques.

(H) Empower parents to seek support and take steps to build proactive coping strategies in all domains of family life.

(I) Provide referral to additional community resources to meet identified needs.

(vi) *PS 50: NPSP protocol.* The installation FAPM ensures that NPSP personnel implement the Service FAP headquarters protocol for NPSP services, including the NPSP intervention plan with clearly measurable goals, based on needs identified by the standard screening instrument, assessment tools, the NPSP staff member's clinical assessment, and active input from the family.

(vii) *PS 51: Frequency of NPSP home visits.* NPSP personnel exercise professional judgment in determining the frequency of home visits based on the assessment of the family, but make a minimum of two home visits to each family per month. If at least two home visits are not provided to a high risk family enrolled in the program, NPSP personnel will document what circumstance(s) occurred to preclude twice monthly home visits and what services/contacts were provided instead.

(viii) *PS 52: Continuing NPSP risk assessment.* The installation FAPM ensures that NPSP personnel assess risk and protective factors impacting parents receiving NPSP home visitation services on an ongoing basis to continuously monitor progress toward intervention goals.

(ix) *PS 53: Opening, transferring, or closing NPSP cases.* The installation FAPM ensures that NPSP cases are opened, transferred, or closed in accordance with Service FAP headquarters policy and guidance.

(x) *PS 54: Disclosure of information in NPSP cases.* Information gathered during NPSP screening, clinical assess-

ments, and in the provision of supportive services or treatment that is protected from disclosure under 5 U.S.C. 552a, DoD 6025.18-R, and 32 CFR part 310 is only disclosed in accordance with 5 U.S.C. 552a, DoD 6025.18-R, 32 CFR part 310, and the Service FAP headquarters implementing policies and guidance.

(4) *Training*—(i) *PS 55: Implementation of training requirements.* The FAP implements coordinated training activities for commanders, senior enlisted advisors, Service members, and their family members, DoD civilians, and contractors.

(ii) *PS 56: Training for commanders and senior enlisted advisors.* The installation commander or senior mission commander must require that qualified FAP trainers defined in accordance with Service FAP headquarters implementing policy and guidance provide training on the prevention of and response to child abuse and domestic abuse to:

(A) Commanders within 90 days of assuming command.

(B) Annually to NCOs who are senior enlisted advisors.

(iii) *PS 57: Training for other installation personnel.* Qualified FAP trainers as defined in accordance with Service FAP headquarters implementing policy and guidance conduct training (or help provide subject matter experts who conduct training) on child abuse and domestic abuse in the military community to installation:

(A) Law enforcement and investigative personnel.

(B) Health care personnel.

(C) Sexual assault prevention and response personnel.

(D) Chaplains.

(E) Personnel in DoDEA schools.

(F) Personnel in child development centers.

(G) Family home care providers.

(H) Personnel and volunteers in youth programs.

(I) Family center personnel.

(J) Service members.

(iv) *PS 58: Content of training.* FAP training for personnel, as required by PS 56 and PS 57, located at paragraphs (d)(4)(ii) and (d)(4)(iii) of this section, includes:

(A) Research-supported protective factors that promote and sustain healthy family relationships.

(B) Risk factors for and the dynamics of child abuse and domestic abuse.

(C) Requirements and procedures for reporting child abuse in accordance with subpart A of this part, 42 U.S.C. 13031, 28 CFR 81.2, and DoD Instruction 6400.03.

(D) The availability of domestic abuse victim advocates and response to restricted and unrestricted reports of incidents of domestic abuse in accordance with DoD Instruction 6400.06.

(E) The dynamics of domestic abuse, reporting options, safety planning, and response unique to the military culture that establishes and supports competence in performing core victim advocacy duties.

(F) Roles and responsibilities of the FAP and the command under the installation's coordinated community response to a report of a child abuse, including the response to a report of child sexual abuse in a DoD sanctioned child or youth activity in accordance with subpart A of this part and DoD 6400.1-M-1, or domestic abuse incident, and actions that may be taken to protect the victim in accordance with subpart A of this part and DoD Instruction 6400.06.

(G) Available resources on and off the installation that promote protective factors and support families at risk before abuse occurs.

(H) Procedures for the management of child abuse and domestic abuse incidents that happen before a Service member is deployed, as set forth in PS 16, located at paragraph (b)(3)(v) of this section.

(I) The availability of transitional compensation for victims of child abuse and domestic abuse in accordance with 5 U.S.C. 552a and DoD Instruction 6400.03, and Service FAP headquarters implementing policy and guidance.

(v) *PS 59: Additional FAP training for NPSP personnel.* The installation FAPM ensures that all personnel offering NPSP services are trained in the content specified in PS 58, located at paragraph (d)(4)(iv) of this section, and in DoD Instruction 6400.05.

(e) *FAP Response to incidents of child abuse or domestic abuse—(1) Reports of child abuse—(i) PS 60: Responsibilities in responding to reports of child abuse.* The installation commander in accordance with subpart A of this part and Service FAP headquarters implementing policy and guidance must issue local policy that specifies the installation procedures for responding to reports of:

(A) Suspected incidents of child abuse in accordance with subpart A of this part, 42 U.S.C. 13031, 28 CFR 81.2, and Service FAP headquarters implementing policies and guidance, federal and State laws, and applicable SOFAs.

(B) Suspected incidents of child abuse involving students, ages 3-18, enrolled in a DoDEA school or any children participating in DoD-sanctioned child or youth activities or programs.

(C) Suspected incidents of the sexual abuse of a child in DoD-sanctioned child or youth activities or programs that must be reported to the DASD(MC&FP) in accordance with DoD Instruction 6400.03 and Service FAP headquarters implementing policies and guidance.

(D) Suspected incidents involving fatalities or serious injury involving child abuse that must be reported to OSD FAP in accordance with subpart A of this part and Service FAP headquarters implementing policies and guidance.

(ii) *PS 61: Responsibilities during emergency removal of a child from the home.*

(A) In responding to reports of child abuse, the FAP complies with subpart A of this part and Service FAP headquarters implementing policy and guidance and installation policies, procedures, and criteria set forth under PS 11, located at paragraph (b)(2)(vii) of this section, during emergency removal of a child from the home.

(B) The FAP provides ongoing and direct case management and coordination of care of children placed in foster care in collaboration with the child welfare and foster care agency, and will not close the FAP case until a permanency plan for all involved children is in place.

(iii) *PS 62: Coordination with other authorities to protect children.* The FAP coordinates with military and local civilian law enforcement agencies, military

investigative agencies, and civilian child protective agencies in response to reports of child abuse incidents in accordance with subpart A of this part, 42 U.S.C. 13031, 28 CFR 81.2, and DoD 6400.1–M–1 and appropriate MOUs under PS 5, located at paragraph (b)(2)(i) of this section.

(iv) *PS 63: Responsibilities in responding to reports of child abuse involving infants and toddlers from birth to age 3.* Services and support are delivered in a developmentally appropriate manner to infants and toddlers, and their families who come to the attention of FAP to ensure decisions and services meet the social and emotional needs of this vulnerable population.

(A) FAP makes a direct referral to the servicing early intervention agency, such as the Educational and Developmental Intervention Services (EDIS) where available, for infants and toddlers from birth to 3 years of age who are involved in an incident of child abuse in accordance with 20 U.S.C. 921 through 932 and chapter 33.

(B) FAP provides ongoing and direct case management services to families and their infants and toddlers placed in foster care or other out-of-home placements to ensure the unique developmental, physical, social-emotional, and mental health needs are addressed in child welfare-initiated care plans.

(v) *PS 64: Assistance in responding to reports of multiple victim child sexual abuse in dod sanctioned out-of-home care.*

(A) The installation FAPM assists the installation commander in assessing the need for and implementing procedures for requesting deployment of a DoD FACAT in cases of multiple-victim child sexual abuse occurring in DoD-sanctioned or operated activities, in accordance with DoD Instruction 6400.03 and Service FAP headquarters implementing policies and guidance.

(B) The installation coordinator for the FACAT before it arrives at the installation.

(2) *PS 65: Responsibilities in Responding to Reports of Domestic Abuse.* Installation procedures for responding to unrestricted and restricted reports of domestic abuse are established in accordance with DoD Instruction 6400.06 and

Service FAP headquarters implementing policy and guidance.

(3) *Informed consent*—(i) *PS 66: Informed consent for FAP clinical assessment, intervention services, and supportive services or clinical treatment.* Every person referred for FAP clinical intervention and supportive services must give informed consent for such assessment or services. Clients are considered voluntary, non-mandated recipients of services except when the person is:

(A) Issued a lawful order by a military commander to participate.

(B) Ordered by a court of competent jurisdiction to participate.

(C) A child, and the parent or guardian has authorized such assessment or services.

(ii) *PS 67: Documentation of informed consent.* FAP staff document that the person gave informed consent in the FAP case record, in accordance with DoD Instruction 6400.06 and the Service FAP headquarters implementing policies and guidance.

(iii) *PS 68: Privileged communication.* Every person referred for FAP clinical intervention and support services is informed of their right to the provisions of privileged communication by specified service providers in accordance with Military Rules of Evidence 513 and 514 in the Manual for Courts Martial, current edition (available at <http://www.apd.army.mil/pdffiles/mcm.pdf>, Section III, pages III–34 to III–36.).

(4) *Clinical case management and risk management*—(i) *PS 69: FAP case manager.* A clinical service provider is assigned to each FAP referral immediately when the case enters the FAP system in accordance with Service FAP headquarters implementing policy and guidance.

(ii) *PS 70: Initial risk monitoring.* FAP monitoring of the risk of further abuse begins when the report of suspected child abuse or domestic abuse is received and continues through the initial clinical assessment. The FAP case manager requests information from a variety of sources, in addition to the victim and the abuser (whether alleged or adjudicated), to identify additional risk factors and to clarify the context of the use of any violence, and ascertains the level of risk and the risk of

lethality using standardized instruments in accordance with subpart A of this part and DoD Instruction 6400.06, and Service FAP headquarters policies and guidance.

(iii) *PS 71: Ongoing risk assessment.* (A) FAP risk assessment is conducted from the clinical assessment until the case closes:

(1) During each contact with the victim;

(2) During each contact with the abuser (whether alleged or adjudicated);

(3) Whenever the abuser is alleged to have committed a new incident of child abuse or domestic abuse;

(4) During significant transition periods for the victim or abuser;

(5) When destabilizing events for the victim or abuser occur; or

(6) When any clinically relevant issues are uncovered during clinical intervention services.

(B) The FAP case manager monitors risk at least quarterly when civilian agencies provide the clinical intervention services or child welfare services through MOUs with such agencies.

(C) The FAP case manager monitors risk at least monthly when the case is high risk or involves chronic child neglect or child sexual abuse.

(iv) *PS 72: Communication of increased risk.* The FAPM communicates increases in risk or risk of lethality to the appropriate commander(s), law enforcement, or civilian officials. FAP clinical staff assess whether the increased risk requires the victim or the victim advocate to be urged to review the victim's safety plan.

(5) *Clinical assessment*—(i) *PS 73: Clinical assessment policy.* The installation FAPM establishes procedures for the prompt clinical assessment of victims, abusers (whether alleged or adjudicated), and other family members, who are eligible to receive treatment in a military medical facility, in reports of child abuse and unrestricted reports of domestic abuse in accordance with subpart A of this part and DoD 6025.18-R when applicable and Service FAP headquarters policies and guidance, including:

(A) A prompt response based on the severity of the alleged abuse and fur-

ther risk of child abuse or domestic abuse.

(B) Developmentally appropriate clinical tools and measures to be used, including those that take into account relevant cultural attitudes and practices.

(C) Timelines for FAP staff to complete the assessment of an alleged abuse incident.

(ii) *PS 74: Gathering and disclosure of information.* Service members who conduct clinical assessments and provide clinical services to Service member abusers (whether alleged or adjudicated) must adhere to Service policies with respect to advisement of rights in accordance with 10 U.S.C. chapter 47, also known as “The Uniform Code of Military Justice”. Clinical service providers must also seek guidance from the servicing legal office when a question of applicability arises. Before obtaining information about and from the person being assessed, FAP staff fully discuss with such person:

(A) The nature of the information that is being sought.

(B) The sources from which such information will be sought.

(C) The reason(s) why the information is being sought.

(D) The circumstances in accordance with 5 U.S.C. 552a, DoD 6025.18-R, 32 CFR part 310, and Service FAP headquarters policies and guidance under which the information may be released to others.

(E) The procedures under 5 U.S.C. 552a, DoD 6025.18-R, 32 CFR part 310, and Service FAP headquarters policies and guidance for requesting the person's authorization for such information.

(F) The procedures under 5 U.S.C. 552a, DoD 6025.18-R, 32 CFR part 310, and Service FAP headquarters policies and guidance by which a person may request access to his or her record.

(iii) *PS 75: Components of clinical assessment.* FAP staff conducts or ensures that a clinical service provider conducts a clinical assessment of each victim, abuser (whether alleged or adjudicated), and other family member who is eligible for treatment in a military

medical treatment facility, in accordance with PS 73, located at paragraph (e)(5)(i) of this section, including:

- (A) An interview.
- (B) A review of pertinent records.
- (C) A review of information obtained from collateral contacts, including but not limited to medical providers, schools, child development centers, and youth programs.
- (D) A psychosocial assessment, including developmentally appropriate assessment tools for infants, toddlers, and children.
- (E) An assessment of the basic health, developmental, safety, and special health and mental health needs of infants and toddlers.
- (F) An assessment of the presence and balance of risk and protective factors.
- (G) A safety assessment.
- (H) A lethality assessment.
- (iv) *PS 76: Ethical conduct in clinical assessments.* When conducting FAP clinical assessments, FAP staff treat those being clinically assessed with respect, fairness, and in accordance with professional ethics.

(6) *Intervention strategy and treatment plan*—(i) *PS 77: Intervention strategy and treatment plan for the alleged abuser.* The FAP case manager prepares an appropriate intervention strategy based on the clinical assessment for every abuser (whether alleged or adjudicated) who is eligible to receive treatment in a military treatment facility and for whom a FAP case is opened. The intervention strategy documents the client's goals for self, the level of client involvement in developing the treatment goals, and recommends appropriate:

- (A) Actions that may be taken by appropriate authorities under the coordinated community response, including safety and protective measures, to reduce the risk of another act of child abuse or domestic abuse, and the assignment of responsibilities for carrying out such actions.
- (B) Treatment modalities based on the clinical assessment that may assist the abuser (whether alleged or adjudicated) in ending his or her abusive behavior.

(C) Actions that may be taken by appropriate authorities to assess and monitor the risk of recurrence.

(ii) *PS 78: Commanders' access to relevant information for disposition of allegations.* FAP provides commanders and senior enlisted personnel timely access to relevant information on child abuse incidents and unrestricted reports of domestic abuse incidents to support appropriate disposition of allegations. Relevant information includes:

- (A) The intervention goals and activities described in PS 77, located at paragraph (e)(6)(i) of this section.
- (B) The alleged abuser's prognosis for treatment, as determined from a clinical assessment.

(C) The extent to which the alleged abuser accepts responsibility for his or her behavior and expresses a genuine desire for treatment, provided that such information obtained from the alleged abuser was obtained in compliance with Service policies with respect to advisement of rights in accordance with 10 U.S.C. chapter 47.

(D) Other factors considered appropriate for the command, including the results of any previous treatment of the alleged abuser for child abuse or domestic abuse and his or her compliance with the previous treatment plan, and the estimated time the alleged abuser will be required to be away from military duties to fulfill treatment commitments.

(E) Status of any child taken into protective custody.

(iii) *PS 79: Supportive services plan for the victim and other family members.* The FAP case manager prepares a plan for appropriate supportive services or clinical treatment, based on the clinical assessments, for every victim or family member who is eligible to receive treatment in a military treatment facility, who expresses a desire for FAP services, and for whom a FAP case is opened. The plan recommends one or more appropriate treatment modalities or support services, in accordance with subpart A of this part and DoD Instruction 6400.05 and Service FAP headquarters policies and guidance.

(iv) *PS 80: Clinical consultation.* All FAP clinical assessments and treatment plans for persons in incidents of

child abuse or domestic abuse are reviewed in the CCSM, in accordance with DoD 6025.18-R when applicable, 32 CFR part 310, and Service FAP headquarters policies and guidance.

(7) *Intervention and treatment*—(i) *PS 81: Intervention services for abusers.* Appropriate intervention services for an abuser (whether alleged or adjudicated) who is eligible to receive treatment in a military medical program are available either from the FAP or from other military agencies, contractors, or civilian services providers, including:

(A) Psycho-educationally based programs and services.

(B) Supportive services that may include financial counseling and spiritual support.

(C) Clinical treatment specifically designed to address risk and protective factors and dynamics associated with child abuse or domestic abuse.

(D) Trauma informed clinical treatment when appropriate.

(ii) *PS 82: Supportive services or treatment for victims who are eligible to receive treatment in a military treatment facility.* Appropriate supportive services and treatment are available either from the FAP or from other military agencies, contractors, or civilian services providers, including:

(A) Immediate and ongoing domestic abuse victim advocacy services, available 24 hours per day through personal or telephone contact, as set forth in DoD Instruction 6400.06 and Service FAP headquarters policies and guidance.

(B) Supportive services that may include financial counseling and spiritual support.

(C) Psycho-educationally based programs and services.

(D) Appropriate trauma informed clinical treatment specifically designed to address risk and protective factors and dynamics associated with child abuse or domestic abuse victimization.

(E) Supportive services, information and referral, safety planning, and treatment (when appropriate) for child victims and their family members of abuse by non-caretaking offenders.

(iii) *PS 83: Supportive services for victims or offenders who are not eligible to receive treatment in a military treatment facility.* Victims must receive initial

safety-planning services only and must be referred to civilian support services for all follow-on care. Offenders must receive referrals to appropriate civilian intervention or treatment programs.

(iv) *PS 84: Ethical conduct in supportive services and treatment for abusers and victims.* When providing FAP supportive services and treatment, FAP staff treats those receiving such supportive services or clinical treatment with respect, fairness, and in accordance with professional ethics.

(v) *PS 85: CCSM review of treatment progress.* Treatment progress and the results of the latest risk assessment are reviewed periodically in the CCSM in accordance with subpart A of this part.

(A) Child sexual abuse cases are reviewed monthly in the CCSM.

(B) Cases involving foster care placement of children are reviewed monthly in the CCSM.

(C) All other cases are reviewed at least quarterly in the CCSM.

(D) Cases must be reviewed within 30 days of any significant event or a pending significant event that would impact care, including but not limited to a subsequent maltreatment incident, geographic move, deployment, pending separation from the Service, or retirement.

(vi) *PS 86: Continuity of services.* The FAP case manager ensures continuity of services before the transfer or referral of open child abuse or domestic abuse cases to other service providers:

(A) At the same installation or other installations of the same Service FAP headquarters.

(B) At installations of other Service FAP headquarters.

(C) In the civilian community.

(D) In child welfare services in the civilian community.

(8) *Termination and case closure*—(i) *PS 87: Criteria for case closure.* FAP services are terminated and the case is closed when treatment provided to the abuser (whether alleged or adjudicated) is terminated and treatment or supportive services provided to the victim are terminated.

(A) Treatment provided to the abuser(s) (whether alleged or adjudicated) is terminated only if either:

(1) The CCSM discussion produced a consensus that clinical objectives have been substantially met and the results of a current risk assessment indicate that the risk of additional abuse and risk of lethality have declined; or

(2) The CCSM discussion produced a consensus that clinical objectives have not been met due to:

(i) Noncompliance of such abuser(s) with the requirements of the treatment program.

(ii) Unwillingness of such abuser(s) to make changes in behavior that would result in treatment progress.

(B) Treatment and supportive services provided to the victim are terminated only if either:

(1) The CCSM discussion produced a consensus that clinical objectives have been substantially met; or

(2) The victim declines further FAP supportive services.

(ii) *PS 88: Communication of case closure.* Upon closure of the case the FAP notifies:

(A) The abuser (whether alleged or adjudicated) and victim, and in a child abuse case, the non-abusing parent.

(B) The commander of an active duty victim or abuser (whether alleged or adjudicated).

(C) Any appropriate civilian court currently exercising jurisdiction over the abuser (whether alleged or adjudicated), or in a child abuse case, over the child.

(D) A civilian child protective services agency currently exercising protective authority over a child victim.

(E) The NPSP, if the family has been currently receiving NPSP intensive home visiting services.

(F) The domestic abuse victim advocate if the victim has been receiving victim advocacy services.

(iii) *PS 89: Disclosure of information.* Information gathered during FAP clinical assessments and during treatment or supportive services that is protected from disclosure under 5 U.S.C. 552a, DoD 6025.18-R, and 32 CFR part 310 is only disclosed in accordance with 5 U.S.C. 552a, DoD 6025.18-R, 32 CFR part 310, and Service FAP headquarters implementing policies and guidance.

(f) *Documentation and records management—(1) Documentation of NPSP cases—*

(i) *PS 90: NPSP case record documenta-*

tion. For every client screened for NPSP services, NPSP personnel must document in accordance with Service FAP headquarters policies and guidance, at a minimum:

(A) The informed consent of the parents based on the services offered.

(B) The results of the initial screening for risk and protective factors and, if the risk was high, document:

(1) The assessment(s) conducted.

(2) The plan for services and goals for the parents.

(3) The services provided and whether suspected child abuse or domestic abuse was reported.

(4) The parents' progress toward their goals at the time NPSP services ended.

(ii) *PS 91: Maintenance, storage, and security of NPSP case records.* NPSP case records are maintained, stored, and kept secure in accordance with DoD 6025.18-R when applicable, 32 CFR part 310, and Service FAP headquarters policies and guidance.

(iii) *PS 92: Transfer of NPSP case records.* NPSP case records are transferred in accordance with DoD 6025.18-R when applicable, 32 CFR part 310, and Service FAP headquarters policies and procedures.

(iv) *PS 93: Disposition of NPSP records.* NPSP records are disposed of in accordance with DoD 6025.18-R when applicable, 32 CFR part 310, and Service FAP headquarters policies and guidance.

(2) *Documentation of reported incidents—(i) PS 94: 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, an accurate accounting of all risk levels, actions taken, assessments conducted, foster care placements, clinical services provided, and results of the quarterly CCSM from the initial report of an incident to case closure in accordance with Service FAP headquarters policies and guidance.

(ii) *PS 95: Documentation of multiple incidents.* Multiple reported incidents of child abuse and unrestricted reports of domestic abuse involving the same Service member or family members are documented separately within one FAP case record.

(iii) *PS 96: Maintenance, storage, and security of FAP case records.* FAP case

records are maintained, stored, and kept secure in accordance with Service FAP headquarters policies and procedures.

(iv) *PS 97: Transfer of FAP case records.* FAP case records are transferred in accordance with DoD 6025.18-R when applicable, 32 CFR part 310, and Service FAP headquarters policies and procedures.

(v) *PS 98: Disposition of FAP records.* FAP records are disposed of in accordance with DoD Directive 5015.2, "DoD Records Management Program" (available at <http://www.dtic.mil/whs/directives/corres/pdf/501502p.pdf>) and Service FAP headquarters policies and guidance.

(3) *Central registry of child abuse and domestic abuse incidents*—(i) *PS 99: Recording data into the Service FAP headquarters central registry of child abuse and domestic abuse incidents.* Data pertaining to child abuse and unrestricted domestic abuse incidents reported to FAP are added to the Service FAP headquarters central registry of child and domestic abuse incidents. Quarterly edit checks are conducted in accordance with Service FAP headquarters policies and procedures. Data that personally identifies the sponsor, victim, or alleged abuser are not retained in the central registry for any incidents that did not meet criteria for entry or on any victim or alleged abuser who is not an active duty member or retired Service member, DoD civilian employee, contractor, or eligible beneficiary.

(ii) *PS 100: Access to the DoD central registry of child and domestic abuse incidents.* Access to the DoD central registry of child and domestic abuse incidents and disclosure of information therein complies with DoD 6400.1-M-1 and Service FAP headquarters policies and guidance.

(iii) *PS 101: Access to Service FAP headquarters central registry of child and domestic abuse reports.* Access to the Service FAP headquarters central registry of child and domestic abuse incidents and disclosure of information therein complies with DoD 6400.1-M-1 and Service FAP headquarters policies and procedures.

(4) *Documentation of restricted reports of domestic abuse*—(i) *PS 102: Documentation of restricted reports of domestic*

abuse. Restricted reports of domestic abuse are documented in accordance with DoD Instruction 6400.06 and Service FAP headquarters policies and guidance.

(ii) *PS 103: Maintenance, storage, security, and disposition of restricted reports of domestic abuse.* Records of restricted reports of domestic abuse are maintained, stored, kept secure, and disposed of in accordance with DoD Instruction 6400.06 and Service FAP headquarters policies and procedures.

(g) *Fatality notification and review*—(1) *Fatality notification*—(i) *PS 104: Domestic abuse fatality and child abuse fatality notification.* The installation FAC establishes local procedures in compliance with Service FAP headquarters implementing policy and guidance to report fatalities known or suspected to have resulted from an act of domestic abuse, child abuse, or suicide related to an act of domestic abuse or child abuse that involve personnel assigned to the installation or within its area of responsibility. Fatalities are reported through the Service FAP headquarters and the Secretaries of the Military Departments to the DASD(MC&FP) in compliance with subpart A of this part and DoD Instruction 6400.06, and Service FAP headquarters implementing policy and guidance.

(ii) *PS 105: Timeliness of reporting domestic abuse and child abuse fatalities to DASD(MC&FP).* The designated installation personnel report domestic abuse and child abuse fatalities through the Service FAP headquarters channels to the DASD(MC&FP) within the timeframe specified in DoD Instruction 6400.06 in accordance with the Service FAP headquarters implementing policy and guidance.

(iii) *PS 106: Reporting format for domestic abuse and child abuse fatalities.* Installation reports of domestic abuse and child abuse fatalities are reported on the DD Form 2901, "Child Abuse or Domestic Abuse Related Fatality Notification," and in accordance with subpart A of this part.

(2) *Review of fatalities*—(i) *PS 107: Information forwarded to the Service FAP headquarters fatality review.* The installation provides written information concerning domestic abuse and child abuse fatalities that involve personnel

assigned to the installation or within its area of responsibility promptly to the Service FAP headquarters fatality review team in accordance with DoD Instruction 6400.06 and in the format specified in the Service FAP headquarters implementing policy and guidance.

(ii) *PS 108: Cooperation with non-DoD fatality review teams.* Authorized installation personnel provide information about domestic abuse and child abuse fatalities that involve personnel assigned to the installation or within its area of responsibility to non-DoD fatality review teams in accordance with written MOUs and 5 U.S.C. 552a and 32 CFR part 310.

(h) *QA and accreditation or inspections—(1) QA—(i) PS 109: Installation FAP QA program.* The installation FAC will establish local QA procedures that address compliance with the PSs in this section in accordance with subpart A of this part and Service FAP head-

quarters implementing policy and guidance.

(ii) *PS 110: QA Training.* All FAP personnel must be trained in installation QA procedures.

(iii) *PS 111: Monitoring FAP compliance with PSs.* The installation FAPM monitors compliance of FAP personnel to installation QA procedures and the PSs in this section.

(2) *Accreditation or inspections—(i) PS 112: Accreditation or inspections.* The installation FAP undergoes accreditation or inspection at least every 4 years to monitor compliance with the PSs in this section, in accordance with subpart A of this part and Service FAP headquarters policies and guidance.

(ii) *PS 113: Review of accreditation and inspection results.* The installation FAC reviews the results of the FAP accreditation review or inspection and submits findings and corresponding corrective action plans to the Service FAP headquarters in accordance with its implementing policy and guidance.

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Subparts C–D [Reserved]

Subpart E—Guidelines for Clinical Intervention for Persons Reported as Domestic Abusers

AUTHORITY: 10 U.S.C. chapter 47, 42 U.S.C. 5106g, 42 U.S.C. 13031.

§ 61.25 Purpose.

(a) This part is composed of several subparts, each containing its own purpose. This subpart implements policy, assigns responsibilities, and provides procedures for addressing child abuse and domestic abuse in military communities.

(b) Restricted reporting guidelines are provided in DoD Instruction 6400.06, “Domestic Abuse Involving DoD Military and Certain Affiliated Personnel” (available at <http://www.dtic.mil/whs/directives/corres/pdf/640006p.pdf>). This subpart prescribes guidelines for Family Advocacy Program (FAP) assessment, clinical rehabilitative treatment, and ongoing monitoring of individuals who have been reported to FAP by means of an unrestricted report for domestic abuse against:

- (1) Current or former spouses, or
- (2) Intimate partners.

§ 61.26 Applicability.

This subpart applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to in this subpart as the “DoD Components”).

§ 61.27 Definitions.

Unless otherwise noted, the following terms and their definitions are for the purpose of this subpart.

Abuser. An individual adjudicated in a military disciplinary proceeding or civilian criminal proceeding who is found guilty of committing an act of domestic violence or a lesser included offense, as well as an individual alleged to have committed domestic abuse, in-

cluding domestic violence, who has not had such an allegation adjudicated.

Abuser contract. The treatment agreement between the clinician and the abuser that specifies the responsibilities and expectations of each party. It includes specific abuser treatment goals as identified in the treatment plan and clearly specifies that past, present, and future allegations and threats of domestic abuse and child abuse or neglect will be reported to the active duty member’s commander, to local law enforcement and child protective services, as appropriate, and to the potential victim.

Clinical case management. Defined in subpart B of this part.

Clinical case staff meeting (CCSM). Defined in subpart B of the part.

Clinical intervention. Defined in subpart B of this part.

Domestic abuse. Domestic violence or a pattern of behavior resulting in emotional/psychological abuse, economic control, and/or interference with personal liberty that is directed toward a person who is:

- (1) A current or former spouse;
- (2) A person with whom the abuser shares a child in common; or
- (3) A current or former intimate partner with whom the abuser shares or has shared a common domicile.

Domestic violence. An offense under the United States Code, the UCMJ, or State law involving the use, attempted use, or threatened use of force or violence against a person, or a violation of a lawful order issued for the protection of a person, who is:

- (1) A current or former spouse.
- (2) A person with whom the abuser shares a child in common; or
- (3) A current or former intimate partner with whom the abuser shares or has shared a common domicile.

FAP Manager. Defined in subpart A of this part.

Incident determination committee. Defined in subpart A of this part.

Intimate partner. A person with whom the victim shares a child in common, or a person with whom the victim shares or has shared a common domicile.

Risk management. Defined in subpart B of this part.

Severe abuse. Exposure to chronic pattern of emotionally abusive behavior with physical or emotional effects requiring hospitalization or long-term mental health treatment. In a spouse emotional abuse incident, this designation requires an alternative environment to protect the physical safety of the spouse. Exposure to a chronic pattern of neglecting behavior with physical, emotional, or educational effects requiring hospitalization, long-term mental health treatment, or long-term special education services. Physical abuse resulting in major physical injury requiring inpatient medical treatment or causing temporary or permanent disability or disfigurement; moderate or severe emotional effects requiring long-term mental health treatment; and may require placement in an alternative environment to protect the physical safety or other welfare of the victim. Sexual abuse involving oral, vaginal, or anal penetration that may or may not require one or more outpatient visits for medical treatment; may be accompanied by injury requiring inpatient medical treatment or causing temporary or permanent disability or disfigurement; moderate or severe emotional effects requiring long-term mental health treatment; and may require placement in an alternative environment to protect the physical safety or welfare of the victim.

Unrestricted report. A process allowing a victim of domestic abuse to report an incident using current reporting channels, *e.g.* chain of command, law enforcement or criminal investigative organization, and FAP for clinical intervention.

§ 61.28 Policy.

In accordance with subpart A of this part and DoD Instruction 6400.06, it is DoD policy to:

- (a) Develop PSs and critical procedures for the FAP that reflect a coordinated community response to domestic abuse.
- (b) Address domestic abuse within the military community through a coordinated community risk management approach.
- (c) Provide appropriate individualized and rehabilitative treatment that

supplements administrative or disciplinary action, as appropriate, to persons reported to FAP as domestic abusers.

§ 61.29 Responsibilities.

(a) The Under Secretary of Defense for Personnel and Readiness (USD(P&R)):

(1) Sponsors FAP research and evaluation and participates in other federal research and evaluation projects relevant to the assessment, treatment, and risk management of domestic abuse.

(2) Ensures that research is reviewed every 3 to 5 years and that relevant progress and findings are distributed to the Secretaries of the Military Departments using all available Web-based applications.

(3) Assists the Secretaries of the Military Departments to:

- (i) Identify tools to assess risk of recurrence.
- (ii) Develop and use pre- and post-treatment measures of effectiveness.
- (iii) Promote training in the assessment, treatment, and risk management of domestic abuse.

(b) The Secretaries of the Military Departments issue implementing guidance in accordance with this part. The guidance must provide for the clinical assessment, rehabilitative treatment, and ongoing monitoring and risk management of Service members and eligible beneficiaries reported to FAP for domestic abuse by means of an unrestricted report.

§ 61.30 Procedures.

(a) *General principles for clinical intervention*—(1) *Components of clinical intervention.* The change from abusive to appropriate behavior in domestic relationships is a process that requires clinical intervention, which includes ongoing coordinated community risk management, assessment, and treatment.

(2) *Military administrative and disciplinary actions and clinical intervention.* The military disciplinary system and FAP clinical intervention are separate processes. Commanders may proceed with administrative or disciplinary actions at any time.

(3) *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 stopping abusive behaviors.

(4) *Therapeutic alliance*—(i) Although clinical intervention must address abuser accountability, clinical assessment and treatment approaches should be oriented to building a therapeutic alliance with the abuser so that he or she is sincerely motivated to take responsibility for his or her actions, improve relationship skills, and end the abusive behavior.

(ii) Clinical intervention will neither be confrontational nor intentionally or unintentionally rely on the use of shame to address the abuser's behavior. Such approaches have been correlated in research studies with the abuser's premature termination of or minimal compliance with treatment.

(A) It is appropriate to encourage abusers to take responsibility for their use of violence; however, in the absence of a strong, supportive, therapeutic relationship, confrontational approaches may induce shame and are likely to reduce treatment success and foster dropout. Approaches that create and maintain a therapeutic alliance are more likely to motivate abusers to seek to change their behaviors, add to their relationship skills, and take responsibility for their actions. Studies indicate that a strong therapeutic alliance is related to decreased psychological and physical aggression.

(B) A clinical style that helps the abuser identify positive motivations to change his or her behavior is effective in strengthening the therapeutic alliance while encouraging the abuser to evaluate his or her own behavior. Together, the therapist and abuser attempt to identify the positive consequences of change, identify motivation for change, determine the obstacles that lie in the path of change, and identify specific behaviors that the abuser can adopt.

(5) *Criteria for clinical intervention approaches*. Clinical intervention approaches should reflect the current state of knowledge. This subpart recommends an approach (or multiple approaches) and procedures that have one or more of these characteristics:

(i) Demonstrated superiority in formal evaluations in comparison to one or more other approaches.

(ii) Demonstrated statistically significant success in formal evaluations, but not yet supported by a consensus of experts.

(iii) The support of a consensus due to significant potential in the absence of statistically significant success.

(iv) Significant potential when consensus does not yet exist.

(6) *Clinical intervention for female abusers*. Findings from research and clinical experience indicate that women who are domestic abusers may require clinical intervention approaches other than those designed specifically for male abusers.

(i) Attention should be given to the motivation and context for their use of abusive behaviors to discover whether or not using violence against their spouse, former spouse, or intimate partner has been in response to his or her domestic abuse.

(ii) Although both men and women who are domestic abusers may have undergone previous traumatic experiences that may warrant treatment, women's traumatic experiences may require additional attention within the context of domestic abuse.

(7) *Professional standards*. Domestic abusers who undergo clinical intervention will be treated with respect, fairness, and in accordance with professional ethics. All applicable rights of abusers will be observed, including compliance with the rights and warnings in 10 U.S.C. 831, chapter 47, also known and referred to in this subpart as the "Uniform Code of Military Justice (UCMJ)" for abusers who are Service members.

(i) Clinical service providers who conduct clinical assessments of or provide clinical treatment to abusers will adhere to Service policies with respect to the advisement of rights pursuant to the UCMJ, will seek guidance from the supporting legal office when a question of applicability arises, and will notify the relevant military law enforcement investigative agency if advisement of rights has occurred.

(ii) Clinical service providers and military and civilian victim advocates must follow the Privacy Act of 1974, as

amended, and other applicable laws, regulations, and policies regarding the disclosure of information about victims and abusers.

(iii) Individuals and agencies providing clinical intervention to persons reported as domestic abusers will not discriminate based on race, color, religion, gender, disability, national origin, age, or socioeconomic status. All members of clinical intervention teams will treat abusers with dignity and respect regardless of the nature of their conduct or the crimes they may have committed. Cultural differences in attitudes will be recognized, respected, and addressed in the clinical assessment process.

(8) *Clinical case management.* The FAP clinical service provider has the responsibility for clinical case management.

(b) *Coordinated community risk management—(1) General.* A coordinated community response to domestic abuse is the preferred method to enhance victim safety, reduce risk, and ensure abuser accountability. In a coordinated community response, the training, policies, and operations of all civilian and military human service and FAP clinical service providers are linked closely with one another. Since no particular response to a report of domestic abuse can ensure that a further incident will not occur, selection of the most appropriate response will be considered one of coordinated community risk management.

(2) *Responsibility for coordinated community risk management.* Overall responsibility for managing the risk of further domestic abuse, including developing and implementing an intervention plan when significant risk of lethality or serious injury is present, lies with:

(i) The Service member's commander when a Service member is a domestic abuser or is the victim (or their military dependent is the victim) of domestic abuse.

(ii) The commander of the installation or garrison on which a Service member who is a domestic abuser or who is the victim (or their military dependent who is the victim) of domestic abuse may live.

(iii) The commander of the military installation on which the civilian is housed for a civilian abuser accompanying U.S. military forces outside the United States.

(iv) The FAP clinical service provider or case manager for liaison with civilian authorities in the event the abuser is a civilian.

(3) *Implementation.* Coordinated community risk management requires:

(i) The commander of the military installation to participate in local coalitions and task forces to enhance communication and strengthen program development among activities. In the military community, this may include inviting State, local, and tribal government representatives to participate in their official capacity as non-voting guests in meetings of the Family Advocacy Committee (FAC) to discuss coordinated community risk management in domestic abuse incidents that cross jurisdictions. (See subpart B of this part for FAC standards.)

(A) Agreements with non-federal activities will be reflected in signed MOU.

(B) Agreements may be among military installations of different Military Services and local government activities.

(ii) Advance planning through the installation FAC by:

(A) The commander of the installation.

(B) FAP and civilian clinical service providers.

(C) Victim advocates in the military and civilian communities.

(D) Military chaplains.

(E) Military and civilian law enforcement agencies.

(F) Military supporting legal office and civilian prosecutors.

(G) Military and civilian mental health and substance abuse treatment agencies.

(H) DoDEA school principals or their designees.

(I) Other civilian community agencies and personnel including:

(1) Criminal and family court judges.

(2) Court probation officials.

(3) Child protective services agencies.

(4) Domestic abuse shelters.

(iii) FAP clinical service providers to address:

(A) Whether treatment approaches under consideration are based on individualized assessments and directly address other relevant risk factors.

(B) Whether the operational tempo of frequent and lengthy deployments to accomplish a military mission affects the ability of active duty Service members to complete a State-mandated treatment program.

(C) Respective responsibilities for monitoring abusers' behavior on an ongoing basis, developing procedures for disclosure of relevant information to appropriate authorities, and implementing a plan for intervention to address the safety of the victim and community.

(4) *Deployment.* Risk management of a Service member reported to FAP as a domestic abuser prior to a military deployment, when his or her deployment is not cancelled, or reported to FAP as a domestic abuser while deployed requires planning for his or her return to their home station.

(i) The installation FAC should give particular attention to special and early returns so during deployment of a unit, the forward command is aware of the procedures to notify the home station command of regularly-scheduled and any special or early returns of such personnel to reduce the risk of additional abuse.

(ii) An active duty Service member reported as a domestic abuser may be returned from deployment early for military disciplinary or civilian legal procedures, for rest and recuperation (R&R), or, if clinical conditions warrant, for treatment not otherwise available at the deployed location and if the commander feels early return is necessary under the circumstances. To prevent placing a victim at higher risk, the deployed unit commander will notify the home station commander and the installation FAP in advance of the early return, unless operational security prevents such disclosure.

(5) *Clinical case management.* Ongoing and active case management, including contact with the victim and liaison with the agencies in the coordinated community response, is necessary to ascertain the abuser's sincerity and changed behavior. Case management requires ongoing liaison and contact

with multiple information sources involving both military and surrounding civilian community agencies. Clinical case management includes:

(i) *Initial clinical case management.* Initial case management begins with the intake of the report of suspected domestic abuse, followed by the initial clinical assessment.

(ii) *Periodic clinical case management.* Periodic case management includes the FAP clinical service provider's assessment of treatment progress and the risk of recurrence of abuse. Treatment progress and the results of the latest risk assessment should be discussed whenever the case is reviewed at the CCSM.

(iii) *Follow-up.* As a result of the risk assessment, if there is a risk of imminent danger to the victim or to another person, the FAP clinical service provider may need to notify:

(A) The victim or other person at risk and the victim advocate to review, and possibly revise, the safety plan.

(B) The appropriate military command, and military or civilian law enforcement agency.

(C) Other treatment providers to modify their intervention with the abuser. For example, the provider of substance abuse treatment may need to change the requirements for monitored urinalysis.

(c) *Clinical assessment—(1) Purposes.* A structured clinical assessment of the abuser is a critical first step in clinical intervention. The purposes of clinical assessment are to:

(i) Gather information to evaluate and ensure the safety of all parties—victim, abuser, other family members, and community.

(ii) Assess relevant risk factors, including the risk of lethality.

(iii) Determine appropriate risk management strategies, including clinical treatment; monitoring, controlling, or supervising the abuser's behavior to protect the victim and any individuals who live in the household; and victim safety planning.

(2) *Initial information gathering.* Initial information gathering and risk assessment begins when the unrestricted report of domestic abuse is received by FAP.

(i) Since the immediacy of the response is based on the imminence of risk, the victim must be contacted as soon as possible to evaluate her or his safety, safety plan, and immediate needs. If a domestic abuse victim advocate is available, the victim advocate must contact the victim. If a victim advocate is not available, the clinician must contact the victim. Every attempt must be made to contact the victim via telephone or email to request a face-to-face interview. If the victim is unable or unwilling to meet face-to-face, the victim's safety, safety plan, and immediate needs will be evaluated by telephone.

(ii) The clinician must interview the victim and abuser separately to maximize the victim's safety. Both victim and abuser must be assessed for the risk factors in paragraphs (c)(4) and (c)(6) of this section.

(A) The clinician must inform the victim and abuser of the limits of confidentiality and the FAP process before obtaining information from them. Such information must be provided in writing as early as practical.

(B) The clinician must build a therapeutic alliance with the abuser using an interviewing style that assesses readiness for and motivates behavioral change. The clinician must be sensitive to cultural considerations and other barriers to the client's engagement in the process.

(iii) The clinician must also gather information from a variety of other sources to identify additional risk factors, clarify the context of the use of any violence, and determine the level of risk. The assessment must include information about whether the Service member is scheduled to be deployed or has been deployed within the past year, and the dates of scheduled or past deployments. Such sources of information may include:

(A) The appropriate military command.

(B) Military and civilian law enforcement.

(C) Medical records.

(D) Children and other family members residing in the home.

(E) Others who may have witnessed the acts of domestic abuse.

(F) The FAP central registry of child maltreatment and domestic abuse reports.

(iv) The clinician will request disclosure of information and use the information disclosed in accordance with 32 CFR part 310 and DoD 6025.18–R, “DoD Health Information Privacy Regulation” (available at <http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf>).

(3) *Violence contextual assessment.* The clinical assessment of domestic abuse will include an assessment of the use of violence within the context of relevant situational factors to guide intervention. Relevant situational factors regarding the use of violence include, but are not limited to:

(i) *Exacerbating factors.* Exacerbating factors include whether either victim or domestic abuser:

(A) Uses violence as an inappropriate means of expressing frustrations with life circumstances.

(B) Uses violence as a means to exert and maintain power and control over the other party.

(C) Has inflicted injuries on the other party during the relationship, and the extent of such injuries.

(D) Fears the other.

(ii) *Mitigating factors.* Mitigating factors include whether either victim or domestic abuser uses violence:

(A) In self-defense.

(B) To protect another person, such as a child.

(C) In retaliation, as noted in the most recent incident or in the most serious incident.

(4) *Lethality risk assessment.* The clinician must assess the risk for lethality in every assessment for domestic abuse, whether or not violence was used in the present incident. The lethality assessment will assess the presence of these factors:

(i) For both victim and domestic abuser:

(A) Increased frequency and severity of violence in the relationship.

(B) Ease of access to weapons.

(C) Previous use of weapons or threats to use weapons.

(D) Threats to harm or kill the other party, oneself, or another (especially a child of either party).

(E) Excessive use of alcohol and use of illegal drugs.

(F) Jealousy, possessiveness, or obsession, including stalking.

(ii) For the domestic abuser only:

(A) Previous acts or attempted acts of forced or coerced sex with the victim.

(B) Previous attempts to strangle the victim.

(iii) For the victim only:

(A) The victim's attempts or statements of intent to leave the relationship.

(B) If the victim is a woman, whether the victim is pregnant and the abuser's attitude regarding the pregnancy.

(C) The victim's fear of harm from the abuser to himself or herself or any child of either party or other individual living in the household.

(5) *Results of lethality risk assessment.* When one or more lethality factors are identified:

(i) The clinician will promptly contact the appropriate commander and military or civilian law enforcement agency and the victim advocate.

(ii) The commander or military law enforcement agency will take immediate steps to protect the victim, addressing the lethality factor(s) identified.

(iii) The victim advocate will contact the victim to develop or amend any safety plan to address the lethality factor(s) identified.

(iv) The commander will intensify ongoing coordinated community risk management and monitoring of the abuser.

(6) *Assessment of other risk factors.* The clinician will separately assess the victim and abuser for other factors that increase risk for future domestic abuse. Such risk factors to be assessed include, but are not limited to, the abuser's:

(i) Previous physical and sexual violence and emotional abuse committed in the current and previous relationships. The greater the frequency, duration, and severity of such violence, the greater the risk.

(ii) Use of abuse to create and maintain power and control over others.

(iii) Attitudes and beliefs directly or indirectly supporting domestic abusive behavior. The stronger the attitudes and beliefs, the greater the risk.

(iv) Blaming of the victim for the abuser's acts. The stronger the attribution of blame to the victim, the greater the risk.

(v) Denial that his or her abusive acts were wrong and harmful, or minimization of their wrongfulness and harmfulness.

(vi) Lack of motivation to change his or her behavior. The weaker the motivation, the greater the risk.

(vii) Physical and/or emotional abuse of any children in the present or previous relationships. The greater the frequency, duration, and severity of such abuse, the greater the risk.

(viii) Physical abuse of pets or other animals. The greater the frequency, duration, and severity of such abuse, the greater the risk.

(ix) Particular caregiver stress, such as the management of a child or other family member with disabilities.

(x) Previous criminal behavior unrelated to domestic abuse. The greater the frequency, duration, and severity of such criminal behavior, the greater the risk.

(xi) Previous violations of civil or criminal court orders. The greater the frequency of such violations, the greater the risk.

(xii) Relationship problems, such as infidelity or significant ongoing conflict.

(xiii) Financial problems.

(xiv) Mental health issues or disorders, especially disorders of emotional attachment or depression and issues and disorders that have not been treated successfully.

(xv) Experience of traumatic events during military service, including events that resulted in physical injuries.

(xvi) Any previous physical harm, including head or other physical injuries, sexual victimization, or emotional harm suffered in childhood and/or as a result of violent crime outside the relationship.

(xvii) Fear of relationship failure or of abandonment.

(7) *Periodic risk assessment.* The FAP clinical service provider will periodically conduct a risk assessment with input from the victim, adding the results of such risk assessments to the

abuser's treatment record in accordance with subpart B of this part, and incorporating them into the abuser's clinical treatment plan and contract. Risk assessment will be conducted:

(i) At least quarterly, but more frequently as required to monitor safety when the current situation is deemed high risk.

(ii) Whenever the abuser is alleged to have committed a new incident of domestic abuse or an incident of child abuse.

(iii) During significant transition periods in clinical case management, such as the change from assessment to treatment, changes between treatment modalities, and changes between substance abuse or mental health treatment and FAP treatment.

(iv) After destabilizing events such as accusations of infidelity, separation or divorce, pregnancy, deployment, administrative or disciplinary action, job loss, financial issues, or health impairment.

(v) When any clinically relevant issues are uncovered, such as childhood trauma, domestic abuse in a prior relationship, or the emergence of mental health problems.

(8) *Assessment of events likely to trigger the onset of future abuse.* The initial clinical assessment will include a discussion of potential events that may trigger the onset of future abuse, such as pregnancy, upcoming deployment, a unilateral termination of the relationship, or conflict over custody and visitation of children in the relationship.

(9) *Tools and instruments for assessment.* The initial clinical assessment process will include the use of appropriate standardized tools and instruments, Service-specific tools, and clinical interviewing. Unless otherwise indicated, the results from one or more of these tools will not be the sole determinant(s) for excluding an individual from treatment. The tools should be used for:

(i) Screening for suitability for treatment.

(ii) Tailoring treatment approaches, modalities, and content.

(iii) Reporting changes in the level of risk.

(iv) Developing risk management strategies.

(v) Making referrals to other clinical service providers for specialized intervention when appropriate.

(d) *Clinical treatment*—(1) *Theoretical approaches.* Based on the results of the clinical assessment, the FAP clinical service provider will 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 approaches. See paragraph (a)(5) of this section for criteria for clinical intervention approaches.

(2) *Treatment Planning.* A FAP clinical service provider will develop a treatment plan for domestic abuse that is based on a structured assessment of the particular relationship and risk factors present.

(i) The treatment plan will not be based on a generic "one-size-fits-all" approach. The treatment plan will consider that people who commit domestic abuse do not compose a homogeneous group, and may include people:

(A) Of both sexes.

(B) With a range of personality characteristics.

(C) With mental illness and those with no notable mental health problems.

(D) Who abuse alcohol or other substances and/or use illegal drugs and those who do not.

(E) Who combine psychological abuse with coercive techniques, including violence, to maintain control of their spouse, former spouse, or intimate partner and those who do not attempt to exert coercive control.

(F) In relationships in which both victim and domestic abuser use violence (excluding self-defense).

(ii) Due to the demographics of the military population, structure of military organizations, and military culture, it is often possible to intervene in a potentially abusive relationship before the individual uses coercive techniques to gain and maintain control of the other party. Thus, a reliance on addressing the abuser's repeated use of power and control tactics as the sole or

primary focus of treatment is frequently inapplicable in the military community.

(iii) Treatment objectives, when applicable, will seek to:

(A) Educate the abuser about what domestic abuse is and the common dynamics of domestic abuse in order for the abuser to learn to identify his or her own abusive behaviors.

(B) Identify the abuser's thoughts, emotions, and reactions that facilitate abusive behaviors.

(C) Educate the abuser on the potential for re-abusing, signs of abuse escalation and the normal tendency to regress toward previous unacceptable behaviors.

(D) Identify the abuser's deficits in social and relationship skills. Teach the abuser non-abusive, adaptive, and pro-social interpersonal skills and healthy sexual relationships, including the role of intimacy, love, forgiveness, development of healthy ego boundaries, and the appropriate role of jealousy.

(E) Increase the abuser's empathic skills to enhance his or her ability to understand the impact of violence on the victim and empathize with the victim.

(F) Increase the abuser's self-management techniques, including assertiveness, problem solving, stress management, and conflict resolution.

(G) Educate the abuser on the socio-cultural basis for violence.

(H) Identify and address issues of gender role socialization and the relationship of such issues to domestic abuse.

(I) Increase the abuser's understanding of the impact of emotional abuse and violence directed at children and violence that is directed to an adult but to which children in the family are exposed.

(J) Facilitate the abuser's acknowledgment of responsibility for abusive actions and consequences of actions. Although the abuser's history of victimization should be addressed in treatment, it should never take precedence over his or her responsibility to be accountable for his or her abusive and/or violent behavior, or be used as an excuse, rationalization, or distraction from being held so accountable.

(K) Identify and confront the abuser's issues of power and control and the use of power and control against victims.

(L) Educate the abuser on the impact of substance abuse and its correlation to violence and domestic abuse.

(iv) These factors should inform treatment planning:

(A) *Special objectives for female abusers.* Findings from research and clinical experience indicate that clinical treatment based solely on analyses of male power and control may not be applicable to female domestic abusers. Clinical approaches must give special attention to the motivation and context for use of violence and to self-identified previous traumatic experiences.

(B) *Special Strategies for Grieving Abusers.* When grief and loss issues have been identified in the clinical assessment or during treatment, the clinician will incorporate strategies for addressing grief and loss into the treatment plan. This is especially important if a victim has decided to end a relationship with a domestic abuser because of the abuse.

(1) Abusers with significant attachment issues who are facing the end of a relationship with a victim are more likely to use lethal violence against the victim and children in the family. This is exemplified by the statement: "If I can't have you no one else can have you."

(2) They are also more likely to attempt suicide. This is exemplified by the statement: "Life without you is not worth living."

(C) *Co-Occurrence of substance abuse.* The coordinated community management of risk is made more difficult when the person committing domestic abuse also abuses alcohol or other substances. When the person committing domestic abuse also abuses alcohol or other substances:

(1) Treatment for domestic abuse will be coordinated with the treatment for substance abuse and information shared between the treatment providers in accordance with applicable laws, regulations, and policies.

(2) Special consideration will be given to integrating the two treatment programs or providing them at the same time.

(3) Information about the abuser's progress in the respective treatment programs will be shared between the treatment providers. Providing separate treatment approaches with no communication between the treatment providers complicates the community's management of risk.

(D) *Co-occurrence of child abuse.* When a domestic abuser has allegedly committed child abuse, the clinician will:

(1) Notify the appropriate law enforcement agency and other civilian agencies as appropriate in accordance with 42 U.S.C. 13031.

(2) Notify the appropriate child protective services agency and the FAP supervisor to ascertain if a FAP child abuse case should be opened in accordance with DoD Instruction 6400.06 and 42 U.S.C. 5106g.

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

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

(5) Continuously assess the abuser as a parent or caretaker as appropriate throughout the treatment process.

(6) Address the impact of the abuser's domestic abuse directed against the victim upon children in the home as a part of the domestic abuser clinical treatment.

(E) *Occurrence of sexual abuse within the context of domestic abuse.* Although sexual abuse is a subset of domestic abuse, victims may not recognize that sexual abuse can occur in the context of a marital or intimate partner relationship. Clinicians should employ specific assessment strategies to identify the presence of sexual abuse within the context of domestic abuse.

(F) *Deployment.* Deployment of an active duty Service member who is a domestic abuser is a complicating factor for treatment delivery.

(1) A Service member who is scheduled to deploy in the near future may be highly stressed and therefore at risk for using poor conflict management skills.

(2) While on deployment, a Service member is unlikely to receive clinical treatment for the abuse due to mission requirements and unavailability of such treatment.

(3) A deployed Service member reported to FAP as a domestic abuser may return from deployment early for military disciplinary or civilian legal procedures, for R&R, or if clinical conditions warrant early return from deployment for treatment not otherwise available at the deployed location and if the commander feels early return is necessary under the circumstances. The home station command and installation FAP must be notified in advance of the early return of a deployed Service member with an open FAP case, unless operational security prevents disclosure, so that the risk to the victim can be assessed and managed.

(4) A Service member who is deployed in a combat operation or in an operation in which significant traumatic events occur may be at a higher risk of committing domestic abuse upon return.

(5) The Service member may receive head injuries. Studies indicate that such an injury increases the risk of personality changes, including a lowered ability to tolerate frustration, poor impulse control, and an increased risk of using violence in situations of personal conflict. If the Service member has a history of a head injury prior to or during deployment, the clinician should ascertain whether the Service member received a medical assessment, was prescribed appropriate medication, or is undergoing current treatment.

(6) The Service member may suffer from depression prior to, during, or after deployment and may be at risk for post-traumatic stress disorder. Studies indicate that males who are depressed are at higher risk of using violence in their personal relationships. If the Service member presents symptoms of depression, the clinician should ascertain whether the Service member has received a medical assessment, was prescribed appropriate medication, or is undergoing current treatment.

(3) *Treatment modalities.* Clinical treatment may be provided in one or more of these modalities as appropriate to the situation:

(i) *Group therapy.* Group therapy is the preferred mode of treatment for domestic abusers because it applies the

concept of problem universality and offers opportunities for members to support one another and learn from other group members' experiences.

(A) The decision to assign an individual to group treatment is initially accomplished during the clinical assessment process; however, the group facilitator(s) should assess the appropriateness of group treatment for each individual on an ongoing basis.

(B) The most manageable maximum number of participants for a domestic abuser treatment group with one or two facilitators is 12.

(C) A domestic abuser treatment group may be restricted to one sex or open to both sexes. When developing a curriculum or clinical treatment agenda for a group that includes both sexes, the clinician should consider that the situations in paragraphs (d)(3)(i)(C)(1) through (d)(3)(i)(C)(3) are more likely to occur in a group that includes both sexes.

(1) Treatment-disruptive events such as sexual affairs or emotional coupling.

(2) Jealousy on the part of the non-participant victim.

(3) Intimidation of participants whose sex is in the minority within the group.

(D) A group may have one or two facilitators; if there are two facilitators, they may be of the same or both sexes.

(ii) *Individual treatment.* In lieu of using a group modality, approaches may be applied in individual treatment if the number of domestic abusers at the installation entering treatment is too small to create a group.

(iii) *Conjoint treatment with substance abusers.* When small numbers of both domestic abusers and substance abusers make separate treatment groups impractical, therapists should consider combining abusers into the same group because co-occurrence of domestic abuse and substance abuse has been documented in scientific literature and the content for clinical treatment of domestic abuse and substance abuse is very similar. 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 in paragraph (e) of this section.

(iv) *Conjoint treatment of victim and abuser.* Domestic abuse in a relationship may be low-level in severity and frequency and without a pervasive pattern of coercive control.

(A) *Limitations on Use.* Conjoint treatment may be considered in such cases where the abuser and victim are treated together, but only if all of these conditions are met:

(1) Each of the parties separately and voluntarily indicates a desire for this approach.

(2) Any abuse, especially any violence, was infrequent, not severe, and not intended or likely to cause severe injury.

(3) The risk of future violence is periodically assessed as low.

(4) Each party agrees to follow safety guidelines recommended by the clinician.

(5) The clinician:

(i) Has the knowledge, skills, and abilities to provide conjoint treatment therapy as well as treat domestic abuse.

(ii) Fully understands the level of abuse and violence and specifically addresses these issues.

(iii) Takes appropriate measures to ensure the safety of all parties, including regular monitoring of the victim and abuser, using all relevant sources of information. The clinician will take particular care to ensure that the victim participates voluntarily and without fear and is contacted frequently to ensure that violence has not recurred.

(B) *Contra-indications.* Conjoint treatment will be suspended or discontinued if monitoring indicates an increase in the risk for abuse or violence. Conjoint treatment will not be used if one or more of these factors are present:

(1) The abuser:

(i) Has a history or pattern of violent behavior and/or of committing severe abuse.

(ii) 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.

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

(i) Participates under threat, coercion, duress, intimidation, or censure,

and/or otherwise participates against his or her will.

(ii) Has a substance abuse problem that would preclude him or her from substantially benefiting from conjoint treatment.

(iii) 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 conjoint treatment.

(v) *Couple's meetings.* Periodic case management meetings with the couple, as opposed to the ongoing conjoint therapy of a single victim and abuser, may be used only after the clinician (or clinicians) has made plans to ensure the safety of the victim. All couples meetings must be structured and co-facilitated by the clinician(s) providing treatment to the abusers and support for the victims to ensure support and protection for the victims.

(4) *Treatment contract.* Properly informing the abuser of the treatment rules is a condition for treating violations as a risk management issue. The clinician will prepare and discuss with the abuser an agreement between them that will serve as a treatment contract. The agreement will be in writing and the clinician will provide a copy to the abuser and retain a copy in the treatment record. The contract will include:

(i) *Goals.* Specific abuser treatment goals, as identified in the treatment plan.

(ii) *Time and attendance requirements.* The frequency and duration of treatment and the number of absences permitted.

(A) Clinicians may follow applicable State standards specifying the duration of treatment as a benchmark unless otherwise indicated.

(B) An abuser may not be considered to have successfully completed clinical treatment unless he or she has completed the total number of required sessions. An abuser may not miss more than 10 percent of the total number of required sessions. On a case-by-case basis, the facilitator should determine whether significant curriculum content has been missed and make-up sessions are required.

(iii) *Crisis plan.* A response plan for abuser crisis situations (information on referral services for 24-hour emergency calls and walk-in treatment when in crisis).

(iv) *Abuser responsibilities.* The abuser must agree to:

(A) Abstain from all forms of domestic abuse.

(B) Accept responsibility for previous abusive and violent behavior.

(C) Abstain from purchasing or possessing personal firearms or ammunition.

(D) Talk openly and process personal feelings.

(E) Provide financial support to his or her spouse and children per the terms of an agreement with the spouse or court order.

(F) Treat group members, facilitators, and clinicians with respect.

(G) Contact the facilitator prior to the session when unable to attend a treatment session.

(H) Comply with the rules concerning the frequency and duration of treatment, and the number of absences permitted.

(v) *Consequences of treatment contract violations.* Violation of any of the terms of the abuser contract may lead to termination of the abuser's participation in the clinical treatment program.

(A) Violations of the abuser contract may include, but are not limited to:

(1) Subsequent incidents of abuse.

(2) Unexcused absences from more than 10 percent of the total number of required sessions.

(3) Statements or behaviors of the abuser that show signs of imminent danger to the victim.

(4) Behaviors of the abuser that are escalating in severity and may lead to violence.

(5) Non-compliance with co-occurring treatment programs that are included in the treatment contract.

(B) If the abuser violates any of the terms of the abuser contract, the clinician or facilitator may terminate the abuser from the treatment program; notify the command, civilian criminal justice agency, and/or civilian court as appropriate; and notify the victim if contact will not endanger the victim.

(C) The command should take any action it deems appropriate when notified that the abuser's treatment has been terminated due to a contract violation.

(vi) *Conditions of information disclosure.* The circumstances and procedures, in accordance with applicable laws, regulations, and policies, under which information may be disclosed to the victim and to any court with jurisdiction.

(A) Past, present, and future acts and threats of child abuse or neglect will be reported to the member's commander; child protective services, when appropriate; and the appropriate military and/or civilian law enforcement agency in accordance with applicable laws, regulations, and policies.

(B) Recent and future acts and threats of domestic abuse will be reported to the member's commander, the appropriate military and/or civilian law enforcement agency, and the potential victim in accordance with applicable laws, regulations, and policies.

(vii) *Complaints.* The procedures according to which the abuser may complain regarding the clinician or the treatment.

(5) *Treatment outside the FAP.* If the abuser's treatment is provided by a clinician outside the FAP, the FAP clinical service provider will follow procedures in accordance with relevant laws, regulations, and policies regarding the confidentiality and disclosure of information. FAP may not close an open FAP case as resolved if the abuser does not consent to release of information from the outside provider confirming goal achievement, treatment progress, or risk reduction.

(6) *Criteria for evaluating treatment progress and risk reduction.* The FAP clinical service provider will assess progress in treatment and reduction of risk consistent with subpart B of this part. If a risk factor is not addressed within the FAP but is being addressed by a secondary clinical service provider, the FAP clinical service provider will ascertain the treatment progress or results in consultation with the secondary clinical service provider. Treatment progress should be assessed periodically using numerous sources, especially, but not limited to, the victim. In making contact with the victim and

in using the information, promoting victim safety is the priority. Progress in clinical treatment and risk reduction is indicated by a combination of:

(i) *Abuser behaviors and attitudes.* An abuser is demonstrating progress in treatment when, among other indicators, he or she:

(A) Demonstrates the ability for self-monitoring and assessment of his or her behavior.

(B) Is able to develop a relapse prevention plan.

(C) Is able to monitor signs of potential relapse.

(D) Has completed all treatment recommendations.

(ii) *Information from the victim and other relevant sources.* The abuser is demonstrating progress in treatment when the victim and other relevant sources of information state any one or combination of the following: That the abuser has:

(A) Ceased all domestic abuse.

(B) Reduced the frequency of non-violent abusive behavior.

(C) Reduced the severity of non-violent abusive behavior.

(D) Delayed the onset of abusive behavior.

(E) Demonstrated the use of improved relationship skills.

(iii) *Reduced ratings on risk assessment variables that are subject to change.* The abuser has successfully reduced risk when the assessment of his or her risk is rated at the level the Military Service has selected for case closure.

(e) *Personnel qualifications*—(1) *Minimum qualifications.* All personnel who conduct clinical assessments of and provide clinical treatment to domestic abusers must have these minimum qualifications:

(i) A master's or doctoral-level human service and/or mental health professional degree from an accredited university or college.

(ii) The highest license in a State or clinical license in good standing in a State that authorizes independent clinical practice.

(iii) 1 year of experience in domestic abuse and child abuse counseling or treatment.

(2) *Additional training.* All personnel who conduct clinical assessments of and/or provide clinical treatment to

domestic abusers must undergo this additional training:

(i) Within 6 months of employment, orientation into the military culture. This includes training in the Service rank structures and military protocol.

(ii) A minimum of 15 hours of continuing education units within every 2 years that are relevant to domestic abuse and child abuse. This includes, but is not limited to, continuing education in interviewing adult victims of domestic abuse, children, and domestic abusers, and conducting treatment groups.

(iii) Service FAP Managers must develop policies and procedures for continued education with clinical skills training that validates clinical competence, and not rely solely on didactic or computer disseminated training to meet continuing education requirements.

(f) *QA—(1) QA procedures.* The FAP Manager must ensure that clinical intervention undergoes these QA procedures:

(i) A quarterly peer review of a minimum of 10 percent of open clinical records that includes procedures for addressing any deficiencies with a corrective action plan

(ii) A quarterly administrative audit of a minimum of 10 percent of open records that includes procedures for addressing any deficiencies with a corrective action plan.

(2) *FAC responsibilities.* The installation FAC will analyze trends in risk management, develop appropriate agreements and community programs with relevant civilian agencies, promote military interagency collaboration, and monitor the implementation of such agreements and programs on a regular basis consistent with subpart B of this part.

(3) *Evaluation and accreditation review.* The installation domestic abuse treatment program will undergo evaluation and/or accreditation every 4 years, including an evaluation and/or accreditation of its coordinated community risk management program consistent with subpart B of this part.

PART 66—QUALIFICATION STANDARDS FOR ENLISTMENT, APPOINTMENT, AND INDUCTION

Sec.

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AUTHORITY: 10 U.S.C. 504, 505, 520, 532, 12102, 12201, and 12205.

SOURCE: 80 FR 16270, Mar. 27, 2015, unless otherwise noted.

§ 66.1 Purpose.

In accordance with the authority in DoD Directive 5124.02, “Under Secretary of Defense for Personnel and Readiness (USD(P&R))” (available at <http://www.dtic.mil/whs/directives/correspdf/512402p.pdf>), this part:

(a) Updates established policies and responsibilities for basic entrance qualification standards for enlistment, appointment, and induction into the Military Services and delegates the authority to specify certain standards to the Secretaries of the Military Departments.

(b) Establishes the standards for age, aptitude, citizenship, dependents, education, medical, character/conduct, physical fitness, and other disqualifying conditions, which are cause for non-qualification for military service. Other standards may be prescribed in the event of national emergency.

(c) Sets standards designed to ensure that individuals under consideration for enlistment, appointment, or induction are able to perform military duties successfully, and to select those who are the most trainable and adaptable to Service life.

§ 66.2 Applicability.

This part applies to:

(a) Office of the Secretary of Defense, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of