BY ORDER OF THE COMMANDER,
35TH FIGHTER WING

35 FW INSTRUCTION 40-301

11 APRIL 2003

Medical Command

FAMILY ADVOCACY PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFPD 40-3, Family Advocacy Program, and outlines the policies and procedures set forth in Air Force Instruction 40-301 Family Advocacy, for identification, protection, treatment and prevention of family maltreatment and of family members with exceptional needs. It assigns responsibilities and explains procedures for the management of the Family Advocacy Program (FAP). This instruction requires the identification of Air Force exceptional family members, mandates reporting of all incidents of family maltreatment by all base organizational units and active duty members. It outlines mandatory requirements of the Family Advocacy Committee (FAC), the Family Maltreatment Case Management Team (FMCMT), the Child Sexual Maltreatment Response Team (CSMRT) and the High Risk for Violence Response Team (HRVRT). This instruction applies to all active duty members assigned or associated with Misawa Air Base (AB), Japan.

This instruction requires collecting and maintaining information protected by the Privacy Act of 1974 authorized by 10 U.S.C. 8013 and E.O. 9397. System of records notice F168 AF SG B and Family Advocacy Program Record applies.

SUMMARY OF REVISIONS

This instruction was reaccomplished to conform to October 2002 revisions of the Family Advocacy Program Standards.

1. References.

1.1. AFI 40-301, Family Advocacy Program.

1.2. AFPD 40-3, Family Advocacy Program.

1.3. USAF July 1998 Family Advocacy Program Standards.

2. Responsibilities.

2.1. The installation commander has responsibility for implementing the Family Advocacy Program (FAP), ensuring program effectiveness, and gathering all necessary support.

2.2. The mission of the Misawa AB FAP is to promote the health and well being of military families, so as to maintain the readiness ability of the active duty member.

2.2.1. The Misawa AB FAP will provide a varied range of services including primary prevention services, secondary prevention services, the New Parent Support Program (NPSP) and assessment and treatment of child and spouse maltreatment.

2.2.2. The Misawa AB FAP will assist families having members with exceptional needs in locating and accessing necessary medical and educational services.

2.3. The Misawa AB FAP will work on a collaborative basis with community agencies to assist in providing services to families.

2.4. All military personnel and individuals affiliated with Misawa AB and its organizations and tenants will report all identified incidents of suspected or known child or spouse maltreatment to the FAP.

2.4.1. After-hours reports of child and spouse maltreatment will be taken by the Mental Health on-call provider through notification by the Security Forces Squadron (SFS) or the emergency room.

2.4.2. All active duty sponsors with family members having special medical and/or educational needs will be referred to and enrolled in the Special Needs Identification Program (SNIP)

3. Family Advocacy Committee (FAC).

3.1. The FAC will be chaired by the 35th Medical Group Commander (35 MDG/CC) and composed of the following members as listed in AFI 40-301: the installation Vice Commander (or designee), the Family Advocacy Officer (FAO), the Family Advocacy Outreach Manager (FAOM), the Family Support Center Director, the Staff Judge Advocate (35 FW/JA), the Chief or Deputy Chief of Personnel, the installation Chief of Security Police (of designee), the Air Force Office of Special Investigations (AFOSI) Detachment Commander, the installation Staff Chaplain, the Chief of Military Equal Opportunity (MEO), and the Directors of the Child Development Center and Youth Activities.

3.1.1. The FAC may add other members at the discretion of the chairperson.

3.2. The FAC will meet once a quarter or at the call of the chairperson to accomplish the following tasks.

3.2.1. Set policy and procedures for operating the FAP, based on this instruction and FAP standards.

3.2.2. Advocate to establish and improve services that promote healthy families.

3.2.3. Solicit the resources needed to successfully run the FAP.

3.2.4. Coordinate activities of different organizations that contribute to the FAP and identify resources and service delivery problems.

3.2.5. Review available data on families to identify at-risk groups requiring prevention services and to detect trends. Use findings to ensure that responsible programs are implemented.

3.2.6. Monitor training programs for FAP personnel.

3.2.7. Establish a cooperative working relationship with local community agency personnel.

3.2.8. Develop and maintain a directory of community resources.

3.2.9. Establish the FMCMT, the CSMRT and the HRVRT.

4. Family Maltreatment.

4.1. The Family Maltreatment component of the FAP provides identification, evaluation, and treatment services through a FMCMT. This team establishes and monitors family maltreatment program and services.

4.2. The FAO will chair the FMCMT, and membership will be composed of: the Family Advocacy Treatment Manager(s) (FATM), 35 FW/JA representative, 35 MDG representative (doctor, registered nurse or nurse practitioner), 35 SFS representative, a Chaplain, a Youth Services representative, an EDIS representative, a Mental Health Flight representative, a Family Support Center representative, a DoDDS representative, an AFOSI representative and a Naval Criminal Investigative Service (NCIS) representative.

4.2.1. The FMCMT will meet at least monthly or at the call of the chairperson to accomplish the following tasks.

4.2.2. Ensure all reports of suspected family maltreatment are investigated within 72 hours.

4.2.3. Establish procedures for the unit commander to follow in offering protective services to family members.

4.2.4. Determine the status of all cases.

4.2.5. Ensure the preparation and submission of appropriate forms to report maltreatment according to FAP standards.

4.2.6. Ensure the preparation and submission of required Department of Defense (DoD) forms and reports.

4.2.7. Identify family maltreatment trends, using available data on families.

4.2.8. Identify at-risk groups requiring prevention services.

4.2.9. Review all open family maltreatment cases at least quarterly to ensure that the case management plan is current; substantiated sexual abuse cases will be reviewed monthly.

4.2.10. Establish procedures for hospitalizing victims of family maltreatment when no alternatives are available.

4.2.11. Ensure the appropriate procedures are followed in cases of child sexual abuse and in cases with a high risk for violence.

4.3. When allegations of extra-familial maltreatment occur in DoD sanctioned youth or child care activities, the FAO will coordinate with the Medical Group and Wing Commander for consideration to request the Family Advocacy Command Assistance Team (FACAT).

4.4. Incidents of family maltreatment that result in death are classified as high interest. These cases will be handled with sensitivity to the family and others involved.

4.4.1. The 35 FW/CC, 35 MDG/CC and AFOSI will be notified immediately.

4.4.2. A FAP record will be opened in the name of the deceased. A FAP assessment will be conducted and services will be offered to the family.

4.4.3. If a death occurs in an open FAP maltreatment case, a review of the case will be conducted.

5. Child Sexual Maltreatment Response Team (CSMRT).

5.1. The CSMRT is a multidisciplinary team designed to effectively manage the initial response to child sexual maltreatment allegations.

5.2. The FAO is responsible for the family maltreatment component of the FAP and will serve as chair of the CSMRT.

5.2.1. Composition of the CSMRT will include a Family Advocacy clinician, OSI, Judge Advocate, 35 SFS representative and representatives from other agencies having legal, investigative or child protection responsibilities, when appropriate.

5.3. The CSMRT will be notified immediately when allegations of child sexual maltreatment occur. If this occurs during non-duty hours, the on-call provider handling the situation should ascertain that the CSMRT (AFOSI and Legal) have been notified and coordinate with AFOSI, who will be conducting the interview. The on-call provider's purpose is to assess the victim for risk and safety, but not conduct a thorough evaluation or interview of the alleged maltreatment.

5.4. Following notification of child sexual maltreatment suspicion, the FAO will initiate the CSMRT meeting. This meeting will occur in a timely manner not to exceed 72 hours. The purpose of the initial meeting will be to review the allegation, coordinate a course of action for the CSMRT and tend to the well being of the victims, their family, and the alleged offender.

5.5. The AFOSI will assess the allegation to determine the facts and circumstances of the alleged offense, which will either corroborate or refute the allegation. The AFOSI will ensure the alleged victim is interviewed if there is an investigation. The FAP may assist by providing an interviewer.

5.6. The FAO will be responsible for conducting a thorough safety and risk assessment and providing recommendations regarding care, providing clinical interviews as required, proper notification of base authorities, and ensuring proper documentation of all activities regarding the investigation.

5.7. The 35 FW/JA will provide victim/witness assistance to non-offending parents regarding procedures and disclosure of information through the Victim/Witness Assistance Program, AFI 51-201.

5.8. Appointed team members and their alternates will meet at least bi-annually to clarify roles and responsibilities and provide education regarding child sexual abuse and safety planning.

5.9. Members of the FAC and FMCMT will be trained a minimum of annually about the CSMRT.

6. High Risk for Violence Response Team (HRVRT).

6.1. The HRVRT is a multidisciplinary team designed to effectively manage potentially dangerous situations involving FAP clients when either: a) Members of a family unit may be in imminent danger of being harmed by other family members. Family members may include active duty, spouses, children, stepchildren, ex-spouses, or ex-stepparents, and b) Staff members may be in imminent danger of being harmed by a Family Advocacy client or former client.

6.2. The goals of the HRVRT are to use and coordinate FAP, Unit/Squadron/Wing command and community response to decrease the risk of violence to family members or FAP personnel.

6.3. The FAO is responsible for the family maltreatment component of the FAP and will serve as chair of the HRVRT.

6.3.1. The composition of HRVRT will include: the FAO (HRVRT Chairperson), the Family Advocacy staff member working with the family of concern, Squadron Commander, 35 SFS Commander (or designee), Staff Judge Advocate, Mental Health Provider, AFOSI representative, and representatives from other agencies having legal, investigative, or protective responsibilities, as appropriate (e.g., base housing, local police, etc.).

6.4. The FAO will be notified immediately when there is a threat of immediate harm to an individual within the FAP system. After duty hours, the on-call Mental Health provider will be notified.

6.5. Upon notification of suspicion of potential threat of harm by an individual(s), the FAO will activate the HRVRT. The HRVRT will assess the level of danger, then develop and implement a course of action to manage the risk. The FAC Chairperson will be notified and invited to attend the HRVRT meeting to oversee and give advice on any items requiring action.

6.6. The FAO/HRVRT will involve the threatened individual(s) in the safety planning process.

6.7. If the FAC chairperson or representative is unavailable for the HRVRT meeting, the FAO will report the HRVRT finding, plans, and activities to the next scheduled FAC and FMCMT.

6.8. Appointed team members and their alternates will meet at least bi-annually to clarify roles and responsibilities and provide education regarding family violence and safety planning.

6.9. Members of the FAC and FMCMT will be trained a minimum of annually about the HRVRT.

7. Special Needs Identification Program (SNIP).

7.1. The SNIP is designed to identify eligible DoD families with exceptional medical, dental, social services, or educational needs.

7.2. Referrals will be made to the SNIP when a need is identified by a medical provider, when an IEP is written by the school or when a special need is identified during an overseas clearance.

7.3. It is the responsibility of the active duty member to ensure enrollment in SNIP once an exceptional family member is identified.

7.4. Families identified as eligible for SNIP will be helped to obtain required services and ensured access to necessary services if reassigned.

8. The Outreach Program.

8.1. The Family Advocacy Outreach Program will be managed by the FAOM.

8.2. The FAOM will establish a working relationship with the installation and community agencies that provide services for military families, and will share information with these agencies about available community education and life skill training resources.

8.3. Conduct a yearly community outreach needs assessment.

8.4. Determine how to intervene in situations that may provoke family maltreatment.

8.5. Establish primary maltreatment prevention services.

8.6. Establish secondary maltreatment services for adults, teens, and children.

8.7. Develop an annual Outreach Program Management Plan with related activity plans.

8.8. Develop appropriate training programs for commanders and first sergeants, medical and dental staff, 35 SFS, AFOSI, Family Support Center staff, Child Development and Youth Services staffs, family home day care providers and other base helpers and volunteers.

8.9. Establish Outreach Program files, including forms and reports following HQ AFMOA/SGPS guidelines.

8.10. Develop a formal evaluation process to monitor outreach programs and resources.

9. New Parent Support Program (NPSP).

9.1. The NPSP will be managed by the Family Advocacy Nurse and Family Advocacy Treatment Manager.

9.2. Primary and secondary prevention services will be provided to first time parents and families with children age 0-3 years old.

9.3. Educational and informational/referral services will be provided to eligible clients.

9.4. Eligible clients who desire NPSP services will be seen during the initial prenatal orientation and shortly after discharge.

9.5. The program will comply with HQ AFMOA/SGPS guidelines regarding data collection and reporting of program activities.

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Commander