

**BY ORDER OF THE COMMANDER
HEADQUARTERS, 11TH WING**



**BOLLING AIR FORCE BASE
INSTRUCTION 40-1
20 NOVEMBER 2003**

Medical Services

FAMILY ADVOCACY PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements **AFI 40-301, 1 May 2002, Family Advocacy**, and it establishes the Bolling Air Force Base (BAFB) Family Advocacy Program (FAP). It explains policies and procedures for identification, treatment, and prevention of family maltreatment. It requires that all suspected reports of family maltreatment will be referred to the Bolling AFB FAP Office. It also requires that all family members identified, as having exceptional medical or educational conditions will be referred directly to the Special Needs Coordinator (SNC) at the Bolling AFB FAP Office. This instruction assigns responsibilities and explains procedures for the management of the FAP. It applies to all assigned and attached units and personnel in the National Capital Region and DoD civilian employees IAW the National Capital Region Family Advocacy Program Regional Consortium (FAP-RC) Memorandum of Agreement, April 2003.

SUMMARY OF REVISIONS

This document is substantially revised and must be completely reviewed.

1. Organizational Structure and Assigned Responsibilities.

- 1.1. The 11th Wing Commander's responsibilities.
 - 1.1.1. Ensures the implementation and management of the base FAP, ensuring program effectiveness and gathering all necessary support.
 - 1.1.2. Appoints the Commander, 11 MDG to administer and monitor the installation Family Advocacy Committee (FAC).
 - 1.1.3. Serves as a member of the FAC or delegates this responsibility to the 11 WG Vice Commander.

1.1.4. Ensures all incidents of suspected family maltreatment are reported to the Family Advocacy Officer and to AFOSI. Also ensures that the Special Needs Coordinator (SNC) has information about all family members with special medical or educational needs.

2. Family Advocacy Committee (FAC) responsibilities.

2.1. Have the Commander, 11 MDG, serve as chair of the installation FAC. The Commander, 11 MDG, may delegate this responsibility to the Chief of the Medical Staff. The FAC will be composed of the following:

- HQ 11 WG/CV
- HQ 11 WG/HC
- HQ 11WG/JA or designee
- Family Advocacy Officer (FAO)
- Family Advocacy Outreach Manager (FAOM)
- 11 MSS/CC
- 11 MSS/DPF
- 11 SFS/CC or designee
- Commander, Det 332/AFOSI
- 11 MSG
- Representative - First Sergeant Council

2.2. The FAC may invite representatives of local civilian Child Protection Services (CPS) agencies and other members at the discretion of the chairperson.

- 2.2.1. Set policy and procedures for establishing and operating its FAP and meet quarterly or at the chairperson's request.
- 2.2.2. Advocate establishing and improving services that promote healthy families.
- 2.2.3. Establish and periodically review the Base Youth Supervision Guidelines (see [Attachment 1](#)).
- 2.2.4. Solicit resources needed to successfully run the FAP.
- 2.2.5. Coordinate activities of different organizations that contribute to the FAP and identify resources and service delivery problems.
- 2.2.6. Monitor training programs for personnel having responsibilities in support of the FAP.
- 2.2.7. Establish a cooperative working relationship with base and local community agencies.
- 2.2.8. Ensure that all Memorandum of Understandings (MOU) necessary to implement the FAP are developed, maintained and reviewed periodically.
- 2.2.9. Develop and maintain a directory of community resources.

2.2.10. Establish the Family Maltreatment Case Management Team (FMCMT), Child Sexual Maltreatment Response Team (CSMRT), High Risk for Violence Response Team (HRVRT) and the Incident Status Determination Review (ISDR) Process.

2.2.11. Monitor the activities of the above management teams; review their policy recommendations and ensure their effectiveness.

3. Program Components.

3.1. Family Maltreatment Program.

3.1.1. Purpose. To identify, report, treat and prevent maltreatment of Air Force family members.

3.1.2. Family Maltreatment Case Management Team (FMCMT).

3.1.2.1. The FAO is responsible for the management of the Family Advocacy program and will serve as the chair of the FMCMT.

3.1.2.2. Composition of the FMCMT will be multi-disciplinary and determined by the FAC and members will be appointed in writing. Changes will be reflected in the FAC minutes. The FMCMT will meet at the call of the chairperson, but at least monthly.

3.1.3. FMCMT responsibilities.

3.1.3.1. Ensure preliminary risk, safety and psychosocial assessment of all family maltreatment cases.

3.1.3.2. Set up procedures for ensuring the safety of family maltreatment victims.

3.1.3.3. Review all referrals of family maltreatment, decide case status determinations and develop treatment plans, as appropriate.

3.1.3.4. Document case management team meetings and decisions. Refer to cases by the case number in the minutes.

3.1.3.5. Provide unit commanders with written findings and recommendations regarding case status, participation in treatment, administrative actions and other support of command actions.

3.1.3.6. Review each open, substantiated case at least quarterly, except child sexual abuse cases, which are reviewed monthly.

3.1.3.7. Refer to the FAC maltreatment cases and issues requiring action beyond the scope of the FMCMT.

3.1.4. Child Sexual Maltreatment Response Team (CSMRT).

3.1.4.1. Purpose. To manage initial response to child sexual maltreatment referrals where prosecution is possible, the alleged victim is in imminent danger of further maltreatment or there is a possibility of multiple victims and to minimize the number of investigative interviews and medical examinations to reduce the emotional trauma of the response process.

3.1.4.2. Composition of the CSMRT will be established by the FAC and will include:

- A Family Advocacy clinician (FAO or Family Advocacy Treatment Manager)
- A representative Air Force Office of Special Investigations (AFOSI)

- A representative Staff Judge Advocate (HQ 11 WG/JA). When appropriate, others included will be representative(s) from other agencies having legal, investigative or child protection responsibilities [e.g., local Child Protective Services, (CPS) representative]

3.1.5. CSMRT responsibilities.

3.1.5.1. Develop local policy and procedures to ensure the CSMRT is notified within 24 hours from the time an initial allegation of child sexual maltreatment is reported.

3.1.5.2. Meet within 48 hours after notification of alleged sexual maltreatment, but no later than 72 hours after. This may be accomplished telephonically or electronically.

3.1.5.3. Assess the allegation(s) and the risk of further maltreatment of the alleged victim(s).

3.1.5.4. Coordinate a course of action and begin implementation within 72 hours of notification.

3.1.5.5. Attend to the medical and mental health needs of the victim(s), his/her family and the alleged offender including the need of a medical assessment and/or medical treatment for the victim(s) as well as, the need of a mental health evaluation for the alleged victim(s) and/or the alleged offender.

3.1.5.6. To develop a strategy for interviewing the victim(s), including who will conduct the interview, what information needs to be gathered from the interview, where to conduct the interview and determine if the interview is to be videotaped or recorded.

3.1.5.7. The FAO is responsible for reporting the CSMRT findings to the FMCMT and appropriate key base personnel.

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

3.1.6.1. Purpose: To create an inter-agency response team for potentially dangerous situations where active duty and/or family members are at risk of being imminently harmed by other family members. These individuals include Family Advocacy Program (FAP) patients or referrals to FAP. The HRVRT is established by the Family Advocacy Committee (FAC) to identify all high risk and imminently dangerous FAP patients and also to plan and implement a course of action to ensure the safety of the potential victims. The FAO will report the HRVRT findings, plans and actions to the Family Maltreatment Case Management Team (FMCMT) and the FAC Chairperson.

3.1.6.2. Composition: HRVRT representatives will include the following:

- A Family Advocacy Clinician (Family Advocacy Officer or Family Advocacy Treatment Manager)

- Mental Health clinician

- Members of the Security Forces (11 SFS)

- Representative Air Force Office of Special Investigations (AFOSI)

- Representative Staff Judge Advocate (HQ 11 WG/JA). The service member's Squadron Commander or designee and other local agency representatives will be included in team case management, as appropriate.

3.1.7. HRVRT responsibilities.

3.1.7.1. Responsibilities: The HRVRT will develop local policies and procedures to ensure that the FAP clinician is notified when a potential threat of harm to an active duty member, a family member, or a FAP staff member exists. The HRVRT team members are responsible for reporting all incidents of suspected family high risk and imminently dangerous situations and/or persons.

3.1.7.2. The FAP clinician will activate the HRVRT (telephonically and/or by electronic mail) within 8 hours of the initial identification and reporting. The team will meet within 24 hours after notification to assess the level of danger and coordinate an inter-disciplinary intervention plan of action to manage the risk of family violence to a person(s) and to ensure safety to the threatened person(s). Coordination may be accomplished by telephone, electronic mail, or in person.

3.1.7.3. The FAP clinician will complete a comprehensive clinical evaluation within 72 hours to assess whether an individual is at risk for committing violence or harm to himself/herself or others where serious personal injury or death may result. The FAP clinician will discuss with HRVRT representatives the assessment of the identified at risk individual's ability to participate in the safety planning process. Also, whether a safety plan has already been formulated for the individual at another base and how well the individual and family have complied with the plan.

3.1.7.4. The SFS, AFOSI, and FAP will identify and notify to the HRVRT all persons who are at potentially high risk for harming family members. They will provide updated information on the organization's involvement as it relates to the HRVRT.

3.1.7.5. The JA representative will provide legal consultation on high-risk for violence situations where threats to harm have been made to family members or FAP staff. The representative will provide updated information about possible or pending UCMJ actions to the HRVRT.

3.1.7.6. The Family Advocacy Officer (FAO) will be responsible for reporting the HRVRT findings to the FAC and FMCMT.

3.1.8. Reporting procedures. All agencies, departments or individuals affiliated with Bolling AFB and the Pentagon must report all incidents of suspected or established family maltreatment directly to the Family Advocacy Office, Security Forces or AFOSI. All suspicions of child maltreatment must be reported to the appropriate civilian CPS agency. The base FAO is primarily responsible for coordinating and reporting abuse and neglect cases to civilian authorities. The FAO serves as the reporting liaison for military and civilian agencies. When the FAO is unavailable (e.g., TDY or on leave) base agencies will contact the Bolling Family Advocacy Treatment Manager (FATM) or Mental Health provider during duty hours, or the Malcolm Grow Medical Center Emergency Room at Andrews AFB, MD during non-duty hours.

3.1.9. Family Maltreatment Case Management. The Bolling AFB FAP will manage cases of Air Force (AF) families when the active duty member is assigned to the 11th Wing, to a Bolling AFB tenant, to the Pentagon, or to any organization in the National Capital Region serviced by the 11th Wing Military Personnel Flights (either at Bolling AFB or the Pentagon). In cases of dual military families, Bolling AFB FAP will manage the case when the primary offender is assigned to the 11th Wing, Bolling AFB or the Pentagon. AF members assigned to other bases will be managed by their assigned bases. Members of other Uniformed Services assigned to or residing on Bolling AFB will be referred to their local service FAP.

3.1.10. Medical Group (MDG) personnel responsibilities.

3.1.10.1. When treating a patient involved in an act of family maltreatment, make sure the patient is medically stable, with immediate referral to an appropriate medical center when there is a severe or life threatening injury.

3.1.10.2. Notify the FAO and the military member's commander or first sergeant of the patient's condition.

3.1.10.3. Contact the Commander, 11 MDG and the Family Advocacy Officer, in child maltreatment cases, if the parent refuses to hospitalize the child or take the child to an appropriate medical center for further assessment.

3.1.10.4. Be sensitive to the clues of possible spouse abuse trauma, especially when trauma is unexplained or inconsistent with the nature of the injury, and if spouse maltreatment is suspected.

3.1.10.5. Provide for necessary medical treatment and documentation of the injuries.

3.1.10.6. Notify the Special Needs Coordinator (SNC) of Air Force family members identified as having special medical or educational needs.

3.1.11. 11th Security Forces (SFS) responsibilities.

3.1.11.1. Officers responding to reported incidents of family maltreatment will ensure the safety of the individual involved. The officers responding should consult with the FAO to receive assistance in dealing with abusive or negligent families.

3.1.11.2. The 11th Security Forces Law Enforcement Desk will notify the FAO of all incidents involving suspected cases of maltreatment. A copy of the incident report will be made available to the FAO for inclusion in the FAP record. FAP staff may pick up reports on the following day from the 11 SFS/SFA.

3.1.11.3. The Law Enforcement Desk will contact the member's commander or first sergeant.

3.1.11.4. It is the FAO's responsibility to ensure a notification matrix for duty/non-duty hours is posted with the 11 SFS/SFO (Law Enforcement Desk).

3.1.12. Det 332, HQ AFOSI responsibilities.

3.1.12.1. The AFOSI Family Advocacy Program liaison will notify the FAO of all cases involving suspected or established family maltreatment that come to the attention of Detachment 332, HQ AFOSI, Bolling AFB, DC.

3.1.12.2. Notify the member's commander or first sergeant.

3.1.12.3. Personnel will notify the FAO when a Defense Criminal Investigation Index (DCII) reveals information regarding previous incidents involving the family in question.

3.1.12.4. Regional Forensic Consultant - AFOSI 33 Field Investigations Squadron (FIS) at Andrews AFB, MD will provide training upon request for medical personnel and child care center personnel to assist them in spotting injuries consistent with child abuse. Requests for training should be made to *AFOSI 33 FIS, Andrews AFB, MD*.

3.1.13. Commanders and First Sergeants responsibilities.

- 3.1.13.1. Coordinate with the FAO to provide a safe environment for the victim.
- 3.1.13.2. Exercise their authority over the member to provide an initial “cooling off” period if it is deemed necessary.
- 3.1.13.3. Report all families experiencing family maltreatment to the FAP office to arrange for therapeutic counseling and referral assistance as required.
- 3.1.13.4. Assess whether immediate contact with the Staff Judge Advocate’s office is necessary in a given situation. Coordinate with HQ 11 WG/JA on range of responses by the commander.
- 3.1.13.5. Refer unit member to FAP if the member’s family members have special medical or educational needs.

3.1.14. Community Agencies’ responsibilities.

- 3.1.14.1. Although the Bolling AFB FAP has no jurisdiction over civilian agencies, community agencies will be encouraged to notify the FAO or appropriate Child Protective Service of any incidents of child maltreatment involving military families connected with 11th Wing, Bolling AFB or the Pentagon that come to their attention.
- 3.1.14.2. The Bolling AFB FAP office will work on a collaborative basis with community agencies to assist in providing necessary service to military families experiencing family maltreatment.

3.2. Family Advocacy Prevention Program.

3.2.1. Purpose. The purpose of the Family Advocacy Prevention Program is to enhance mission and family readiness by reducing the number and severity of incidents of maltreatment through advocacy for nonviolent communities. Prevention services include: Outreach Program, New Parent Support Program, and Family Advocacy Strength-based Therapy (FAST) Services.

3.2.2. Outreach Program.

3.2.2.1. The Outreach Program is designed to enhance coping capacity within families that are at risk for family maltreatment, i.e. services designed to promote family wellness, maximize knowledge, skills and abilities and strengthen coping, adaptive and resilience skills. Types of primary prevention services include informational brochures, news articles and briefings, couple communication classes, parenting classes, stress management, playgroups and special family events. Types of secondary prevention services, designed for individuals and families who are “*at risk*” for family violence, include step-parenting workshops, and education, skills development, and support groups for single parents and teens.

3.2.2.2. The Family Advocacy Outreach Manager (FAOM) is the Family Advocacy Prevention team leader and will serve as the primary FAP representative on the Integrated Delivery System (IDS) Committee.

3.2.2.2.1. As a member of the IDS, the FAOM will:

3.2.2.2.1.1. Develop collaborative prevention programs with other agencies based on the military community’s current needs and ensures their implementation and presentation.

3.2.2.2.1.2. Design, develop, coordinate, deliver, and market primary and secondary

prevention programs that build on community assets, responds to current community needs, in collaboration with the IDS and FAP staff and ensure they are approved by the FAC.

3.2.2.2.2. FAOM will prioritize Outreach Program responsibilities in four main areas: Family Violence Education and Prevention Training; Outreach Program Management; Prevention Team Leadership; and IDS Community Collaboration.

3.2.2.2.3. The FAOM will implement community organization strategies in collaboration with the IDS and other key organizations and stakeholders and to increase awareness of family maltreatment, promote the family awareness program, to develop a collaborative plan for reducing risk factors within the community, identifying community strengths and facilitating program and community results that foster and to promote community resiliency.

3.2.3. New Parent Support Program (NPSP).

3.2.3.1. The New Parent Support Program is a home-based family maltreatment prevention program for military families, tailored to the installation's needs and circumstances. The NPSP utilizes universal services to address the prevention of maltreatment in military families during pregnancy and/or with children ages birth to three years. The NPSP is also designed to build healthy communities, and to enhance mission readiness.

3.2.3.2. The Family Advocacy Nurse (FAN) is a member of the multidisciplinary FAP team and is responsible for providing comprehensive home-based prevention services to families to prevent child and spouse maltreatment. The FAN will implement and manage the NPSP.

3.2.3.2.1. The FAN serves as a consultant to the FMCMT.

3.2.3.2.2. The FAN will provide home-based services that include education, support and anticipatory guidance in such areas as growth and development across the life span, nutrition, parenting, attachment/bonding, individual and family health related issues, family violence dynamics, problem solving, family communication skills and bereavement.

3.2.4. Family Advocacy Strength-based Therapy (FAST)

3.2.4.1. FAST services are secondary prevention counseling services designed to provide psychosocial assessments and therapeutic interventions to families at risk for maltreatment where there is no open maltreatment record and the family is not eligible for New Parent Support Program.

3.2.4.2. The FATM or the FAO may provide FAST services to active duty members and families only when the following conditions are met:

- The New Parent Support Program (NPSP) is fully supported by Treatment Managers, and after managing all maltreatment client services and all social work needs of NPSP clients, the FAO and/or FATM has space available to provide FAST services.
- FAST clients must be eligible beneficiaries, with priority to active duty members and their families.
- The family does not have an open maltreatment record and is not eligible for NPSP.

- As a result of a FAST services psychosocial assessment, the family is considered to be at risk for family maltreatment.

3.2.4.3. Referrals for FAST services may come from unit leadership, medical providers and personnel from other agencies or self-referral.

3.2.4.4. FAST services are voluntary. FAP staff will NOT encourage Commanders to direct clients to participate.

3.3. Guidance for Special Needs Identification

3.3.1. Purpose. The purpose of identifying family members with special needs is to identify the availability of medical and educational services required for family members prior to reassignment.

3.3.1.1. Special Need: A medical, psychological, or educational condition of a chronic nature, which requires the active management by a medical sub-specialty, or special education personnel.

3.3.2. The Special Needs Coordinator (SNC) is the action officer for Special Needs Identification and Assignment Coordination and is responsible for oversight of all functions and will serve as a member of the FAC.

3.3.3. If command information is known, the SNC must inform the gaining command section about the special needs with “high risk of harm to oneself or others” probability of incoming active duty member or his/her family member prior to expected date of arrival of said active duty member.

3.3.4. Procedures.

3.3.4.1. When a special need is identified in an active duty Air Force family member, the SNC will provide assistance to the sponsor and family in the special needs identification and assignment coordination process.

3.3.4.2. The SNC will assist family members in conducting:

- Assessments for “Q-code” identification.
- Family Member Relocation Clearances (FMRC) on AF Form 1466, *Request for Family Members and Education Clearance for Travel* and DD Form 2792, *Exceptional Family Member Medical & Educational Summary*.
- Facility Determination Inquiries (FDI).
- EFMP assignment issues.
- Information and Referral services to military and local communities.

WILLIAM A. CHAMBERS, Colonel, USAF
Commander

Attachment 1

BOLLING AFB YOUTH SUPERVISION GUIDELINES

Notes: The ages specified are based on the average child’s ability to demonstrate age-appropriate behavior. Children who do not consistently demonstrate age-appropriate behavior should not be given the same degree of self-management responsibilities. In all instances below where a “yes” is indicated, the parent is responsible for using reasonable judgment and for any incident or mishap (not considered preventable), which occurs.

Age Of Child	Left Without Sitter In Quarters for Two Hours or Less	Left Without Sitter in Quarters for More Than Two Hours	Left Alone Overnight	Outside Unattended During Daylight Hours (To Include Playing)	Left In Car Unattended	Child Sit Siblings	Child Sit Others
Newborn Through Age 4	No	No	No	No	No	No	No
Age 5 Through Age 6	No	No; except at age 6 may walk to and from school	No	Yes; playground or yard with immediate access (visual sight or hearing distance) to adult supervision***	No	No	No
Age 7 Through Age 9	No	No; except may walk to and from school	No	Yes; with access to adult supervision***	Yes; except in hot weather; keys removed and hand brake applied; 5 minutes maximum in hot weather, 15 in other weather, adult within sight	No	No

Age Of Child	Left Without Sitter In Quarters for Two Hours or Less	Left Without Sitter in Quarters for More Than Two Hours	Left Alone Overnight	During Daylight Hours (To Include Playing)	Left In Car Unattended	Child Sit Siblings	Child Sit Others
Age 10 Through Age 11	Yes; with ready access(phone number to anAdult supervision)*/**	No for 10 yrs olds; 11 yr olds only with access to adult assistance for no more than 2 hours	No	Yes	Yes; keys removed and hand brake applied	Yes for a short span of time; 11 years old or sixth grade minimum have the minimum amount of time of two (2) hours*/**	No
Age 12 Through Age 14	Yes	Yes during daytime hours before curfew; NO after curfew	No children 15 or freshmen in high school may be left Alone overnight; with access to adult supervision; sponsor must be in local area.***	Yes	Yes	Yes*	Yes** 12 years of age or 7 th grade minimum
Age 15 Through High School Graduation	Yes	Yes	Yes; minors age 16 and older may be left alone for short TDYs or leaves, not to exceed 5 consecutive days. These minors must have some type of adult supervision available to make periodic checks.	Yes	Yes	Yes**	Yes**

* Home-alone training by youth center or other source required

** Red Cross baby-sitting training or equivalent required

*** Adult supervision is defined as someone who has or assumes responsibility for the child, e.g., parent, guardian, care provider, friend