U.S. ARMY FAMILY ADVOCACY PROGRAM

CHILD ABUSE MANUAL

Case Management ❖ Assessment ❖ Treatment ❖ Follow-up

This material was developed for the U. S. Army Community and Family Support Center, Family Advocacy Program by staff of the Family Life Development Center in cooperation with Cornell Cooperative Extension, Cornell University, Ithaca, New York. The material is based upon work supported by the Extension Service, U. S. Department of Agriculture, under special project number 97-EXCA-3-0559.

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

MCHO-CL-H (608-18a)

MEMORANDUM FOR COMMANDERS, U.S. ARMY MEDCOM RMCS/MEDCENS/MEDDACS,
ATTN: CHIEF, SOCIAL WORK SERVICE

SUBJECT: Child Abuse Manual (CHAM)

1. In early l997, each Chief, Social Work Service (C, SWS) was provided a Spouse Abuse Manual (SPAM) for the management and case determination process in spouse abuse cases. Subsequently, copies were provided to each individual social worker and case manager.

2. Enclosed is the CHAM, companion piece to the SPAM.

3. Effective immediately, these manuals will be utilized in SWS for the assessment, presentation to the Case Review Committee (CRC), case management, and treatment of child/spouse abuse cases.

4. This is the final phase of our process of ongoing standardization of the Family Advocacy Program (FAP) service delivery in SWS. Compliance with this process will result in a reduced substantiated case load, while continuing to provide a focus on services to families in the earliest phases of domestic and child rearing problems. These manuals will also provide a consistency of process, visible and reassuring to client's commanders which should result in increased support in meeting the client's needs and in increased support to the FAP.

5. With the recent reduction in the Army's, and resultantly the MEDCOM's, FAP budget, it is essential that we manage effectively and efficiently and with maximum impact while using reduced resources. The use of the SPAM and CHAM will facilitate that accomplishment.

6. Our point of contact is Mary W. Behrend, Behavioral Health Division, Office of the Assistant Chief of Staff for Health Policy and Services, DSN 471-6767 or Commercial (210) 221-6767.

FOR THE COMMANDER:

JOHN S. PARKER
Brigadier General, MC
Deputy Chief of Staff for Operations,
Health Policy and Services

Encl

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
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FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

22 DEC 1995

MCHO-CL-H (608-18a)

MEMORANDUM FOR Commanders, MEDCOM HSSAs (Prov)/MEDCENs/MEDDACs

SUBJECT: Revised Protocol for Child Abuse and Neglect (PCAN), l995

1. Reference U.S. Army Health Services Command Pamphlet 608-1, Family Advocacy Program (FAP), 27 Jul 94.

2. Enclosed is the revised PCAN. The PCAN, required in Army Regulation (AR) 608-18, Army Family Advocacy Program, 1 Sep 95, was originally published in l988 with detailed introduction, instructions, samples and forms.

3. The revised version is designed to be a user friendly check list with instructions incorporated in the text. It also reflects more current knowledge of child sexual abuse and examinations.

4. This PCAN supersedes any other in use. Use of the PCAN is not an option. It is a legal/medical document designed to completely document medical findings and services. It provides a complete data base that will ensure adequate service delivery to child victims and prepare medical personnel to properly and completely testify in court or reply to an Inspector General Action Request or Congressional Inquiry.

5. Completed PCANs become part of both the child abuse/neglect case file and the medical file.

6. Pediatric Social Work Service and Emergency Room are to develop standing operating procedures for implementation upon receipt.

7. Thank you for your care of and concern for the most helpless and dependent of victims, our children.

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

MCJA 18 April 1995

MEMORANDUM FOR HUMAN RESOURCES MANAGEMENT DIVISION, ATTN: MRS. BEHREND

SUBJECT: Protocol for Child Abuse and Neglect (PCAN)

1. The following comments pertain to your revised Protocol for Child Abuse and Neglect.

2. I recommend including the Article 31 form. The general rule is that Article 31 warnings need not be given when a soldier is questioned for legitimate medical reasons. There are exceptions, however, and the proper scope of legitimate medical questioning is not clearly defined. Providing warnings has several advantages.

a. Failure to provide required warnings will almost always result in exclusion of that evidence at trial. Often statements by the accused are essential to the prosecution; losing a case is a high price to pay for failing to provide required warnings.

b. In child abuse cases, often fine lines are drawn by the courts concerning the requirement to provide warnings. In the absence of rights warnings, the soldier is almost certainly going to challenge the admissibility of any statements; this probably will result in one or more court appearances by the physician(s) and possibly other health care providers, involving substantial time of the physician(s), attorneys, and others.

c. As an example of the above, I mentioned United States v. Alexander, 18 M.J. 84 (CMA l984), in which a physician questioned a soldier suspected of child abuse without providing rights warnings, and subsequently a criminal investigator read that soldier his rights and questioned him. At trial, the soldier's defense counsel argued the statement to the investigator should have been excluded, because of the earlier unwarned statement to the physician. The Court of Military Appeals treated the statement to the physician as illegal but then found nothing in that interview incriminated the soldier or compelled him to make the later incriminating admissions to the criminal investigator. The point is the physician's failure to provide warnings resulted in needless litigation and the substantial risk of excluding critical evidence.

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INTRODUCTION

1.1 PURPOSE: To provide program guidance to implementing a standard comprehensive, quality child abuse treatment program in the U.S. Army for offenders and children who are abused, neglected, or who witnessed domestic violence.

1.2 References:

a. Public Law 93-247, Child Abuse Prevention and Treatment Act of l974.

b. Public Law 95-266, The Child Abuse Prevention and Treatment and Adoption Program Act of l978.

c. Public Law 97-291, Victim and Witness Protection Act of l982.

d. Public Law 101-647, Crime Control Act of l990.

e. Child Abuse Prevention and Treatment Act (re-authored l984).

f. Title 10, United States Code, Section 2683.

g. DOD Directive 6400.1, Family Advocacy Program.

h. DOD Directive 6400.2, Child and Spouse Abuse Report.

I. DOD Directive 6400.3, Family Advocacy Command Assistance Team.

j. AR 608-l8, The Army Family Advocacy Program.

1.3 **AR 608-I8:** This regulation establishes the Department of Army policy on the prevention, identification, reporting, investigation, and treatment of spouse and child abuse.

1.4 **MANUAL:** This manual addresses child abuse.

a. It is recognized that child and spouse abuse are often interrelated. Both may occur together or at different times in the same family. Children may be adversely affected by domestic violence.

b. Objectives include:

(1) Ensure safety of the victim. Short and long-term services are provided to protect victims and at-risk family members.

(2) Prevention of abuse. Prevention is addressed by providing services to both “at-risk” families and to victims of abuse, including the offender.

(3) Provision of clinical treatment and intervention services are combined to provide a comprehensive treatment program for both victims and offenders.

c. Concepts include:

(1) Assessment driven treatment and a comprehensive program are essential for prevention and treatment of child abuse.

(2) The offender is held responsible for his or her behavior. Responsibility includes realization that abuse is not acceptable behavior, a change in behavior is necessary and expected, intervention is required, and reparation for damages may be necessary.

(3) Coordinated systems approach is employed: Policies, procedures, and agencies work together to maximize the effectiveness of the program.

(4) Treatment and program administration are consistently evaluated to ensure program effectiveness.

FAMILY ADVOCACY PROGRAM: CHILD ABUSE

2.1 ARMY FAMILY PROGRAMS:

a. The Army is an institution, not an occupation or a job. As an institution, the Army has a moral and ethical obligation to those who serve and to their families. They in turn have responsibilities to the Army.

b. Families have an important impact on the Army's ability to accomplish its mission. A crucial human goal of the Army is to foster wholesome lives for military families and the communities in which they live.

c. There are a number of family programs which contribute to the wellness of the Army family. One such program as identified in AR 608-I8 is "The Army Family Advocacy Program (FAP)." The FAP is a vigorous proactive program designed to address child abuse and neglect and spouse abuse.

2.2 FAMILY ADVOCACY PROGRAM:

a. The primary goal of the FAP is to alleviate and prevent abuse by providing a variety of services to strengthen Army families and enhance their ability to adapt to military life. The aim of the FAP is to protect those who are victims of abuse, to treat families affected by abuse, and to assure the availability of highly trained professionals to intervene in spouse and child abuse cases.

b. Appropriate intervention requires coordinated actions by both the military and civilian community which are guided by:

(1) Multidisciplinary interventions based upon standards of practice and current research knowledge, which are designed to permanently stop violent and abusive behavior.

(2) Policies and procedures that create a collective, community-wide effort to help and assist families.

(3) Networking that joins the expertise, knowledge, and ability of all service providers into an effective response on behalf of victims and their families.

(4) Quality management procedures which assess the effectiveness of intervention and the consistency of service provider application of established policies and procedures.

(5) Securing and managing resources for victims that reduce their vulnerability to and dependence on abusers.

(6) Accountability for offenders that is based on sanctions and, where appropriate, rehabilitation.

(7) Provision of highly trained professionals to implement the program and to provide treatment.

CHILD ABUSE: DEFINITIONS

3.1 CHILD ABUSE PROGRAM OBJECTIVE:

a. Identify and assess possible victims of abuse.

b. Stop the abuse.

c. Coordinate with military and civilian agencies to ensure victim safety, long-term protection, and support.

d. Provide state-of-the-art intervention and treatment for children, offenders, and families.

e. Hold offenders accountable.

f. Apply system-wide policies and procedures.

g. Implement Quality Management procedures to ensure compliance with established practice and program standards.

3.2 FAMILY ADVOCACY PROGRAM-CHILD ABUSE: The following concepts embody the philosophical framework concerning child abuse.

a. Violence against children is unacceptable.

b. Violence is often a tactic used to maintain power and control.

c. Child abuse is a widespread social phenomenon. Early interventions may effectively break the cycle of violence. Most abusive behavior is learned, but may be ameliorated through an effective intervention program.

d. A soldier/parent who engages in child abuse cannot be considered a good soldier/parent. The soldier/parent is responsible and accountable for his or her abusive behavior, and this behavior is contrary to the CORE VALUES and standards for personal excellence in the Army.

e. Soldiers who commit multiple, subsequent incidents of abuse or who commit severe abuse will be recommended for administrative separation from active duty (see level 5 abuse in Appendix I and Chapter 5).

f. Victims of domestic violence have the right to take reasonable actions to protect themselves and to be protected from abuse.

g. The integrity and autonomy of the victim must be supported.

h. A consistent, coordinated team response is required in ALL incidents of child abuse.

i. Child abuse is a criminal act.

j. The rights of the alleged offender must be respected and preserved.

k. Child abuse is not caused by substance abuse.

l. Child abuse is not a “private” affair or strictly a family matter. It is a community issue and necessitates a community response.

m. The abused child does not cause the abuse or merit the abuse by behaving in ways that are unacceptable to the offender.

3.3 DEFINITIONS:

a. **TYPE OF VICTIM - CHILD:** An unmarried minor, whether a biological child, adopted child, foster child, stepchild, or ward of a military member or a civilian for whom treatment is authorized in a medical facility of the Military Services, who is under the age of 18 years or is incapable of self-support because of a mental or physical incapacity.

b. **CHILD PHYSICAL ABUSE:** A type of maltreatment that refers to physical acts that caused or may have caused physical injury to the victim. Includes injuries to a child such as brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, shaking or twisting of infants and young children, dislocations or sprains, internal injury, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts, or other physical injury that seriously impairs the health or physical well-being of the victim. Minor injuries include cuts,

bruises, or welts or other shaking or twisting incidents that do not result in injury that impairs the health or physical well-being of the victim.

c. **CHILD PROTECTIVE SERVICES**: Any state, local, or foreign department, agency, or office that provides child protective services to families affected by child abuse.

d. **CHILD SEXUAL ABUSE**: The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct) or the rape, molestation, prostitution, or other such forms of sexual exploitation of children, or incest with children. All sexual activity between an offender, male or female, regardless of age, and a child, when the offender is in a position of power over the child, whether in a caretaker role or not, is considered sexual abuse. The child victim should be considered for appropriate FAP services, if eligible.

e. IAW AR 608-18, Glossary, Section II, Terms, page 45, sexual maltreatment specifically includes but is not limited to the following (State law may provide additional grounds).

(1) Exploitation: Forcing a child to look at an offender's genitals, forcing a child to observe an offender's masturbatory activities, exposing of a child's genitals for gratification of the offender(s) sexual desires, talking to a child in a sexually explicit manner, surreptitious viewing of a child while undressed for the offender(s) sexual gratification, or involving a child in sexual activity such as pornography or prostitution in which the offender does not have direct physical contact with the child.

(2) Rape: Generally, any act of sexual intercourse between an offender and a female committed by force and without consent. Any penetration of the vagina, however slight, constitutes rape when done by force and without consent. Children of tender years who are not capable of understanding the nature of the act are not capable of giving consent. Force may be physical, mental coercion, or emotional manipulation.

(3) Carnal Knowledge: Sexual intercourse under circumstances not amounting to rape between an offender and a child who has not attained the legal age of consent (age 16 under the UCMJ). Any vaginal penetration, however slight, is sufficient to complete the offense. Ignorance of the child's age is not a defense.

(4) Sodomy: Unnatural carnal copulation with another person of the same or opposite sex or with an animal. It is unnatural carnal copulation for a person to take into that person's mouth or anus the sexual organ of another person or of an animal, or to place that person's sexual organ in the mouth or anus of another person or of an animal. Sodomy may be either consensual or forcible. Any penetration, however slight, is sufficient to complete the offense.

(5) Molestation/Indecent Acts: May include fondling or stroking of breasts or genitals, or attempted penetration of the child's vagina or rectum, either digitally or with an object.

(6) Incest: Sexually explicit activity identified above between a child and biological parent, step-parent, adoptive parent, a sibling, or other relative too closely related to be permitted by law to marry. Sexual abuse by familial caretakers (i.e., other live-in guardian) may sometimes be viewed clinically as incest depending on the specifics of the case.

(7) Other Sexual Maltreatment: Other sexual activity with a child, including encouraging another to engage in any of the above activities, encouraging or observing masturbation, taking sexually explicit photographs of a child, etc. May also include acting as a principal or accessory after the fact in any of the above listed activities.

f. **EMOTIONAL ABUSE**: Emotional abuse involves a pattern of active, intentional berating, disparaging, or other abusive behavior toward the victim that may not cause observable injury. Emotional neglect involves passive or passive-aggressive inattention to the victim's emotional needs, nurturing, or psychological well-being.

g. **EXTRAFAMILIAL ABUSE**: This category is applicable in cases of child abuse where the offender has no family relationship to the child. This may range from individuals living or visiting in the same residence who are unrelated to the victim by blood or marriage and are not cohabiting with the child's parent. This also includes individuals having out-of-home-care supervision of the child, such as school, child or family care personnel, volunteers, or other DOD sanctioned or operated activities, such as:

(1) Child Care Centers. Child development or child care services, nursery schools, preschools, or parent co-ops provided in a centralized facility. This does not include home-based child care.

(2) Family Child Care. Home-based child care provided on a regular or daily basis for compensation. This does not include an individual offering random, temporary baby-sitting service.

(3) School Personnel. Any staff member or volunteer in a public or private school.

(4) Youth Personnel. Any staff member or volunteer in a DOD sponsored or sanctioned program, service, or activity focused on youth, including but not limited to recreation, camps, scouting, clubs, and classes (outside the school system).

h. **Family Member**. An individual whose relationship to the sponsor authorizes entitlement to treatment in a medical facility of the Military Services.

i. **Foster Care**. A voluntary or court-mandated program that provides 24-hour care and supportive services in a family home or group facility for children who cannot be properly cared for by their own families.

j. **Foster Child**. A child other than the sponsor's child who resides in the sponsor's home and whose care, comfort, education, and upbringing have been entrusted to the sponsor by a court or a civilian agency or by a parent of the child on a temporary or permanent basis. A

foster child also includes a sponsor's child who has been placed in foster care by a local civilian authority.

k. **Guardian Ad Litem**. A guardian appointed by a court to represent the interests of a child in a child protective case. A guardian ad litem is considered an extension of the court and helps the court decide what is in the best interests of the child. The guardian ad litem may request evaluation and test of the parents and child to assist in the guardian's recommendations to the court.

l. **Installation**. A grouping of facilities, located in the same vicinity, which supports particular functions. Land and improvement permanently affixed there which are under the control of the Department of the Army and used by Army organizations. A military community in foreign countries may be equivalent to an installation.

m. **Legal Assistance Attorneys**. Army lawyers who advise and assist soldiers and their families on family law matters. Such matters include marriage, divorce, adoption, paternity, child custody problems, and financial support obligations. In the context of this regulation, a legal assistance attorney also includes a lawyer retained by a soldier or family member at his or her own expense to handle such legal matters.

n. **Medical Protective Custody**. Emergency medical care or custody of a child without parental consent that is approved by a medical treatment facility commander, in cases where the circumstances or condition of the child are such that continuing care of the child in the care or custody of the parents presents imminent danger to the child's life or health.

o. **Out-of-Home Child Abuse**. Child abuse that occurs in a DOD operated or sanctioned activity. The abuser has a care-taking responsibility or is another adult or child who is commonly present in that environment (e.g., custodial staff).

p. **Outreach**. A method of providing social services by reaching out to potential consumers rather than waiting for them to request assistance.

q. **Parent**. The father or mother of a child related by blood, a father or mother by marriage (step-parent), a father or mother of an adopted child (adoptive parent), a guardian, or any other person charged with a parent's rights, duties, and responsibilities.

r. **Report Point of Contact**. The person or location on the installation designed to receive all reports of spouse and child abuse and to notify the appropriate authorities with regard to such reports.

s. **Ward.** A child (other than the sponsor's child) or adult who resides in the sponsor's home whose care has been entrusted by a court (or voluntarily assumed by the sponsor) because of age or a physical, mental, or emotional disability.

t. **Youthful Sex Offender.** A child under the age of 18 years who commits any act of sexual abuse against any person, including another minor child, either against the victim's will,

through coercion or trickery, fraud, or in an exploitative or threatening manner. Sexual abuse generally may include but is not limited to the acts described under the definition of Child Sexual Abuse, even when applied to an adult. Children of tender years who are not capable of understanding the nature of the act cannot consent.

3.4 INDICATORS OF ABUSE - MILD, MODERATE, AND SEVERE: Some indicators of abuse include:

a. Mild Child Physical Abuse:

(1) Bruises on legs, arms, or buttocks not requiring medical treatment and confined to one area.

(2) Superficial welts, scratches, or abrasions.

(3) Hair pulling that does not remove hair.

(4) Minor physical injury or no medical treatment indicated.

b. Moderate Child Physical Abuse:

(1) Minor burns, blisters, or abrasions confined to a small area on child's arm or leg.

(2) Superficial injuries that are very widespread.

(3) Small cut requiring stitches.

(4) 2nd degree (moderately severe) burns.

(5) Sprains, mild concussions, broken teeth.

(6) Hair pulling that results in hair removal.

(7) Minor or major physical injury; short-term medical treatment (one visit) may be indicated.

c. Severe Child Physical Abuse:

(1) Extensive cuts requiring stitches.

(2) Head injuries.

(3) Internal injuries.

(4) 3rd degree burns to any area of the body.

(5) Minor burns to an extensive area of the body.

(6) Injuries resulting in impairment to sight, hearing, or mental abilities.

(7) Burns or bruises to the genital area.

(8) Extensive and multiple bruises in various states of healing indicating a pattern of abuse.

(9) Cuts, bruises, or abrasions on face, neck, or shoulders.

(10) Minor burns on face or abdomen.

(11) Any use of torture such as electric shock or burning with objects.

(12) Preventing a child from breathing for a short period of time.

(13) Administering to a child any harmful substance or any substance that results in harm to the child.

(14) Major physical injury requiring long-term medical treatment, inpatient care, or alternate placement.

(15) Death.

3.5 CHILD SEXUAL ABUSE:

a. Mild Child Sexual Abuse:

(1) Slight sexual innuendoes or provocative statements that are made to the child by a non-caretaker or caretaker.

(2) No physical contact, no readily apparent physical or emotional harm to child, no medical or mental health treatment indicated.

b. Moderate Child Sexual Abuse:

(1) Parent makes no effort to prevent the child from observing sexual behavior of others.

(2) Adult exposes him/herself to the child but ceases if child objects.

(3) Caretaker has fondled the child or touched the breast or genital area for other than hygienic purposes.

(4) Physical contact that does not involve oral, vaginal, or anal penetration or physical injury. Short-term mental health or medical treatment (one time) may be indicated. Significant verbal or physical maltreatment may have been part of the experience.

c. Severe Child Sexual Abuse:

(1) An adult or older child has engaged child in sexual intercourse, masturbation, or oral genital sex.

(2) Child has been engaged in physically dangerous or sadomasochist practices (even in the absence of intercourse).

(3) Child has been forced by an adult to engage in sexual activity with a child of the same age or younger or with an animal.

(4) Contact involves oral, vaginal, or anal penetration or physical injury. Long-term mental health or ongoing medical treatment may be indicated. Severe verbal threats or physical or emotional maltreatment may be present.

CHILD ABUSE PROCEDURES: STANDARD OF CARE GUIDELINES

4.1 STANDARD OF CARE GUIDELINES FOR CASE MANAGEMENT OF CHILD ABUSE

a. Table I (Table I is in Appendix A) summarizes the majority of the child abuse protocol. It illustrates the flow of procedures from start to finish. Included in the process is the implementation of quality management procedures and the Total Army Quality process (AR 5-1). The table refers to a number of appendices, which are found at the end of this manual. Each individual component of the table will be reviewed.

4.2 TABLE I: STANDARD OF CARE GUIDELINE FOR CASE MANAGEMENT OF CHILD ABUSE

a. The table introduces and stresses a number of assessment and treatment elements that have not been addressed or clearly articulated in regulations or pamphlets regarding child abuse. These elements include:

(1) Assessment drives treatment. Treatment should be based upon the needs of the victim and family as determined by the clinical assessment process. The availability or access to specific psycho-educational and clinical treatment resources should not be the determining factor in selecting a treatment plan. Assessment is absolutely critical to determining the level of abuse, developing a treatment plan, implementing treatment, and ensuring a successful outcome.

(2) The Comprehensive Accreditation Manual for Hospital developed by the Joint Commission on Accreditation of Healthcare Organizations requires that possible victims of abuse are identified and assessed using objective criteria (Assessment of Patients, Standard

1.8). The criteria must address physical assault, rape or other sexual molestation, domestic abuse, and abuse or neglect of elders and children. The evaluation process or assessment must prevent any action or question that could create false memories of abuse in the individual being assessed.

(3) The case manager is responsible for the proposed treatment plan, length of treatment, and the sequencing of treatment for the identified client(s). Sequencing involves moving from one treatment modality to another modality for the treatment of a specific identified problem. This may involve starting with education or individual therapy, then moving to group therapy and, finally, to family therapy.

(4) The case management model forms the foundation for intervention for the clinical portion of the child abuse program.

(5) Child abuse assessment may involve spouse abuse. Children who have witnessed domestic violence may need treatment intervention.

(6) Treatment is evaluated for efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, and efficiency. Administrative and clinical program components must be evaluated for continuous improvement by an established and on-going quality management program or process. Established programs and processes include Family Advocacy Program Standards and Self-Assessment Tool (DoD 6400.1-M), implementation of the Total Army Quality (TAQ) methodology to achieve continuous improvements (AR 5-l), Joint Commission on Accreditation of Healthcare Organizations standards, and quality management recommendations and procedures locally developed.

(7) Five levels of Child Abuse (degrees of severity) are employed to assist with designing a treatment plan and making recommendations to command (see Appendix I).

(8) During the formulation of the treatment plan, all psycho-educational and treatment options must be considered. Psycho-educational programs include extensive non-therapy services such as victim advocacy, parenting, blended families, communications, financial, conflict management, pre-marital counseling, substance abuse counseling, children who witness violence counseling, and victim advocate programs (See Appendix M.).

a. Table I is not totally inclusive of all child abuse functions identified in AR 608-l8. For example, the time required to perform certain functions is not identified.

DESCRIPTION OF EACH COMPONENT OF THE STANDARD OF CARE GUIDELINES FOR THE CASE MANAGEMENT OF CHILD ABUSE

5.1 NINE COMPONENTS:

a. The nine components of the standard of care guidelines for child abuse are identified below.

(1) Case Management Model.

(2) Incident Referral.

(3) Assessment.

(4) Formulation of Problem and Treatment Plan.

(5) CRC Case Presentation.

(6) Treatment.

(7) CRC Follow-up Case Presentation.

(8) Follow-up After Case Closure.

(9) Quality Management Procedures.

b. Each component will be discussed in detail on the following pages.

5.2 CASE MANAGEMENT MODEL-PRACTICE FUNCTIONS (See Appendix B):

a. The clinical case management model identifies generic direct practice functions. The model provides the foundation for the clinical delivery of social or behavioral services. Case management addresses the many needs of service delivery, such as: information gathering, assessment functions, problem identification, identification and coordination of services, treatment, comprehensive delivery of services to a vulnerable population, monitoring of services, and outcome evaluation.

b. The eight elements of the case management model are described below. A chart is provided (see Appendix B) with each element and a description of the intent, function, and skill components of each element.

(1) Interviewing and interviewing skills. Interviewing is the process which captures pertinent information from individuals. There are a number of interviewing skills which contribute to successful interviewing or data collection.

(2) Clinical assessment. The assessment process structures the collection of predetermined information which is essential for problem identification, safety plans, identifying levels of abuse, treatment formulation, predicting treatment outcome, treatment delivery, and follow-up. The assessment instrument is utilized for the collection of information to ensure that only the required information is collected to meet the objective of the assessment.

(3) Formulation of the problem. The collected predetermined information is brought together to form a case summary which addresses etiology, diagnosis, prognosis, and treatment needs. The information is tied together by clinical theory.

(4) Problem list. Each identified problem is documented. The problem list should include the identification of all problems, contributing secondary problems, the level of child abuse (level 1 to 5, see Appendix I), and the severity of the problems.

(5) Treatment plan. All identified problems will be on the treatment plan. A comprehensive treatment plan is developed for each identified problem. Each treatment plan should be congruent with the identified problem (the treatment plan treats the identified problem); the length of treatment, and how the treatment will be delivered or the phasing of treatment should be identified. For example, one identified problem may be treated or sequenced first with a 4 week class in human development, then with 16 weeks of individual therapy, then with 12 weeks of couple therapy, and finally with 10 weeks of family therapy for a total of 42 weeks of treatment. Justification must be provided for all identified problems that will be deferred.

(6) Treatment. The treatment plan is implemented as designed, and treatment is provided. Treatment is directed by the treatment plan. The treatment plan may be modified based upon recurring assessments. Treatment may also include contact by telephone to assess progress of the Treatment Plan or to determine recurring instances.

(7) Evaluation. The efficacy, appropriateness, availability, timeliness, effectiveness, continuity, and efficiency of the treatment process, as well as the safety of and the respect and caring for the victim and offender, are all evaluated during the entire evaluation and treatment process.

(8) Follow-up. After the case is closed, follow-up studies may be conducted to determine the short-term and long-term effectiveness of the treatment program. These follow-up studies are often referred to as "outcome studies."

5.3 INCIDENT REFERRAL:

a. Determine if victim is an eligible military medical beneficiary.

b. Determine if the referral qualifies as a Family Advocacy case.

c. Ensure that all reports of child abuse are assessed. Case determination cannot be made until an assessment is completed.

d. Complete Family Advocacy Intake MEDCOM Form 650-R (see Appendix C).

e. A Level II provider performs initial risk/safety assessment. Use the MEDCOM Form 664-R for this function (see Appendix D). Risk assessment pertains to two components, the first to a case manager making a decision, and second to a specific instrument used for the decision making process. The case manager must be highly competent and skilled to make risk assessment determinations. A case manager using an assessment instrument makes the risk assessment. The assessment instrument does not make a determination of risk. There are four basic approaches to risk assessment instruments, which are:

(1) Matrix approach that utilizes tables composed of factors to rate severity or risk of abuse. Each factor is given a risk score.

(2) Empirical predictor approach that identifies a set of risk factors which are predictive of abuse.

(3) Family assessment approach that consists of scales to assess abuse.

(4) Child at-risk approach that utilizes an ecological model and is centered on specific fields. These fields traditionally include child, parent, family, maltreatment, and intervention. Questions and rating scales are used to identify risk influences.

f. Ensure the safety of the victim/family and offender.

g. Make appropriate notifications (ER, MP, CID, CO, State, etc.).

5.4 ASSESSMENT:

a. Review all available/existing information from collateral organizations.

b. Interview all individuals involved in the incident.

c. Conduct social history (See Family Advocacy Program Social History MEDCOM Form 647-R-E, Appendix E).

d. Conduct psychosocial assessment (the psychosocial assessment may incorporate a social history.) (See Appendix F for examples of psychosocial assessments).

e. Conduct mental status examination; evaluate for suicide, homicide, ETOH/drugs, and weapons. Make appropriate referrals as necessary. The psychosocial assessment may consist of a mental status examination.

f. Conduct Risk Assessment (MEDCOM Form 665-R, Appendix D).

g. Review safety/protection plan with victim, offender, and/or non-offending parent/caregiver as appropriate (See Appendix G for examples of safety/protection plans).

h. Ensure a physician or other health care professional is available to examine all victims of alleged child abuse. Use MEDCOM Protocol For The Initial Identification, Assessment, and Disposition of Child Abuse (See Appendix H).

i. Review medical record of all family members, victim(s), and other child(ren) as indicated.

j. Query the Central Registry for previously substantiated abuse.

k. Evaluate medical history for Shaken Baby Impact Syndrome.

l. Assess psychological or physical harm of each child or children residing in the home.

m. Determine the level of abuse, from Levels 1 to 5, using the Child Abuse Matrix (See Appendix I). Chapter 6 discusses the Child Abuse Matrix.

n. Complete the FAP master problem list (MEDCOM Form 625).

o. Provide a signed copy of the CRC review process document to all clients whose cases will be presented to the CRC, and retain a copy for the clinical case record (See Appendix J).

5.5 FORMULATION OF PROBLEM AND TREATMENT PLAN:

a. Formulate etiology, diagnosis, prognosis, and treatment plan (See MEDCOM Form 626).

.

b. Intervention is problem based. Each identified problem will be adequately defined. This is essential, since a treatment plan is designed to address each problem statement.

c. Treatment plan based on problem formulation, problem list, identified level of abuse (Levels 1 to 5), and treatment planning guide (See appendix K and Chapter 7).

5.6 CRC CASE PRESENTATION:

a. All case presentations are in the same standardized format. See AR 608-l8, Section IX, figure B-l, entitled: "Family Advocacy Initial Case Presentation Format."

b. Company commander or civilian supervisor is invited, in writing, to attend the CRC case presentation.

c. Present the case to the CRC.

d. CRC approves/augments recommended treatment plan if case is substantiated.

e. Prepare and forward DA Form 2486 to PASBA.

f. CRC approves treatment for "at-risk" unsubstantiated cases. Per AR 608-18, the FAP will provide services to "at-risk" families who are vulnerable to the kinds of stresses that can lead to abuse. The purpose of the "at-risk" category is preventive in nature.

5.7 TREATMENT:

a. Implement treatment plan.

b. Case manager actively monitors the case from inception to closure.

c. Evaluate treatment outcome to include reevaluation of risk assessment.

d. Recommend case closure to the CRC. Only the CRC can close a case.

5.8 CRC FOLLOW-UP CASE PRESENTATION:

a. Standardized case review within 90 days (See AR 608-18, Appendix B, Section IX, figure B-2 entitled: "Family Advocacy Review Case Presentation Format").

b. CRC approval for case closure.

5.9 FOLLOW-UP AFTER CASE CLOSURE:

a. Evaluate treatment plan outcome.

b. Conduct relapse evaluation.

5.10 QUALITY MANAGEMENT PROCEDURES:

a. Utilize Family Advocacy Program Standards and Self-Assessment Tool (DoD 6400.1-M).

b. Utilize other program evaluation findings; for example:

(1) Implement quality management indicators to measure compliance and track clinical standards of care (outcome results).

(2) Implement quality management indicators to measure and track compliance to program administrative standards (process results).

(3) Implement Army Management Philosophy, dated 12 June l992, under AR 5-1 which establishes Total Army Quality (TAQ) procedures. The TAQ provides the methodology, tools, and techniques to perform the systematic analyses of organizations and work processes to achieve the requisite improvements.

(4) The Joint Commission on Accreditation of Healthcare Organizations establishes standards for response to child abuse, spouse abuse, and elder abuse.

LEVELS OF ABUSE

6.1 CHILD ABUSE MATRIX:

a. The Child Abuse Matrix (See Appendix I) identifies five levels of child abuse. The level of abuse is identified during the assessment phase. Each level of abuse is defined, and the risk for the victim is identified for each level. Each level of abuse provides guidance for:

(1) Determining the "intent" of intervention.

(2) Recommendations for "clinical intervention" or treatment planning for both the offender, victim(s), and family as applicable. Treatment planning is further delineated by the Treatment Planning Guide, which identifies the "type of treatment" for the offender and victim. The Treatment Planning Guide is discussed in Chapter 7 (See Appendix K).

(3) Command options or recommendations for intervention.

6.2 INCREMENTAL PROGRESSION:

a. Each level of abuse progresses incrementally from none (Level I) to severe, including death (Level 5). The risk for the victim increases incrementally from Level 1 through Level 5 as does the length of treatment and/or services victim, family, and offender.

b. Level 5 recommends intensive treatment for the victim, but may depart from traditional recommendations for the offender. Level 5 recommends treatment for the offender as appropriate. This may include referrals for treatment outside of the FAP. Command op-

tions for the offender may include prosecution under the military justice system and/or civilian court system and/or separation from the service. Command options for the victim include support and compliance with CRC recommendations to the maximum extent possible.

TREATMENT PLANNING GUIDE

7.1 TREATMENT GUIDELINE:

a. The Treatment Planning Guideline corresponds to Levels 1 to 5 of the Child Abuse Matrix.

b. The Treatment Planning Guideline recommends a combination of psycho-educational and treatment sessions for each level of abuse for the offender, victim, and/or other family members.

7.2 LENGTH OF TREATMENT AND SEQUENCING:

a. The identification, utilization, and length of psycho-educational classes are left to the discretion of the CRC. The psycho-educational classes and clinical interventions identified are not inclusive, but are only suggestive. The actual psycho-educational classes and/or interventions required would be based upon the assessment.

b. Recommended number of treatment sessions for each level of abuse is provided.

NOTES

Table 1: Standard of Care Guidelines for Case Management of Child Abuse

Reference: Chapter 4

APPENDIX A: STANDARD OF CARE GUIDELINES FOR CASE MANAGEMENT OF CHILD ABUSE

These standard of care guidelines for the case management of child abuse take the form of a checklist and include important reminders related to the case management process:

- ☑ Incident Referral
- ☑ Assessment
- ☑ Formulation of Problem and Treatment Plan
- ☑ CRC Case Presentation
- ☑ Treatment
- ☑ CRC Follow-up Case Presentation
- ☑ Follow-up After Case Closure
- ☑ Quality Management Procedures

NOTES

TABLE I: STANDARD OF CARE GUIDELINE FOR CASE MANAGEMENT OF CHILD ABUSE

1. CASE MANAGEMENT MODEL (See Appendix B):

a. Interviewing and interviewing skills.
b. Clinical assessment.
c. Formulation of problem.
d. Problem list.
e. Treatment plan.
f. Treatment.
g. Evaluation.
h. Follow-up.

2. INCIDENT REFERRAL	**YES**	**NO**	**N/A**
a. Eligible military beneficiary.			
b. Qualifies as a FAP case.			
c. All reports of child abuse are assessed.			
d. Complete Family Advocacy Intake information (See Appendix C: MEDCOM Form 650-R).			
e. Perform initial Risk/Safety assessment (See Appendix D).			
f. Ensure the safety of the victim/family/offender.			
g. Make appropriate notifications (ETC/MP/CID/CO, State, etc.).			
3. ASSESSMENT			
a. Review all available/existing information from collateral organizations.			
b. Interview all individuals involved in the incident.			
c. Conduct social history (See Appendix E).			
d. Conduct psychosocial assessment (See Appendix F).			
e. Conduct mental status exam; evaluate for suicide, homicide, ETOH/drugs, and weapons (make appropriate referrals as required).			
f. Conduct second Risk Assessment (MEDCOM Form 664-R, Appendix D).			
g. Review safety/protection plan (See Appendix G).			

3. ASSESSMENT, cont.	**YES**	**NO**	**N/A**
h. Request medical evaluation and conduct social work 5-part assessment (See Appendix H).			
i. Request physician review the victim's medical record for history of abuse.			
j. Query the Central Registry for prior substantiated cases of abuse.			
k. Evaluate history of head injury for Shaken Baby Syndrome.			
l. Assessment of psychological or physical harm of all family members residing in the home.			
m. Determine the Level of child abuse; from Level 1 to 5 (See Appendix I).			
n. Complete problem list.			
o. File signed CRC review process Information Paper (See Appendix J).			
4. FORMULATION OF PROBLEM AND TREATMENT PLAN			
a. Formulate the nature of the problem.			
b. Intervention problem based: Each identified problem adequately defined.			
c. Intervention is goal based: Each element of treatment plan addresses each identified problem.			
d. Develop treatment plan based on problem formulation, problem list, identified Level of abuse 1 to 5 (See Appendix I and Chapter 6), and treatment planning guide (See Appendix K and Chapter 7).			
5. CRC CASE PRESENTATION			
a. Standardized presentation (See AR 608-18, Section IX, figure B-1).			
b. Company commander or civilian supervisor notified in writing to attend CRC case presentation.			
c. CRC case presentation.			
d. CRC approves/augments treatment plan.			
e. Prepare and forward DA Form 2486 to PASBA.			
f. CRC approves treatment for "at-risk" unsubstantiated cases.			

6. TREATMENT	YES	NO	N/A
a. Implement treatment plan.			
b. The case manager actively monitors the case from inception to closure.			
c. Evaluate treatment outcome to include Risk Assessment.			
d. Recommend to the CRC case closure.			
7. CRC FOLLOW-UP CASE PRESENTATION			
a. Standardized case review within 90 days (AR 608-18, Section IX, figure B-2).			
b. CRC approval for case closure.			
8. FOLLOW-UP AFTER CASE CLOSURE			
a. Evaluate treatment plan efficiency.			
b. Relapse evaluation.			

NOTES

APPENDIX B: CASE MANAGEMENT MODEL

Case Management Model Chart

Reference: Chapter 5.2 b.

The Clinical Case Management Model addresses patient outreach and identification, individual and family assessment, problems, treatment planning, resource identification, linking of patients with services, advocacy, implementation of the treatment plan, and monitoring of treatment and evaluation. The following chart describes the intent, function, and components of:

- ☑ Interviewing and Interviewing Skills
- ☑ Clinical Assessment (Types)
- ☑ Formulation of the Problem
- ☑ Problem List
- ☑ Treatment Plan
- ☑ Treatment
- ☑ Evaluation
- ☑ Follow-up

	INTERVIEWING & INTERVIEWING SKILLS	CLINICAL ASSESSMENT (TYPES)	FORMULATION OF THE PROBLEM	PROBLEM LIST
INTENT	These skills are essential for data collection and treatment intervention.	Data "bits" are essential for problem etiology, prognosis, and planning.	Utilization of assessment "bits" and problem list to combine or integrate information into a comprehensive problem statement and contributing risk factors.	Identification of problems which will be used in problem formulation and treatment strategy.
COMPONENTS	a. Use of combined skills to collect required clinical assessment data. b. Use of rapport skills to establish therapeutic relationships. c. Use of combined skills in provision of treatment.	a. Collect data to identify nature and cause of problems. b. Differentiation of child abuse from Level 1 to Level 5. c. Diagnostic determination. d. Intervention data and treatment phasing data.	a. Conceptualize the nature of the presenting problem(s). b. Provide clarification of multiple "bits" of information and/or data.	a. Identification and statement of each problem. b. Identification and statement of contributing secondary problems. c. Identification of Level of child abuse from 1 to 5. d. Identification of various problem orders, such as: severity, phasing of treatment, and length of treatment. e. Identification of needed referrals or adjunct services.
FUNCTION	a. Interview control. b. Calibration. c. Validation. d. Congruency. e. Arousal control. f. Male/Female language. g. Metaphor construction. h. Mythology interpretation. i. Frames and language. j. Question construction. k. Disassociation procedures.	a. Crisis intervention. b. Risk assessment. c. Psychosocial assessment. d. Mental Status Exam. e. Social interaction. f. Medical assessment. g. Personality assessment. h. Vocational assessment. i. Stress Management. j. Developmental assessment. k. Motivational solution states.	a. Knowledge of professional literature. b. Knowledge of theories. c. Review all assessment data. d. Knowledge of specific treatment modalities, such as educational, individual, couple, marital, and family. e. Knowledge of child, adult, and family development.	None

TREATMENT PLAN	TREATMENT	EVALUATION	FOLLOW-UP
INTENT			
Development of a comprehensive treatment plan for each identified problem on the problem list.	Provision of appropriate treatment for identified problems.	Measurement of treatment progress and efficiency of a treatment regimen throughout the duration of the treatment process.	Measurement of the effectiveness of the treatment regimen after program completion.
COMPONENTS			
a. To guide the clinician throughout the duration of treatment. b. Adds structure to the treatment process. c. Might be predictive of the course of treatment. d. Helps guide the assignment of "homework."	a. To provide the service that will help the client.	a. To assess the degree of treatment success at the close of treatment.	a. To assess continuation of a violence free relationship.
FUNCTION			
a. Each identified problem has a corresponding treatment plan. b. Treatment plan is congruent with the identified problem(s). c. Length of treatment identified for each problem. d. Treatment phasing identified for each problem. Example for one problem: Human development—4 weeks; Individual therapy—16 weeks; Couple therapy—12 weeks; Family therapy—10 weeks.	a. Knowledge of therapies. b. Knowledge of purpose and limitation of each therapeutic modality. c. Qualified to provide treatment.	**MEASUREMENT TOOLS**: a. Statistical evaluation. b Milestones. c. Level of treatment change. d. Goals achieved. e. Contract compliance. f. Symptom reduction. g. Termination of specific behaviors. h. Achieved desired state. i. Resolved problem state. j. Emotional state in control. k. Attitudinal changes.	**MEASUREMENT TOOLS**: a. Written questionnaire. b. Telephone inquiries of both victims and offenders. c. Command consultation. d. Relapse evaluation.

NOTES

APPENDIX C: FAMILY ADVOCACY INTAKE

MEDCOM FORM 650-R

Reference: Chapter 5.3 d.

This section includes a copy of the MEDCOM Form 650-R.

NOTES

FAMILY ADVOCACY INTAKE

(Privacy act statement contained in case file folder. For use of this form see MEDCOM Pam 608-1)

Date: _____

SPONSOR Name *(Last, First, Middle Initial)*: _____ Age: _____ DOB _____

Grade: _____ Social Security Number: _____ Time in Service: _____

Branch of Service *(check one)*: ☐ USA ☐ USAF ☐ USN ☐ USMC ☐ USCG ☐ RESERVES ☐ OTHER

Status: ☐ ACTIVE DUTY ☐ RETIRED ☐ FAMILY MEMBER ☐ OTHER

Unit: _____

Duty Phone: _____ Commander's Name and Phone: _____

Home Address: _____ Home Phone: _____

ETS Date: _____ PCS Date: _____ DEROS Date: _____

Are you pending deployment? ☐ YES ☐ NO Race/Ethic Group _____

Are you enrolled in PRP? ☐ YES ☐ NO

SPOUSE Name *(Last, First, Middle Initial)*: _____ Age: _____ DOB _____

Grade: _____ Social Security Number: _____ Time in Service: _____

Branch of Service *(check one)*: ☐ USA ☐ USAF ☐ USN ☐ USMC ☐ USCG ☐ RESERVES ☐ OTHER

Status: ☐ ACTIVE DUTY ☐ RETIRED ☐ FAMILY MEMBER ☐ OTHER

Unit: _____

Work/Duty Phone: _____ Commander's Name and Phone: _____

Home Address: _____ Home Phone: _____

ETS Date: _____ PCS Date: _____ DEROS Date: _____

Are you pending deployment? ☐ YES ☐ NO Race/Ethic Group _____

Are you enrolled in PRP? ☐ YES ☐ NO

CHILDREN

	Name (Last, First, Middle initial)	SSN	Sex	Age & DOB	Race	School Grade	Living at Home YES	Living at Home NO
Child 1								
Child 2								
Child 3								
Child 4								
Child 5								

(Use additional sheet, if necessary)

List others living in the home (Aunt, Grandfather, etc): _____

FAMILY ADVOCACY INTAKE (CONTINUED)

CURRENT PROBLEMS

	YES	NO	NA
Child Abuse			
Spouse Abuse			
Financial			
Unit (Job)			
Child Care			
Recent Move			
Pending Move			
Loneliness/Isolation			
Pending Discharge			
Legal			
Physical Medical Problems			
Mental Health Problems			
Family Member Illness			
Family Disagreements			
Religious Differences			
Racial/Cultural Differences			
Death in the Family			
Infidelity			
Housing/Neighborhood Issues			
Alcohol/Drugs			
Sexual Problems			
Child Rearing Methods			
Suicide Attempts			
Criminal Problems			
EFMP			
UCMJ/Disciplinary Actions			

EXPERIENCE WITH COUNSELING

	YES	NO
Chaplains		
Alcohol/Drug		
School counselors		
Marriage and family counseling		
Social Work Service		
Community Mental Health		
Court Mandated counseling		
Child Protective Services		

MARITAL INFORMATION

What is your marital status? ☐ Single ☐ Divorced ☐ Widow/Widower ☐ Separated ☐ Married

Length of marriage _____ yrs

Number of previous marriages _____

Is spouse residing with you? ☐ YES ☐ NO

MEDICATIONS THAT YOU ARE CURRENTLY TAKING

_____ _____

_____ _____

_____ _____

BRIEFLY DESCRIBE WHY YOU ARE HERE

APPENDIX D: RISK/SAFETY ASSESSMENT

MEDCOM FORM 664-R

Reference: Chapter 5.3 e.
Chapter 5.4 f.

This section includes a copy of the MEDCOM Form 664-R.

NOTES

Child Abuse/Neglect Risk Assessment

For use of this form see MEDCOM Pam 608-1

RISK FACTORS	LOW (L)	MODERATE (M)	HIGH (H)	CODE
Severity of abuse	No medical treatment needed	Minor physical injury/treatment*	Major physical injury/hospital-ization*	
Timeliness of seeking medical care	Immediate	Delayed	Significantly delayed	
History of abuse/FAP history	No prior reports or injuries	Prior minor injuries*	Subsequent incidents with major injuries*	
Protection of child	Caretaker will protect children	Questions need to protect children	Will not protect children	
Fear of returning home	None	Some	Significant	
Sexual abuse	No evidence or allegation	Allegation with no evidence	Evidence of sexual abuse*	
Stress factors	None	Minimal	Multiple	
Evidence of neglect	None	Non-life threatening	Life threatening*	
Age	12 +	4 - 11	0 - 3	
Caretaker coping skills	Excellent	Adequate	Poor	
Caretaker substance use	None	Some use, non-contributing factor	Significant use, contributing factor	
Develop-mental & behavioral problems of the child	None	Documented but non-contributing	Documented and contributing	

COMMENTS: _____

DATE: _____

PT NAME: _____

SSN: _____

WORKER: _____

RECOMMENDATIONS:

INSTRUCTIONS

1. Use of this form in instances of child abuse/neglect assessment, and consultation with other professionals, will aid the interviewer in determining the immediate safety of the victim. This determination should be the basis for developing plans and options for the victim and any other children in the household. The safety of the child should always be the prime consideration. The Command must always be notified.

2. In making a determination and plans, consider the following:

a. Any "H" rating must be thoroughly evaluated to determine whether or not the child may be safely returned to the caretaker. If the child can not be returned to the caretaker, other appropriate options (foster care, shelter, confinement of the perpetrator) must be considered.

b. A majority of "M" ratings require additional assessment prior to making a disposition.

c. A majority of "L" ratings indicate there is little or no risk of maltreatment.

d. Items indicated by an "*" are defined in AR 608-18 and local SOPs.

3. Use the 'Comments' section to include the additional information that contributed to making a determination of risk.

4. Discuss any questions of interpretation of the Risk Assessment tool with the Chief Social Work Service, or immediate supervisor.

APPENDIX E: SOCIAL HISTORY [EXAMPLES]

MEDCOM FORM 647-R-E (MCHO) OCT 94

Reference: Chapter 5.4 c.

The following information, as a minimum, must be considered in the development of the social history during the intake/assessment process:

- ☑ Review and discuss intake forms with client(s).
- ☑ Identify the client(s) definition of the presenting problem.
- ☑ Identify and list current problem(s).
- ☑ Inquire about any sexual history/Incest/Rape (recent/past).
- ☑ Past or present history of violence - family and other.
- ☑ Current parent/child relationship(s).
- ☑ Use/abuse of substances (alcohol and drugs).
- ☑ Previous involvement with FAP/CPS.
- ☑ Check the PASBA Central Registry.
- ☑ History of personal or family mental illness:
  - Past and present.
  - Homicidal/suicidal ideation, threats, attempts, etc.
  - Use of psychotropic medication(s).
- ☑ Mental Status Examination
- ☑ Develop a problem list.
- ☑ Outline a treatment plan.

NOTES

FAMILY ADVOCACY PROGRAM (FAP) SOCIAL HISTORY
(See Privacy Act Statement - FAP Case File#____, TAB L)

Date:_____

Section I. Identifying Data:

A. Name of Sponsor _____

Social Security Number _____

Home Address _____

Home Phone Number _____

Duty Phone Number _____

Commander's Name _____

Level of Education _____

B. Name of Spouse _____

Social Security Number _____

Home Address _____

Home Phone Number _____

Work Phone Number _____

Employer's Name _____

Level of Education _____

C. The Presenting Problem as Identified by Each:

1. Husband: _____

2. Wife: _____

D. Referral Source: _____

E. Problem (Event) Identified by Referral Source_____

II. Current Problems:

	YES	NO
Financial	____	____
Unit (Job)	____	____
Child Care	____	____
Recent Move	____	____
Pending Move	____	____
Loneliness/Isolation	____	____
Pending Discharge	____	____
Legal	____	____
Medical	____	____
Family Disagreements	____	____
Religious Differences	____	____
Racial/Cultural Differences	____	____
Deaths in the Family	____	____
Infidelity	____	____

Explain any yes answer: _____

III. History of Violence in the Family, if any:

	YES	NO
1. Did you witness abuse as a child?	____	____
2. Were you abused as a child?	____	____
3. If you were abused, how?		
a. Physically	____	____
b. Sexually	____	____
c. Emotionally	____	____
d. Needs neglected	____	____

4. Have you had any previous involvement with the Family Advocacy Program or the Child Protective Services?

Explain any yes answer: _____

IV. Substance Use/Abuse:

	YES	NO
A. In the current family does anyone use/abuse alcohol/drugs?	____	____

Explain any yes answer: _____

	YES	NO
B. In the families of origin did anyone use/abuse alcohol/drugs?	____	____

Explain any yes answer: _____

V. History of Mental Illness (Include Suicide and Homicide Attempts):

VI. A Description of the Family of Origin (Include how discipline/punishment was handled. Also include their location and their contacts with our client's family):

Husband: _____

Wife: _____

VII. Past Marriages (reasons why they ended: divorce, why?; death, how?):

Husband: _____

Wife: _____

VIII. Description of the Current Family:

A. Husband_____ Date of Birth_____

Wife_____ Date of Birth_____

Date of Marriage_____

Length of Time Known Prior to Marriage_____

How they met_____

Current relationships (define how listed members relate. Include relationships of parents to each other and to <u>each</u> child in the family. Tell who is "in charge" and how):

B. Children	DOB	School

C. Answer the following questions:

	YES	NO
1. Were any of these children unplanned/unwanted?		
2. Do any of these children have medical problems?		
3. Are any of these children difficult or exceptional in any way?		
4. Are there any present special problems?		
5. Did marital relationship change after a child's birth?		

Explain any yes answer:

D. List any other persons in the household. Define their relationship and tell why they are in the household and how they affect it.

E. How is discipline administered and by whom?

F. How are problems solved?

G. How are emotions/feelings handled in the family? (Which emotions are expressed, by whom, when?)

H. What does each partner like/dislike about marriage?

I. What does each parent like/dislike about parenting?

J. Who does the family rely on for help with problems?

K. How is spare time spent?

L. Experience with counseling, if any:

	YES	NO
Chaplains	____	____
Alcohol/Drug	____	____
School counselors	____	____
Marriage and family counseling	____	____
Social work service	____	____
Community mental health	____	____
Court mandated counseling	____	____

Explain any yes answer:

IX. Areas of strength (Include what the clients believe and what you see, note the distinction.)

X. Geneogram (optional)

XI. Social worker description of each partner's affect (include how they present themselves, their cognitive functioning, their professed and displayed value system, their dependency roles, their ability to participate with peers, their willingness to participate in treatment:

Husband: _____

_____

_____

_____

_____

_____

Wife: _____

_____

_____

_____

_____

_____

_____

Signature of individual completing form

APPENDIX F: PSYCHOSOCIAL ASSESSMENT

- FORM DA 4700 (EAMC OP 540, 1 NOV 94)
- DOMESTIC VIOLENCE ASSESSMENT
- ASSESSMENT SCALE
- DOMESTIC VIOLENCE INITIAL ASSESSMENT
- SI: PART 1 & PART 2
- AI: PART 1 & PART 2

Reference: Chapter 5.4 d.

This section includes psychosocial assessments.

NOTES

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
FAMILY ADVOCACY PSYCHOSOCIAL ASSESSMENT SHEET	

SEX: Male/Female STATUS: Spouse or (NS/ND/SS/SD/AS/AD)
Natural/Step/Adopted

AGE:_____

SPONSOR'S NAME:_____ RANK:_____

SSN:_____ ACTIVE DUTY:_____ RETIRED:_____
MILITARY

BRANCH OF SERVICE:_____ UNIT:_____

_____

Referral Source:_____

Reason for Referral:_____

_____

History of Presenting Problem:_____

_____

_____

_____

_____

I. FAMILY/RELIGIOUS HISTORY:

Patient's Place of Birth:_____

Mother's Name:_____ Father's Name:_____

Parents Relationship:_____

Patient's Relationship w/each Parent:_____

Parents use of Discipline:_____

Experiences of Abuse/Neglect (Yes/No) If yes, explain_____

_____

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

*U.S. GPO: 1993-300-727/90365

_____

_____

If yes, how have you protected yourself?_____

Pregnancy History and Results:_____

_____

_____

Child/Children Relationship with Mother/Father:_____

_____

_____

Total Number of Children:_____1st Marriage_____2nd Marriage

Religious Preference:_____

Part Religion plays/played in Life:_____

_____

II. MEDICAL/PSYCHIATRIC HISTORY:

History of Psychiatric, Substance and Medical Illnesses:_____

_____

_____

List illnesses (Usual, Childhood, Major or Present):_____

_____

_____

Childhood diseases or developmental delays:_____

_____

Surgeries:_____

_____

Medications:_____

_____

III. DRUG/ALCOHOL HISTORY:

Use of Alcohol: In the Past? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

At Present? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

Use of Drugs: In the Past? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

At Present? (Yes/No) Type:_____

Frequency:_____ Quantity:_____

Any significant changes in usage pattern? (Yes/No) If yes, explain_____

_____

Age began using Drugs?_____ Alcohol?_____

Any Blackouts? Yes/No Flashbacks? Yes/No DWI's? Yes/No

Any treatment received for drug/alcohol usage? (Yes/No) If yes, please list_____

_____

Do you consider your drug/alcohol usage a problem? (Yes/No)

If yes, explain_____

IV. SCHOOL HISTORY:

Grade completed:_____ College_____ Technical_____

Describe School Performance and Behavior:_____

_____

_____

_____

Describe Relationships with Teachers and Peers:_____

_____

_____

Describe Maintenance of Friendships which began in School:_____

_____

_____

V. EMPLOYMENT HISTORY:

List last (3) Job Positions held (current to latest):

1)_____ 2)_____ 3)_____

Describe Performance on Jobs: 1)_____

_____

2)_____

_____

3)_____

Describe Relationships with Co-Workers/Employers:_____

_____

_____

_____

VI. MARITAL HISTORY:

Marital Status: _____Single _____Married _____Divorced
_____Separated _____Widow/Widower

Length of Marriage:_____Years _____Months

Number of Previous Marriages:_____

Is Spouse residing with you? _____Yes _____No

If **No** due to divorce or separation, discuss nature of problem in relationship:_____

_____

VII. LEGAL PROBLEMS:

List legal difficulties resulting in contact with law enforcement:_____

_____

_____

Dates of jail sentences served:_____

_____

List any present legal concerns:_____

_____

VIII. HOBBIES/SKILLS/INTEREST:

List hobbies enjoy doing:_____

_____

List any specialized skills:_____

_____

List hobbies/special skills that are of interest to you:_____

_____

IX. SUMMARY/RECOMMENDATIONS: **(FOR OFFICE USE ONLY)**

Client's Mental Status:_____

Suicidal/Homicidal Ideations: (Yes/No) If yes, explain_____

_____

_____

_____

Describe how client relates to session:_____

_____

_____

_____

Client’s strengths and problems:_____

_____

_____

_____

Recommendations:_____

_____

_____

_____

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	DOMESTIC VIOLENCE ASSESSMENT
INTRODUCTION	1st SGT POLICE INVOLVEMENT
	CHARGES PENDING COURT DATE
MARITAL HISTORY	DATE OF MARRIAGE # OF CHILDREN/AGES
	DATING BEHAVIOR
	EXPECTATIONS OF RELATIONSHIP
	MAJOR PROBLEMS & WAYS CONFLICTS WERE SOLVED
POWER/CONTROL ISSUES	ISOLATION
	FINANCES
	MALE PRIVILEGE (include housework/parenting)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	USE OF CHILDREN
	ANGER/INTIMIDATION (eg destroying property)
	EMOTIONAL/VERBAL
	THREATS
	SEXUAL
	PHYSICAL ABUSE: INDICATE FREQUENCY
	HIM HER HIM HER
	SLAPPING PUSHING
	PUNCHING CHOKING
	KICKING PULLING HAIR
	RESTRAINING OTHER
	WEAPONS: In House? Used during incident(s)?
	DESCRIBE FIRST EPISODE (INC. DATE)
	DESCRIBE WORST EPISODE

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	USE OF SHELTER/HOTEL/FAMILY/FRIENDS
	INJURIES
	MEDICAL ATTENTION
	NATURE OF SITUATION WHICH PRECIPITATES VIOLENCE (alcohol involvement?)
	INTENT/GOAL
	FEELING AT TIME OF VIOLENCE
	EFFECTS OF VIOLENCE ON:
	OFFENDER -
	VICTIM -
	OTHER -
	CURRENT STATUS OF RELATIONSHIP
	VIOLENCE IN PREVIOUS RELATIONSHIPS (Inc. fighting in school, bars)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical imprint)*

RECORDS MAINTAINED AT: ▶

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
FAMILY HISTORY	RAISED BY SIBLINGS
(of respondent)	PLACE IN FAMILY
	HOW PARENTS RESOLVED CONFLICTS (violence?)
	DISCIPLINE
	EMOTIONAL ABUSE
	PHYSICAL ABUSE
	SEXUAL ABUSE
	FAMILY HISTORY OF SUBSTANCE ABUSE
	FAMILY HISTORY OF MENTAL ILLNESS
INDIVIDUAL'S HISTORY	MENTAL HEALTH HISTORY
	FAMILY ADVOCACY HISTORY
	MARITAL COUNSELING
	CURRENT SUBSTANCE USE
	PREVIOUS ARRESTS

ASSESSMENT SCALE

Name_____ Case #_____ Date_____

Current Battery _____intimate _____non-intimate
_____family/household member
_____stranger

	Part 1	Part 2		Part 1	Part 2
Alcohol Scale	_____	_____	Socialization Scale	_____	_____

DIS Depression Scale _____ Beck Depression Score _____

---

support system? _____ separated from family? _____

military/combat experience? _____ weapons in house? _____

employment history? _____ stable _____ erratic
_____ unemployed (for _____ months/years)

Police Report?_____ Rap Sheet?_____ Victim's Report?_____

History of violence including violence in family of origin (include synopsis of criminal history)

_____
_____
_____
_____
_____

Interviewer's Comments (Clinical judgment):

_____
_____
_____
_____

recommend CD eval _____ recommend psych eval _____

ASSESSMENT

Intimate		Non-intimate	
high risk	_____	high risk	_____
medium risk	_____	medium risk	_____
low risk	_____	low risk	_____

DOMESTIC VIOLENCE INITIAL ASSESSMENT

Date: _____ Interviewer:_____ Case #: _____

In a domestic violence program before? yes _____ no _____

If yes: which program_____

when _____ length of program_____

completed yes _____ no _____

Name: _____ Sex _____
(last) (first) (middle)
Address:_____ City: _____ State: _____

Zip: _____ Home Phone:_____ SS#:_____

Age: _____ DOB:_____

Race: Black _____ White_____ Asian _____ American Indian _____Other_____

Hispanic? yes _____ no _____ Nationality: _____

With whom are you living?_____

Are you separated from your family?_____

Do you see your children?_____

If employed, Occupation:_____ Work ph_____

How long have you worked at this job? _____

How long did you hold last job? _____

What is the longest period you have worked at one job? _____

If unemployed, how long since last employment?_____

What is the highest grade you completed in school?_____

Have you been in the military? _____ in combat? _____

Length of service _____ Type of discharge _____

Keep weapons in the house? _____ How many? _____

Current health problems? _____

Current medications? _____

Current physician/therapist? _____

Emergency contact:_____

Victim's Name:_____

Address:_____City:_____State:_____

Zip:_____ Home Ph:_____Age: _____ DOB:_____

Race: Black_____ White_____ Asian_____ American Indian_____ Other_____

Hispanic? yes_____ no_____ Nationality:_____

Client's relationship to victim:_____

yrs in relationship:_____ # years married:_____

children in home _____ # children biological _____

Employed: yes_____ no_____ Work Phone:_____

What is highest grade victim completed:_____

Victim Advocate/Counselor involved? yes _____ no _____

Who? Spring shelter ____ Spring OR ____ SAO/VA ____ Other _____

LAW ENFORCEMENT INVOLVEMENT: TPD_____ HCSO_____ PCPD_____
TTPD_____ Other_____

Date of arrest_____ Police Report? _____ Rap Sheet? _____

Charges: felony_____ misdemeanor_____

COURT ACTION:

Judge:_____Court date:_____

Plea: Guilty_____ Not Guilty _____ No Contest _____

Disposition: Guilty _____ Not Guilty _____ No contest _____ Contin._____

Probation Officer:_____Phone:_____

HRS Worker:_____Phone:_____

Jail days served:_____ Fine paid: $_____ Term probation:_____mos

Conditions: Treatment_____ CD eval_____ Psych eval_____

Current Injunction for protection? yes_____ no_____

Date Issued:_____length_____

Conditions: FVIP_____ CD eval_____ Supervised Visitation_____
No Contact_____ Other_____

Mutual Injunction? yes_____ no_____

HISTORY OF ABUSE

	yes	no
Have you ever been to counseling for anger/abuse?	_____	_____
Have you ever had a chemical dependency evaluation?	_____	_____
Have you ever been to chemical dependency treatment?	_____	_____

If yes, where_____ when_____

Did you complete treatment? _____ _____

What do you see as the biggest problem in your current relationship?

Brief summary of incident that got you involved with the court (include use of weapon(s))

Was there violence in previous relationships? yes _____ no _____
If yes, please explain. (weapon?)

Worst violent incident you have been involved in in an intimate relationship. (weapon?)

Did you witness physical violence between your parents growing up?
yes _____ no _____ If yes, please explain.

What would you change about the way you were brought up?

Were your parents physically abusive with you? yes _____ no _____
If yes, please describe

How do you discipline your children?_____
Have you ever had fears of hurting your children? yes _____ no _____
If yes, please explain.

Depression Inventory

I. In the past month, have you been very sad or depressed or lost interest in things you used to like? _____
Did this sadness or depression last at least two weeks? _____

(if answer is no for either question, skip to question under the double line)

II. During the time you were depressed:

_____A. Did you lose your appetite for most of the time?
_____B. Did you lose two pounds or more a week?
_____C. Did you have trouble falling asleep, staying asleep or waking up too early in the morning?
_____D. Were you tired most of the time?
_____E. Were you restless and couldn't sit still?
_____F. Were you less interested in sex than usual?
_____G. Did you feel worthless or sinful or guilty?
_____H. Did you have trouble concentrating?
_____I. Did you think about death or suicide or did you want to die?

Have you ever considered suicide?_____ homicide?_____
If yes, do you have a plan? If yes, describe

Below are some examples of abuse. Please check or describe the abusive acts you have committed in this relationship.

1. Physical Abuse

type	yes	no	how often	comments
slapped	___	___	_____	_____
punched	___	___	_____	_____
choked	___	___	_____	_____
pulled hair	___	___	_____	_____
pushed	___	___	_____	_____
restrained	___	___	_____	_____
kicked	___	___	_____	_____
used a weapon	___	___	_____	_____
threw something at victim	___	___	_____	_____
pressured or forced sex	___	___	_____	_____
violent sex attacked breasts or genitals	___	___	_____	_____
stabbed	___	___	_____	_____
shot	___	___	_____	_____
tried to drown or smother	___	___	_____	_____
other	___	___	_____	_____

2. Intimidation (frightened victim by certain looks, gestures, actions, smashing things, destroying property, displaying weapons...is victim afraid of you?)

3. Emotional Abuse (put downs, name calling, humiliation, trying to make victim feel guilty)

4. Isolation (keep victim from going where he/she chooses, listen to phone conversations, check whereabouts, open mail, follow)

5. Minimizing, Denying, Blaming (making light of abuse, saying it didn't happen, saying it's the victim's fault)

6. Using Children (Instilling guilt about children, using visitation to harass victim, threatening to take children away)

7. Male Privilege (treating victim like servant, acting like "the king of the castle", making all the big decisions)

8. Economic Abuse (prevent victim from working outside the home, making him/her ask for money, not letting victim know family income, taking victim's money)

9. Coercion and Threats (threats to take away children, to harm victim or family or friends, to report to HRS, to destroy property, to make victim do something illegal, threats to commit suicide)

10. Violence against Others (including children and including violence against same sex). Have you used a weapon such as a club, tire iron, stick, knife etc?

_____

Prior Arrests/Convictions:

Date	Charge (Note whether felony or misdemeanor)	Disposition

Have you been in jail? _____ How many times? _____

What were the lengths of time?_____

Have you been in prison? _____ How many times? _____

What were the lengths of time?_____

Interviewer comments: (Include impressions about potential lethality, and possible problems)

_____

_____

_____

_____

_____

_____

Interviewer (print or type name) signature date

SI: Part 1

The following are some questions about your life as a child.

_____1. Did your teacher(s) feel that you could do better in grade school?
_____2. Were you ever suspended or expelled from school?
_____3. Did you ever play hooky from school at least five times in a year?
_____4. Did you ever start fights in school?
_____5. Did you ever run away from home overnight at least twice?
_____6. Did you tell a lot of lies when you were a child?
_____7. When you were a child, did you steal things from other children or from stores or from your parents?
_____8. Did you ever try to damage someone's car or property?
_____9. Were you ever arrested as a child or sent to juvenile court?
_____10. Before you were 15, did you get drunk more than once?
_____11. Did you use drugs more than once before you were 15?
_____12. Did you have sex before you were 15?

SI: Part 2
The following are some questions about your life after age 18.

_____1. Have you ever been arrested for anything other than traffic violations?
_____2. Have you ever been convicted of a felony?
_____3. Have you ever been paid for having sex with somebody?
_____4. Have you ever made money finding customers for prostitutes?
_____5. Have you ever made money outside the law?
_____6. Have you ever been sued for a bad debt or had anything repossessed because you were not making payments?
_____7. Have you been divorced more than once?
_____8. When you were married, did you separate more than once?
_____9. Have you had sex with as many as ten people within one year?
_____10. Have you ever been the first to throw something at your spouse or intimate friend more than once?
_____11. Have you ever spanked a child hard enough to bruise the child?
_____12. Other than your spouse or intimate friend, have you ever hit anybody?
_____13. Since you were 18, have you had three or more jobs within a five year period of time?
_____14. Have you ever quit a job before you had another job lined up three or more times?
_____15. On any job you've had since age 18, were you late or absent at least three times in a month?
_____16. Have you ever used an alias?
_____17. Have you ever bummed around for over a month without having a job or a regular place to live?
_____18. Have you ever been without a home for over a month?
_____19. Have you ever been arrested for drunk driving or had an auto accident while drinking?
_____20. In your whole life have you had more than three traffic tickets?

AI: Part 1

_____1. Has your family ever said that you were drinking too much?
_____2. Have your friends, your doctor, your nurse or counselor or your clergyman ever said that you were drinking too much?
_____3. Have you ever had problems at school or on the job because of your drinking?
_____4. Did you ever get kicked out of school or lose a job because of your drinking?
_____5. Did you ever get arrested for drunk driving or have an auto accident because you were drunk?
_____6. Have you ever been arrested for disturbing the peace while you were drinking?
_____7. Have you ever gotten into physical fights while you were drinking?

AI: Part 2

_____1. Have you ever drunk as much as three six-packs of beer or three bottles of wine or one fifth of liquor in one day?
_____2. Have you ever wanted to stop drinking, but could not?
_____3. Have you ever made rules for yourself to control your drinking?
_____4. Have you ever had a blackout while drinking so that the next day you could not remember what you said or did?
_____5. Have you ever gone on benders that lasted at least a couple of days?
_____6. Have you ever kept drinking when you had a serious illness which would be made worse while drinking?
_____7. Has there been a time in your life when you had to have a drink so you could do your ordinary work?

APPENDIX G: SAFETY PLAN [EXAMPLES]

Reference: Chapter 5.4 g.

It is important to discuss safety issues and develop a safety plan. Consider the following.

- ☑ When you are working with a child abuse victim, it is important to develop a safety plan with the non-offending parent, with the offender, and/or care taker.
- ☑ A referral to Child Protective Services **MUST** be made and military and/or civilian police notified.
- ☑ Notify the sponsor's commander.
- ☑ Inform the non-offending family member that, in an emergency, he or she can call 911, the local Child Protective Service number, or the DoD Hot line at 1-800-336-4592.
- ☑ Does she or he have friends or family with whom she or he could stay?
- ☑ Assess the need for out-of-home placement (i.e., shelter, foster care, and/or family support group).
- ☑ Provide information on shelters and emergency services to access at a later date.
- ☑ Are there conditions that limit his or her ability to seek help in a crisis situation? If so, consider alternatives (e.g., LifeLine, telephone reassurance, etc.).
- ☑ Does the victim and non-offending parent have disabilities that require assistance? Give referrals for alternative care providers, if needed.
- ☑ Does the victim or non-offending parent want counseling to help cope with victimization?

See examples of safety/protection plans that are on the following pages.

G.1 SAMPLE SAFETY PLAN

A safety plan, or protection plan, is a tool to help you identify possible ways to protect yourself and your children. The protection plan will give you an awareness of your personal and community resources. Also, it will help you to identify the signs and situations that may precede a violent episode.

We know from research and experience that violence repeats itself and gets worse. We will feel more comfortable working with you after we know that you have a plan to help you get to a safe place if you anticipate or experience your partner's violence again. Answering the following questions will help with that plan.

1. What are some cues, behaviors, or circumstances that have happened before an abusive situation in the past? (i.e. time of day, chemical use, discussion about money, locations, relatives visiting, stress level of partner, etc.)

2. What kinds of things have you tried to protect yourself and your children in the past?

3. Have any of the methods worked?

4. What people or organization can you turn to for help? (Look up the numbers and write them down.)

5. Are you familiar with the legal protection available to you? They are:

6. Are you familiar with the medical services available to you? They are:

It is a good idea to keep a bag of clothes for you and your children packed in case you need to leave quickly. Can you have some money tucked away? You might need the following papers, so have them packed and bring them with you if you can:

- Birth certificates
- Social security numbers
- Any divorce papers or legal action

If I am in a situation where I am afraid violence will occur or is occurring towards me or my children, *I know that the following options are available to me:*

- Relatives or friends I can call for support and/or for a safe place to stay:
- The phone number for the shelter for battered women where I can stay in safety and get other support and help is:
- I can call the police at 911.
- The address and phone number to get an order for protection are:
- One other thing I can do is:

Signed

Intake Person

Note: This can be done in person or over the phone. If done in person, keep a copy for the women's file. If done over the phone, have her pick it up or send it to a *safe place* where she can pick it up.

G.2 PROTECTION PLAN

The objective of our program is to prevent future violence. We know from research and experience that violence repeats itself and gets worse. We believe that the violence is not your fault and you neither cause nor deserve it. Now is the time to plan what to do if there is further violence. A protection plan gives you a way to protect yourself and your children, both by using personal and community resources and becoming aware of signs.

****

1. CUES: SITUATIONAL:

MY CUES	HIS CUES
PHYSICAL: How does your body register stress? (head, face, shoulders, back, digestive system...)	PHYSICAL: When he is under stress or is escalating:
EMOTIONS you experience under stress or in danger.	ACTIONS/BEHAVIORS:
SELF-TALK: What you think and say to yourself.	RED-FLAG WORDS: Things he says when he's escalating:

FANTASY: What things do you imagine or wish happening to you or him?

BEHAVIORS/ACTIONS which you have done in the past to keep yourself safe:

****

2. RESOURCES: Who are the people and to what organization can you turn for help?

Personal: Friends
Family
Neighbors

Legal: _____ for an Order for Protection in _____ County.
_____ Advocate at _____in _____ County.

Shelter:

Medical: Hospital Emergency Services: 911

Crisis #

G.3 SAFETY PLAN

Name:
Case # _____

A Safety (Protection) Plan is a tool to help you identify possible ways to protect yourself and/or your children. The Plan will give you an awareness of personal and community resources. Also it will help you to identify the signs and situation that may precede a violent episode.

We know from research and experience that violence repeats itself and gets worse. We will feel more comfortable working with you after we know you have a plan to help you get to a safe place if you anticipate or experience your partner's violence again. Answering the following questions will help with that plan.

1. What are some cues, behaviors, or circumstances that have happened before an abusive situation in the past? (For example, time of day, alcohol/drug use, money problems, relatives visiting, stress level of partner.)

2. Partner's behavior when angry: (For example, yells, becomes withdrawn, change in facial expression, wrings hands, paces, leaves the room, throws objects, gets close to me, clenches fists. Other.)

3. What people or organization(s) can you turn to for help?
   Relatives_____ Friends_____ Shelter_____ Military_____

4. What kinds of things can you do to protect yourself and/or your children?

5. Are you familiar with the legal protection available to you? Yes_____ No_____
   You can call the police at 911
   You can get an Order of Protection at:

   Thurston County Courthouse
   2000 Lakeridge Drive
   Olympia, WA
   Phone: 752-2500

   Pierce County/City Building
   930 Tacoma Ave. S, Room 108
   Tacoma, WA
   Phone: 592-7455

6. Given Domestic Violence Services pamphlet.

_____
Signed Date

_____
Social Worker (Assistant) Date

APPENDIX H: PROTOCOL FOR THE INITIAL IDENTIFICATION, ASSESSMENT, AND DISPOSITION OF CHILD ABUSE

MEDCOM OP 6-R
MEDCOM 562-R
DA Form 3881

Reference: Chapter 5.4 h.

H.1 Purpose: To establish standardized guidelines and procedures for the initial identification, assessment, and disposition of child abuse cases.

H.2 Definition: Includes physical injury, sexual maltreatment, emotional maltreatment, deprivation of necessities, or combinations of abuse of a child by an individual responsible for the child's welfare under circumstances indicating that the child's welfare is harmed or threatened. The term encompasses both acts and omissions on the part of a responsible person. A "child" is a person under the age of 18 years of age for whom a parent, guardian, foster parent, caretaker, employee of a residential facility, or any staff person providing out-of-home care is legally responsible. The term "child" means a natural child, adopted child, step-child, foster child, or ward. The term also includes an individual of any age who is incapable of self-support because of a mental or physical incapacity and for whom treatment in an MTF is authorized.

H.3 Evidence:

a. Treat all information as forensic evidence.

b. Photographs will be taken as soon after the injuries as possible and, again, 30 hours after the incident.

c. Maintain custody chain-of-evidence IAW standard police chain-of-custody procedures.

H.4 Indicators of Possible Child Abuse:

a. Repeated medical treatment or emergency room visits for physical injury with inadequate, inconsistent, or evasive explanation of injuries.

b. Child threatened or injured with a weapon or other device such as a belt, electrical cord, hairbrush, etc.

c. Unexplained fractures, coma, apnea, repeated toxic ingestion.

d. Chronic neglect involves inattention to the child's minimal needs for nurturing, food, clothing, shelter, medical care, dental care, safety, or education.

e. Unexplained failure to thrive.

f. Child sexual abuse; i.e., any genital trauma, vaginal bleeding, rectal trauma, sexually transmitted diseases, or when a child expresses a history of sexual activity or knowledge of explicit sexual activity beyond what would be expected for the child's chronological age.

H.5 Communicating With the Victim, Alleged Offender, and Family Member:

a. Ensure privacy and confidentiality when interviewing victims and family members.

b. Be empathetic and nonjudgmental.

c. Ask open-ended questions.

d. See Appendix L for additional information.

H.6 Medical History and Physical Examination (check and document).

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: **CHILD ABUSE AND NEGLECT PHYSICAL EXAM** *(For use of this form see MEDCOM Pam 608-1)*	OTSG APPROVED *(Date)*

I. PATIENT IDENTIFICATION DATA

1. Patient's Name *(Last, First, MI):*

2. Patients Date Of Birth:	Sex: MALE ☐ FEMALE ☐

3. Patient's Home Address:	Phone Number:

4. Sponsor's Name:	Marital Status:

5. Sponsor's Social Security Number:

6. Sponsor's Rank/Branch of Service:

7. Sponsor's Military Organization *(Unit)*:

8. Sponsor's Home Address:

9. Spouse's Name:

10. Spouse's Social Security Number:

11. On Post Housing: YES ☐ NO ☐	12. Sponsor's Phone Number: Home:	Duty/Work:

13. Other Children/Adults Living in Home.

NAME	AGE

14. Type of Alleged Maltreatment:

PHYSICAL ☐ SEXUAL ☐ EMOTIONAL ☐ NEGLECT ☐

15. Date of Incident	Date Incident Reported	16. Who Brought Patient in for Examination:

17. Alleged Perpetrator *(Last, First, MI):*

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	☐ HISTORY/PHYSICAL ☐ FLOW CHART ☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify) ☐ DIAGNOSTIC STUDIES ☐ TREATMENT

II. PHYSICAL EXAMINATION *(Check the appropriate box and comment(s), including description)*	
1. GENERAL APPEARANCE	
	a. Within normal limits:
	b. Clothes dirty or inappropriate for climate:
	c. Appears malnourished:
	d. Height: / %
	e. Weight: / %
	f. OFC: / %
	g. Evidence of limp/pain moving:
	h. Withdrawn:
	i. Poor Hygiene:
	j. Other/Comment:
2. HEAD - GENERAL *(Diagram on page 6)*	
	a. Within normal limits:
	b. Shape
	c. Absent hair patches:
	d. Bruises *(Describe age, number, pattern):*
	e. Abrasions:
	f. Lacerations:
	g. Palpable deformities or swelling
	h. Other/Comment:
3. EARS *(Diagram on page 6)*	
	a. Within normal limits:
	b. Hemotympanum:
	c. Ruptured tympanic membrane:
	d. Battles sign:
	e. Injury to pinna/cauliflower ear:
	f. Other/Comment:
4. NOSE *(Diagram on page 6)*	
	a. Within normal limits:
	b. Blood in nares:
	c. Displaced septum:
	d. Bruises/Abrasions
	e. Other/Comment:
5. EYES *(Diagram on page 6)*	
	a. Within normal limits:
	b. Scleral hemorrhage:
	c. Blue Sclera:
	d. Retinal hemorrhage/detachment:
	e. Displaced lens:
	f. Blood in anterior chamber:
	g. Pupils unequal/nonreactive:
	h. Black eyes:
	i. Abnormal EOM:
	j. Other/Comment:
6. MOUTH/THROAT *(Diagram on page 6)*	
	a. Within normal limits:
	b. Torn frenula:
	c. Lacerations - cheeks/lips/gums/tongue:
	d. Loose/broken teeth:
	e. Severe caries:

	6. MOUTH/THROAT (Cont) *(Diagram on page 6)*
	f. Mandibular tenderness, displacement, swelling:
	g. Hematoma inner cheeks:
	h. Other/Comment:
	7. FACE - GENERAL *(Diagram on page 6)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):
	c. Other/Comment:
	8. NECK *(Diagram on page 6)*
	a. Within normal limits:
	b. External Trauma (bruises, abrasions, burns, lacerations):
	c. Choking marks:
	d. Stiff neck:
	e. Other/Comment:
	9. CHEST *(Diagram on page 7)*
	a. Within normal limits:
	b. External Trauma (bruises, abrasions, burns, lacerations):
	c. Unequal breath sounds (hemothorx/penumothorax):
	d. Muffled heart tones (pericardial tampanade/effusion):
	e. Bruises/bite marks on breasts:
	f. Trauma to axillae:
	g. Evidence of rib tenderness/fractures, swelling, deformity:
	h. Other/Comment:
	10. ABDOMEN *(Diagram on page 7)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):
	c. Abdominal tenderness/rebound tenderness/masses:
	d. Protuberant abdomen of malnutrition (abdominal distention or protuberance):
	e. Guiac positive stools:
	f. Absent bowel sounds (Splenomegaly, hepatemegaly):
	g. Other/Comment:
	11. BACK *(Diagram on page 7)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):
	c. Spinal tenderness
	d. Costo vetebral tenderness:
	e. Splinting of back muscles (muscle spasm):
	f. Other/Comment:
	12. EXTREMITIES *(Diagram on page 8)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):

12. EXTREMITIES (Cont) *(Diagram on page 8)*	
	c. Deformities (fractures/periosteal elevation):
	d. Joint Swelling:
	e. Limited range of motion of joint(s):
	f. Localized tenderness:
	g. Other/Comment:

13. NEUROLOGIC	
	a. Within normal limits:
	b. Focal neurologic signs:
	c. Cranial nerve dysfunction:
	d. Nonresponsiveness to pain:
	e. Mental Status:
	f. Cranial nerves:
	g. Reflexes:
	h. Motor strength:
	i. Coordination:
	j. Sensory system:
	k. Cerebellar functions:
	l. Other/Comment:

14. SKIN *(Use diagrams on pages 7 & 8)*

Describe bruises, abrasions, burns, lacerations *(i.e., location, age, number, pattern...etc.)*:

15. LABORATORY

Yes	No	REQUESTED
		a. PTT:
		b. PT:
		c. Platelets:
		d. CBC:
		e. Other:

16. X-RAYS *(Use diagrams on page 9 & 10)*		
Yes	No	REQUESTED
		a. Long Bones:
		b. Skull:
		c. Ribs:
		d. Other:

Yes	No	17. BONE SCAN *(Use diagrams on page 9 & 10)*

18. PHOTOGRAPHS TAKEN BY:

19. REFERRAL TO CHILD PROTECTIVE SERVICES MADE BY:

III. GENITAL/ANAL EXAM FOR SUSPECTED SEXUAL ABUSE *(Check the appropriate area) (Use diagram on page 11)*

Define genital examination techniques in the space provided below:

** NOTE: The use of a colposcope is restricted to only those pediatricians/physicians who have been fully trained in the use of this instrument on children who have been sexually abused.

	LABIA	INTROITUS	VAGINA	CERVIX	PERINEUM	ANUS	PENIS	SCROTUM
a. Within normal limits								
b. Not examined								
c. Bruises/Bites								
d. Redness								
e. Swelling								
f. Abrasions								
g. Lacerations								
h. Blood								
i. Discharge								
j. Scars								
k. Burns								
l. Giac positive stool								
m. Foreign bodies								

n. Other (Describe):

Approximate size of hymenal opening:

Type of measurement: ☐ Visual estimate ☐ Tape measure

☐ Other (Describe):

Anal Tone: ☐ Normal ☐ Lax ☐ Spasm

☐ Other (Describe):

Tanner stages of sexual maturity:

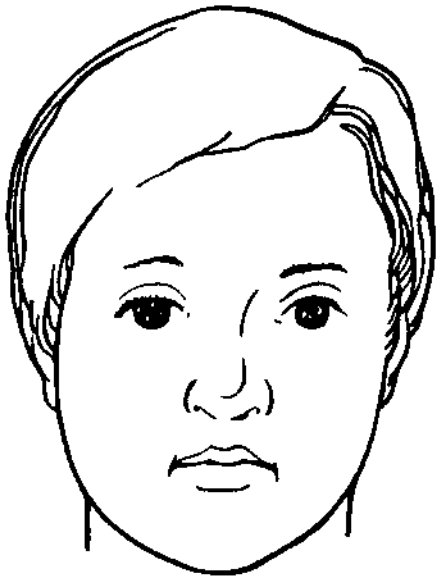
Breast: Pubic Hair: Penis/testes:

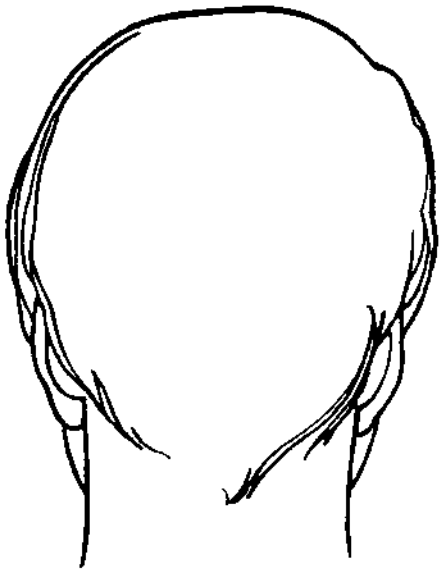
Colposcope used for visual exam: ☐ Yes ☐ No | Colposcope photographs taken: ☐ Yes ☐ No

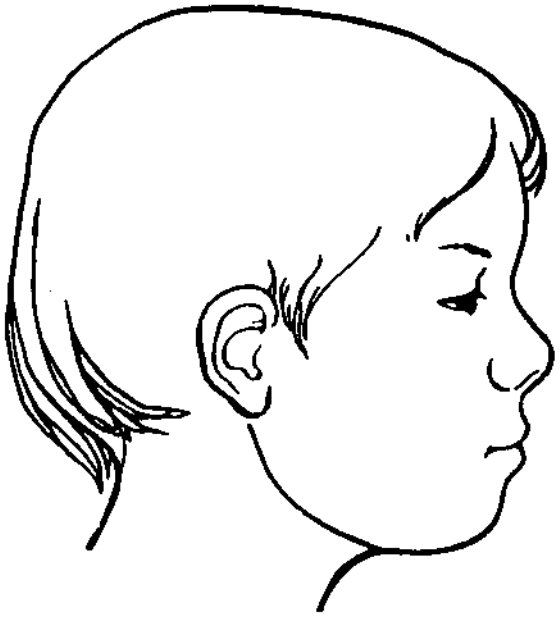
MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

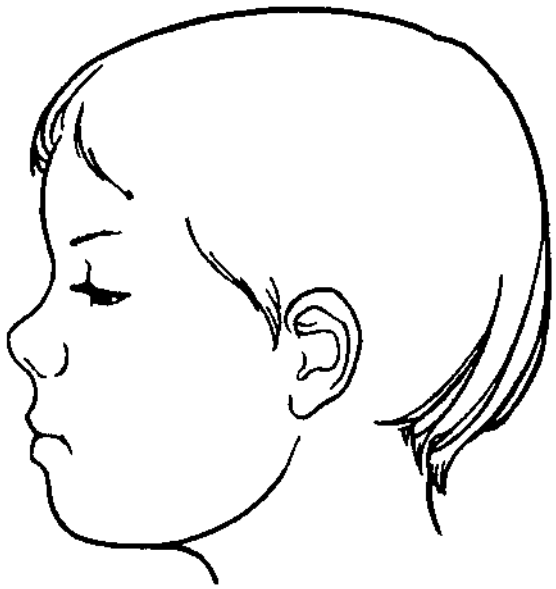
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	DTSG APPROVED *(Date)*









PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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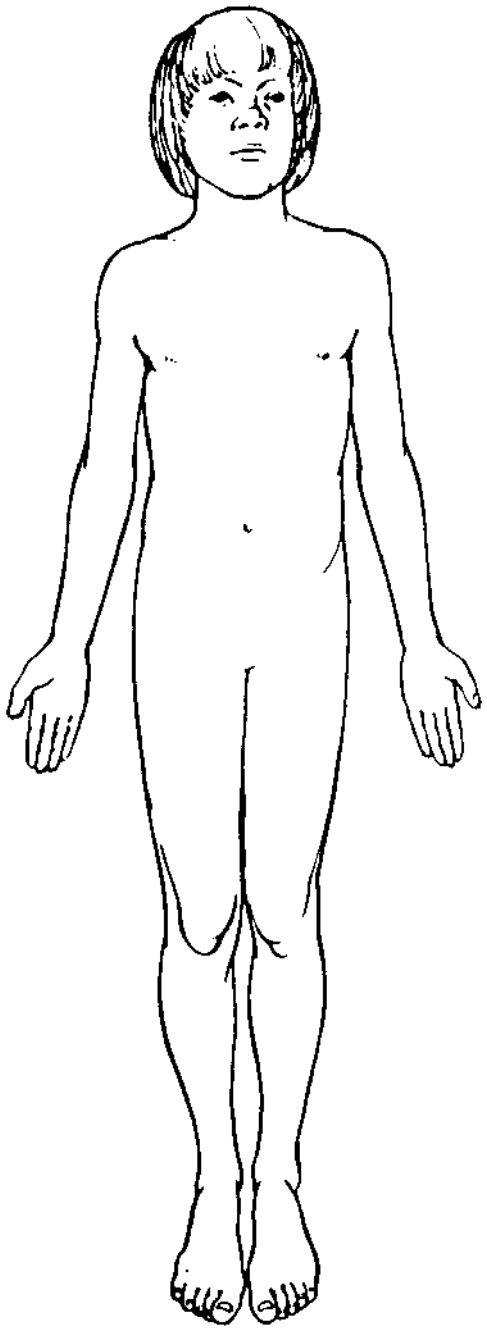

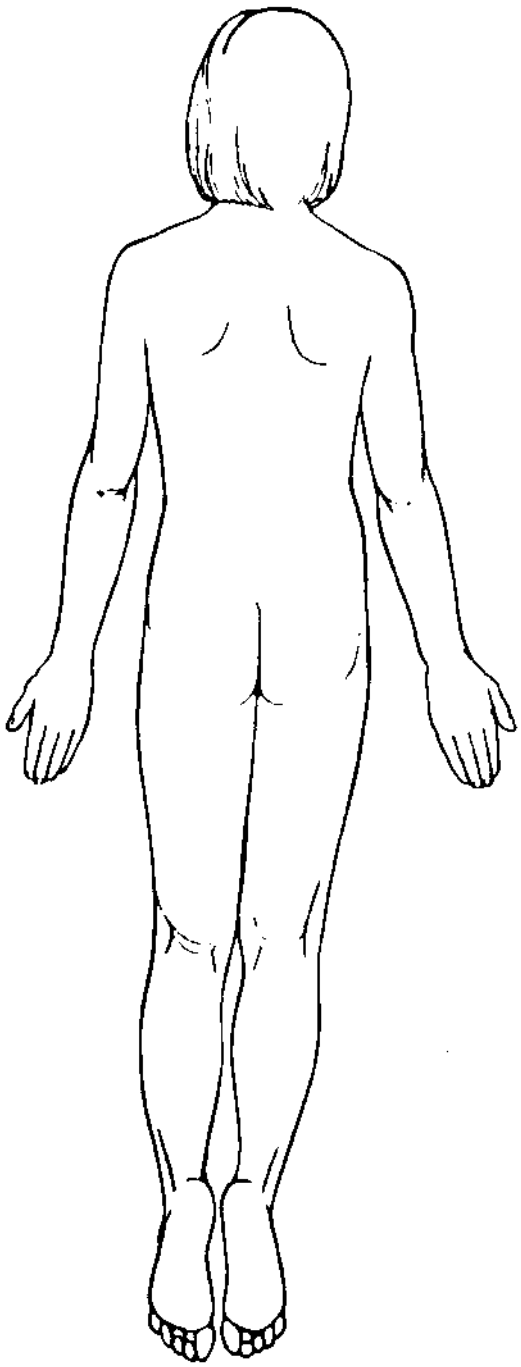

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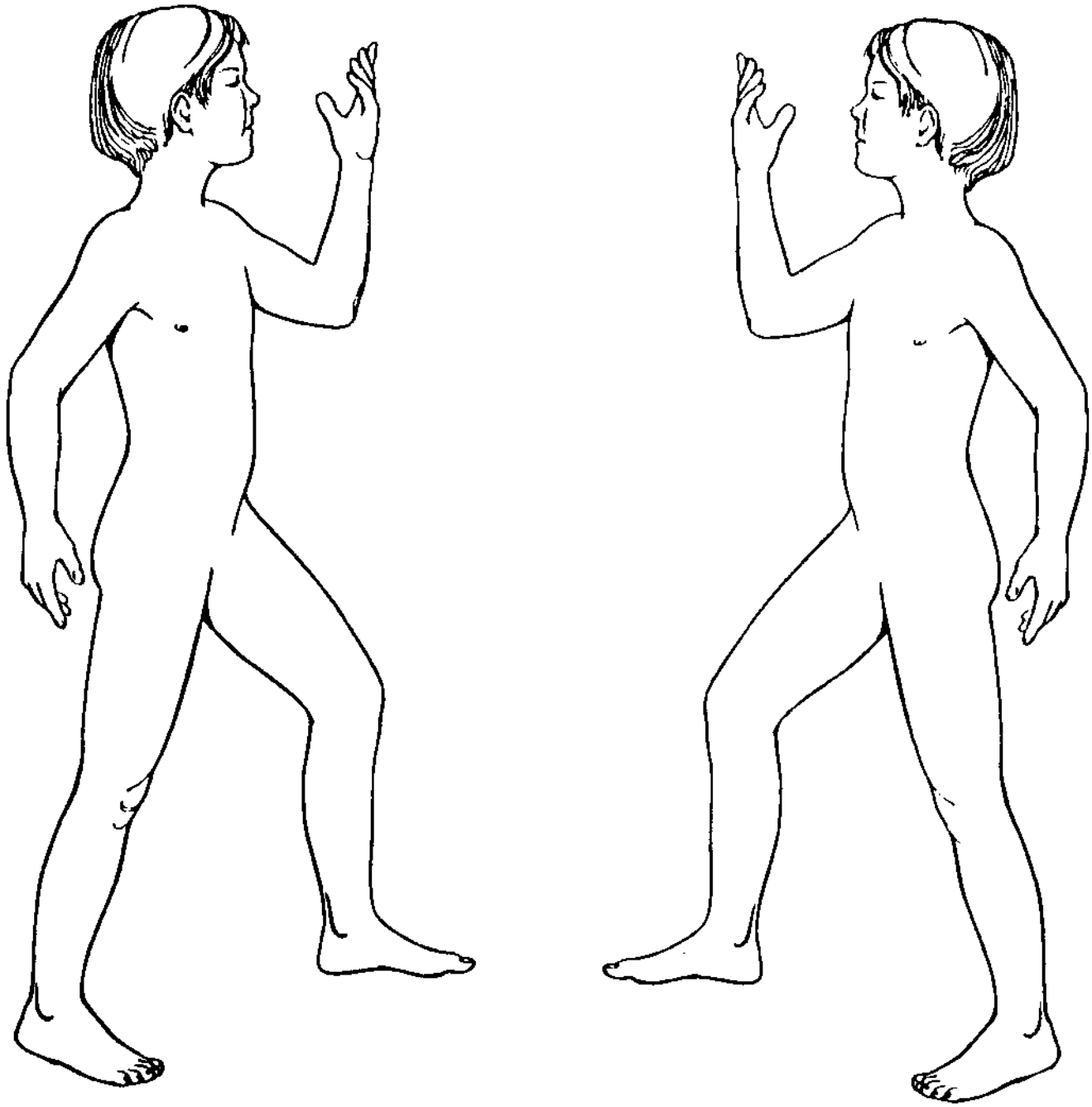

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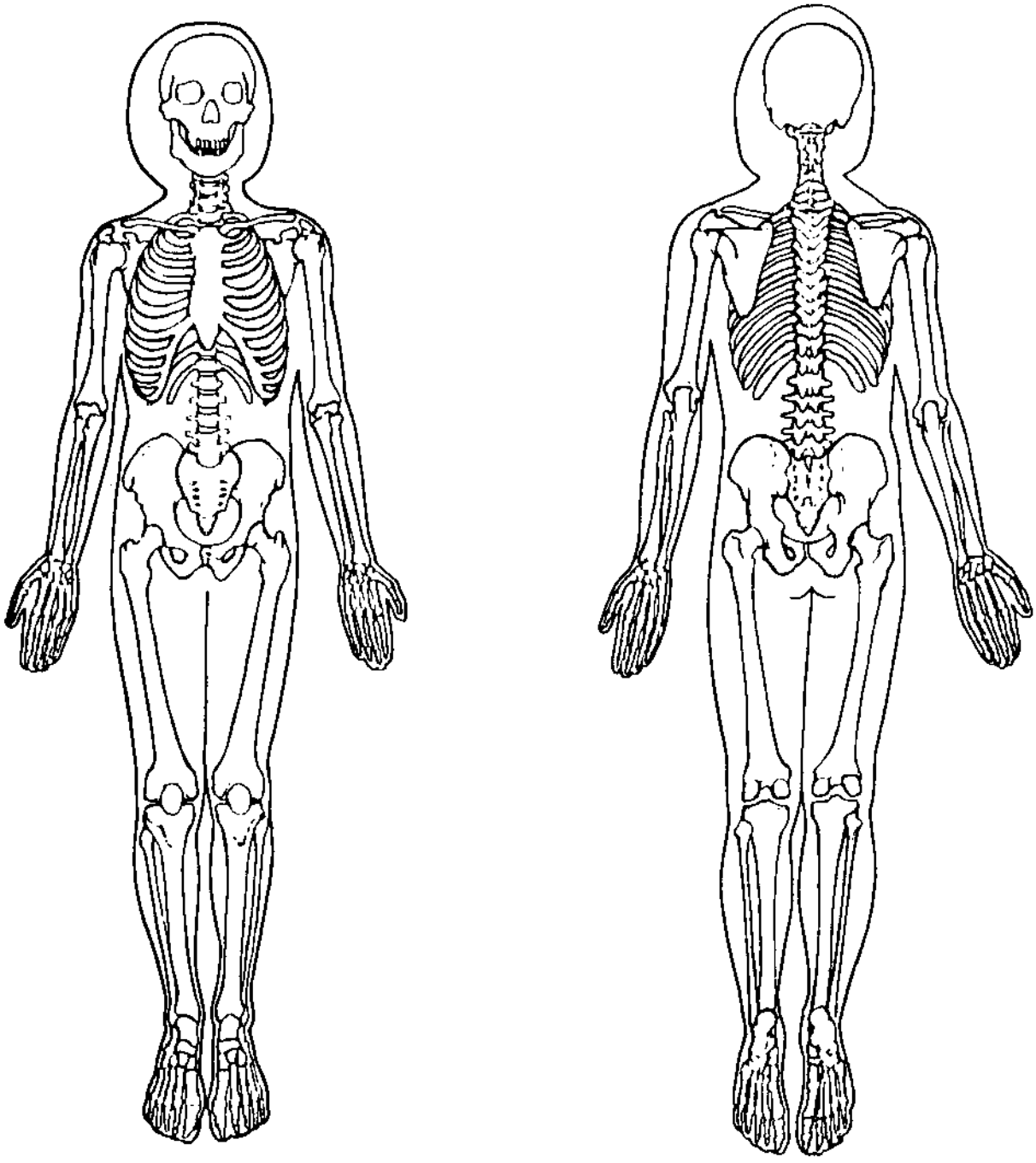

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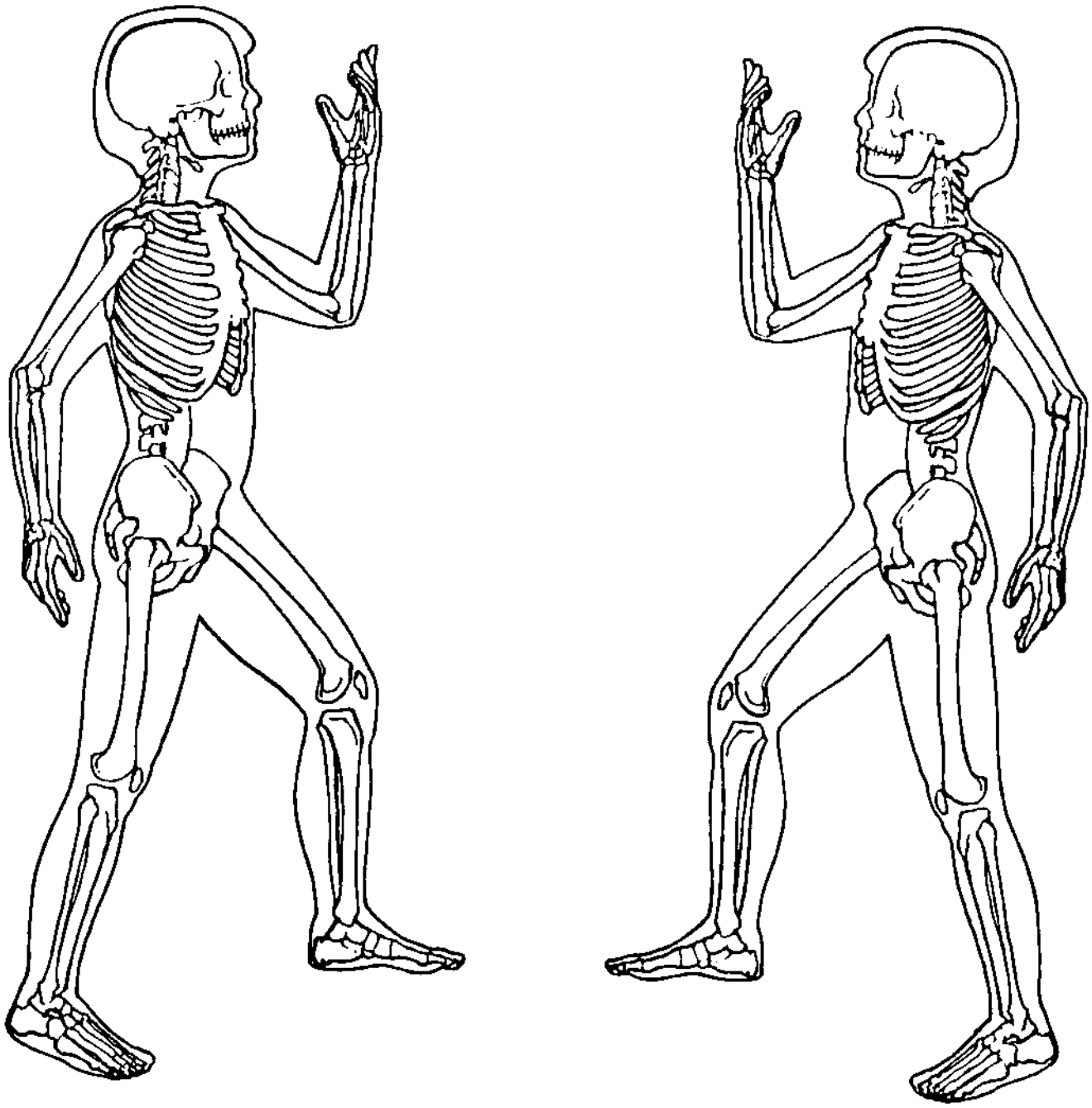

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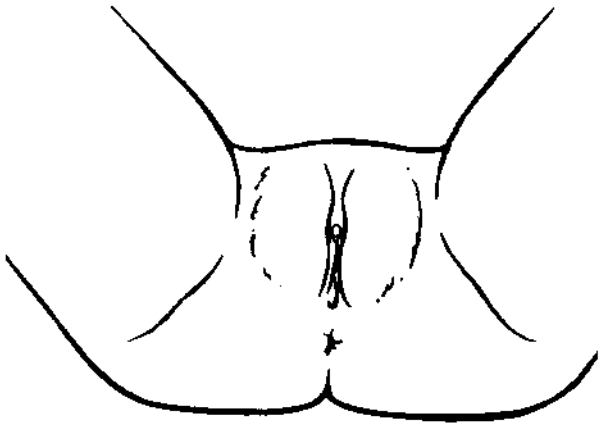

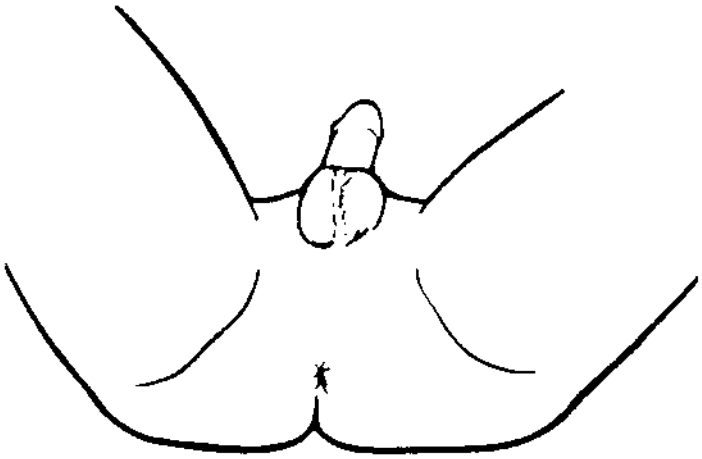

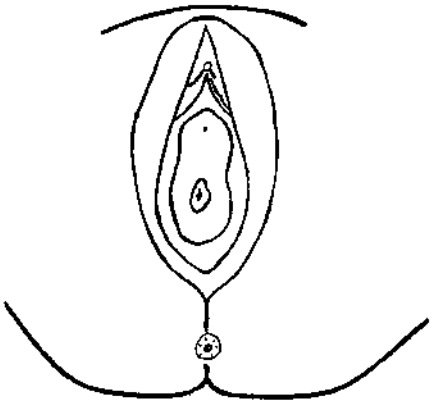

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- ☐ TREATMENT

IV. HISTORY AND IMPRESSIONS

(Include HP, past medical history, family history, social history, and impressions)

TO: _____ DATE: 16 Sep 99

SUBJECT: Child Abuse/Neglect Evaluation Process Advisement

1. Because of the nature/severity/circumstances of your child's injuries, your child _____ is being evaluated for possible child abuse or child neglect. This letter is to inform you of the reasons for this evaluation, your rights during this evaluation, the expected course of the evaluation, and requirements that have been incorporated in this evaluation designed to protect your reputation.

2. All states, territories, and the District of Columbia, requires that any health care provider (doctor, dentist, nurse, corpsman, etc.) report any suspicion of child abuse or child neglect. They have no discretion and must report. Failure to report is an unlawful act that may be punished by civil or criminal penalties. To facilitate evaluation, a standardized procedure has been developed that assures complete and fair evaluation of the case. Each case can then be thoroughly reviewed to determine if child abuse or child neglect did occur. The people conducting the review have experience in this area and are interested in finding the truth, not in ruining reputations or causing unnecessary distress to a family.

3. We want all children to grow and develop under the best possible circumstances. so while we ask your cooperation, at the same time we understand any feelings of hurt, anger, frustration, and defiance that you may feel. It is hoped that you will cooperate, and feel free to ask any questions that you may have. If you feel you cannot communicate with the person doing the initial evaluation, please feel free to ask for someone else to talk to.

4. Your rights will be protected throughout the evaluation. You have the same rights any citizen. Most reports of suspected child abuse or child neglect are proven to be invalid. However, because some cases are valid and may require legal action, in all cases the parents may exercise the legal rights guaranteed by the U.S. Constitution. The rights are as follows:

a. You do not have to answer any questions or say anything. Further, anything you say or do can be used as evidence against you in a civil or criminal trial.

b. If you are subject to the Uniform Code of Military Justice, you have a right to talk to a lawyer before or after questioning, or have a lawyer present with you during questioning. This lawyer can be a civilian lawyer of your own choice at your own expense, or a military lawyer detailed for you at no expense to you. Also, you may ask for a military lawyer of your own choice by name, and he will be detailed for you if his superiors determine he is reasonably available.

c. If you are a civilian, not subject to the Uniform Code of Military Justice, you have a right to talk to a lawyer before or after questioning, or have a lawyer present during questioning. You are also advised that if you are a military dependent, you may wish to consult a legal assistance officer, if available.

d. If you are willing to discuss the injury or medical problem of your child, with or without a lawyer present, you have a right to stop answering questions at any time or speak to a lawyer before answering further.

5. Additionally, you have the right to have your child examined by other physicians or health care providers to obtain an additional opinion. These may be either military or civilian. Be advised that if you choose to have your child examined by a civilian, you will be responsible for any fee.

6. Every effort will be made to provide you information on the status of the case upon your request.

7. Certain other matters are important for you to know:

a. Laws in all states grant immunity from liability for anyone who reports a case of child abuse or child neglect in good faith.

b. State laws in all states grant anonymity protection to anyone reporting child abuse or child neglect. You may not obtain the name of a person reporting you unless they grant release of this information.

c. Many states permit health care providers to x-ray, photograph, or admit a child to a hospital without parental permission. If you are in such a state, you may not block these actions.

8. In evaluations of possible child abuse or child neglect, a standard procedure is followed. Initial data is collected either by the health care provider who makes initial contact, by a physician on duty during off duty hours, or by a pediatrician or other physician designated to handle such cases during duty hours. A thorough history and physical examination will be performed. A social evaluation will be performed by a medical social worker or other designated personnel. Home visits may be made by Community

Health Nurses and/or civilian social workers who work for the state child welfare office. A family advocacy case management team (FACMT) then collects and evaluates all data. They determine if a case is substantiated, unsubstantiated, or suspected. If established they make a plan for working with the family. If unfounded they close the case. If there is any question, they usually monitor the family for a period of time. Further, in most states child welfare agencies may institute investigations which result in criminal and/or civil court proceedings if appropriate. You may wish to consult with legal counsel on your rights and responsibilities regarding a state investigation of alleged child abuse and/or neglect.

9. In all cases, every effort will be made to keep you informed as to how your case is progressing and what decisions are made.

10. If you do have any questions about your situation, you are encouraged to contact a representative of your local FACMT. If legal questions arise you are encouraged to contact your local Staff Judge Advocate.

_____
(NAME)

_____
(GRADE)

_____
(TITLE)

_____
(FACILITY)

I acknowledge receipt of written notification that my child _____ is being evaluated for possible abuse or child neglect. The contents of this letter and its possible implications have been explained to me. I have been provided the telephone numbers of a FACMT representative and the local Staff Judge Advocate.

_____

(NAME)

_____

(RELATIONSHIP)

_____

(DATE)

RIGHTS WARNING PROCEDURE/WAIVER CERTIFICATE

For use of this form, see AR 190-30; the proponent agency is ODCSOPS

DATA REQUIRED BY THE PRIVACY ACT

AUTHORITY: Title 10, United States Code, Section 3012(g)
PRINCIPAL PURPOSE: To provide commanders and law enforcement officials with means by which information may be accurately identified.
ROUTINE USES: Your Social Security Number is used as an additional/alternate means of identification to facilitate filing and retrieval.
DISCLOSURE: Disclosure of your Social Security Number is voluntary.

1. LOCATION		2. DATE	3. TIME	4. FILE NO.
5. NAME *(Last, First, MI)*		8. ORGANIZATION OR ADDRESS		
6. SSN	7. GRADE/STATUS			

PART I - RIGHTS WAIVER/NON-WAIVER CERTIFICATE

Section A. Rights

The investigator whose name appears below told me that he/she is with the United States Army _____ _____ and wanted to question me about the following offense(s) of which I am suspected/accused: _____

Before he/she asked me any questions about the offense(s), however, he/she made it clear to me that I have the following rights:

1. I do not have to answer any question or say anything.
2. Anything I say or do can be used as evidence against me in a criminal trial.
3. *(For personnel subject othe UCMJ* I have the right to talk privately to a lawyer before, during, and after questioning and to have a lawyer present with me during questioning. This lawyer can be a civilian lawyer I arrange for at no expense to the Government or a military lawyer detailed for me at no expense to me, or both.

   - or -

   (For civilians not subject to the UCMJ) I have the right to talk privately to a lawyer before, during, and after questioning and to have a lawyer present with me during questioning. I understand that this lawyer can be one that I arrange for at my own expense, or if I cannot afford a lawyer and want one, a lawyer will be appointed for me before any questioning begins.
4. If I am now willing to discuss the offense(s) under investigation, with or without a lawyer present, I have a right to stop answering questions at any time, or speak privately with a lawyer before answering further, even if I sign the waiver below.

5. COMMENTS *(Continue on reverse side)*

Section B. Waiver

I understand my rights as stated above. I am now willing to discuss the offense(s) under investigation and make a statement without talking to a lawyer first and without having a lawyer present with me.

WITNESSES *(If available)*	3. SIGNATURE OF INTERVIEWEE
1a. NAME *(Type or Print)*	
b. ORGANIZATION OR ADDRESS AND PHONE	4. SIGNATURE OF INVESTIGATOR
2a. NAME *(Type or Print)*	5. TYPED NAME OF INVESTIGATOR
b. ORGANIZATION OR ADDRESS AND PHONE	6. ORGANIZATION OF INVESTIGATOR

Section C. Non-waiver

1. I do not want to give up my rights
   ☐ I want a lawyer ☐ I do not want to be questioned or say anything
2. SIGNATURE OF INTERVIEWEE

ATTACH THIS WAIVER CERTIFICATE TO ANY SWORN STATEMENT *(DA FORM 2823)* SUBSEQUENTLY EXECUTED BY THE SUSPECT/ACCUSED

PART II - RIGHTS WARNING PROCEDURE

THE WARNING

1. WARNING - Inform the suspect/accused of:
   a. Your official position.
   b. Nature of offense(s).
   c. The fact that he/she is a suspect/accused.
2. RIGHTS - Advise the suspect/accused of his/her rights as follows:
   "Before I ask you any questions, you must understand your rights."
   a. "You do not have to answer my questions or say anything."
   b. "Anything you say or do can be used as evidence against you in a criminal trial."
   c. (For personnel subject to the UCMJ) "You have the right to talk privately to a lawyer before, during, and after questioning and to have a lawyer present with you during questioning. This lawyer can be a civilian you arrange for at no expense to the Government or a military lawyer detailed for you at no expense to you, or both."

   - or -

   (For civilians not subject to the UCMJ) You have the right to talk privately to a lawyer before, during, and after questioning and to have a lawyer present with you during questioning. This lawyer can be one you arrange for at your own expense, or if you cannot afford a lawyer and want one, a lawyer will be appointed for you before any questioning begins."
   d. "If you are now willing to discuss the offense(s) under investigation, with or without a lawyer present, you have a right to stop answering questions at any time, or speak privately with a lawyer before answering further, even if you sign a waiver certificate."

Make certain the suspect/accused fully understands his/her rights.

THE WAIVER

"Do you understand your rights?"
(If the suspect/accused says "no," determine what is not understood, and if necessary repeat the appropriate rights advisement. If the suspect/accused says "yes," ask the following question.)

"Have you ever requested a lawyer after being read your rights?"
(If the suspect/accused says "yes," find out when and where. If the request was recent *(i.e., fewer than 30 days ago)*, obtain legal advice whether to continue the interrogation. If the suspect/accused says "no," or if the prior request was not recent, ask him/her the following question.)

"Do you want a lawyer at this time?"
(If the suspect/accused says "yes," stop the questioning until he/she has a lawyer. If the suspect/accused says "no," ask him/her the following question.)

"At this time, are you willing to discuss the offense(s) under investigation and make a statement without talking to a lawyer and without having a lawyer present with you?" *(If the suspect/accused says "no," stop the interview and have him/her read and sign the non-waiver section of the waiver certificate on the other side of this form. If the suspect/accused says "yes," have him/her read and sign the waiver section of the waiver certificate on the other side of this form.)*

SPECIAL INSTRUCTIONS

WHEN SUSPECT/ACCUSED REFUSES TO SIGN WAIVER CERTIFICATE: If the suspect/accused orally waives his/her rights but refuses to sign the waiver certificate, you may proceed with the questioning. Make notations on the waiver certificate to the effect that he/she has stated that he/she understands his/her rights, does not want a lawyer, wants to discuss the offense(s) under investigation, and refuses to sign the waiver certificate.

IF WAIVER CERTIFICATE CANNOT BE COMPLETED IMMEDIATELY: In all cases the waiver certificate must be completed as soon as possible. Every effort should be made to complete the waiver certificate before any questioning begins. If the waiver certificate cannot be completed at once, as in the case of street interrogation, completion may be temporarily postponed. Notes should be kept on the circumstances.

PRIOR INCRIMINATING STATEMENTS:

1. If the supsect/accused has made spontaneous incriminating statements before being properly advised of his/her rights he/she should be told that such statements do not obligate him/her to answer further questions.
2. If the suspect/accused was questioned as such either without being advised of his/her rights or some question exists as to the propriety of the first statement, the accused must be so advised. The office of the serving Staff Judge Advocate should be contacted for assistance in drafting the proper rights advisal.

NOTE: If 1 or 2 applies, the fact that the suspect/accused was advised accordingly should be noted in the comment section on the waiver certificate and initialed by the suspect/accused.

WHEN SUSPECT/ACCUSED DISPLAYS INDECISION ON EXERCISING HIS OR HER RIGHTS DURING THE INTERROGATION PROCESS: If during the interrogation, the suspect displays indecision about requesting counsel (for example, "Maybe I should get a lawyer."), further questioning must cease immediately. At that point, you may question the suspect/accused only concerning whether he or she desires to waive counsel. The questioning may not be utilized to discourage a suspect/accused from exercising his/her rights. (For example, do not make such comments as "If you didn't do anything wrong, you shouldn't need an attorney.")

COMMENTS *(Continued)*

APPENDIX I:
CHILD ABUSE MATRIX

MEDCOM 693R

References: ***Chapter 4.2 a (7)***
Chapter 5.2 b (4)
Chapter 5.4 m.
Chapter 5.5 d.
Chapter 6.1 a.

The child abuse matrix is designed to be a guide for the Case Review Committee (CRC) to determine the level of severity of abuse, and appropriate clinical and command intervention(s). Unit commanders retain the ultimate responsibility and command prerogatives.

On the following pages are the Child Abuse Manual (CHAM) Matrix Instruction Worksheet, the CHAM Matrix, and the CHAM Assessment Worksheet, which will facilitate an understanding of the use of the matrix in the CRC/treatment process. The FAP Assessment Flow Chart outlines the assessment-based-decision making process of the CRC. The enclosed bibliography supports this assessment process.

I.1 CHAM MATRIX INSTRUCTION WORKSHEET

1. The CHAM matrix is designed as a guide for the Case Review Committee CRC) to determine the appropriate level of clinical and command interventions. The use of the CHAM must be based on the receipt of a report of abuse regardless of source. A report is the point of entry for FAP assessment, intervention and services. Without a report there is no regulatory basis for FAP involvement and presentation of a case to the CRC.

2. Use of the Child Abuse Matrix is an assessment-based process. An assessment is accomplished with the full accumulation of information from intake, social history, and clinical and collateral interviews. To facilitate documentation of information gathered at intake, social history, and interviews, complete the CHAM worksheet, MEDCOM Form 693-R, CHAM Assessment Work Sheet, and file in the standard case record at TAB A. Complete a separate worksheet on each child in the household in reported child abuse/neglect instances. Identify information as it relates to each child and parent. Some indicators identify child characteristics; some identify parent characteristics. Essential to an adequate assessment is consideration of the following:

   a. Presence, severity, and/or frequency of injury

   b. Parental characteristics contributing to child maltreatment:

      (1) Psychological impairment (major affective and thought disorders to include personality disorders)

      (2) Inadequate knowledge of child rearing practices and/or child development in general

      (3) Parental substance use/abuse

      (4) Failure to bond with the child (alleged victim)

      (5) Marital problems

      (6) Emotional needs unmet

   c. Child characteristics contributing to maltreatment:

      (1) Difficult temperament

      (2) Special needs child (ren)

      (3) Non-biological child

      (4) Developmental challenges

      (5) Unwanted child

d. Environmental factors contributing to maltreatment:

(1) Life events, i.e., debt, deaths, transfers, etc.

(2) Isolated life style vs. support system

(3) Stress of deployment

(4) Overseas assignment

(5) Illness or death in family

e. History of abuse in the family of origin

f. History of abuse in this family

g. Presence of rigid traditional roles

h. Impulse control

i. Responsibility for or blaming others for their actions

j. Spirituality

k. Attitude toward the evaluation

l. Work performance

m. Family strengths

3. IAW AR 608-18, paragraphs 2-4a, 3-16b, 3-22a, and 3-28 all reported Family Advocacy Program (FAP) cases are assigned a case number and presented to the Case Review Committee (CRC) for determination, regardless of reporting source, to include self referrals.

4. Cases must be presented IAW format and information requirements defined in AR 608-18, FAP, and MEDCOM Pamphlet 608-1, FAP. Presentations are assessment-based and provide the CRC required case information within situational context.

5. Cases found during the assessment process and the pre-CRC clinical staffing to be without merit or foundation (non-credible), may be presented to the CRC in summary form and with the recommendation to the team to not substantiate (Matrix Level I).

6. Cases found during the assessment process and the pre-CRC clinical staffing to be an abuse/neglect event that was an isolated incident should be presented to the CRC in full with a recommendation for team determination. If the team determines the allegation/re-

port to be not substantiated, but that risk factors exist for the family or individuals, a plan to address the family's on-going needs must be developed and offered at the appropriate Matrix Level.

7. Cases assessed and pre-staffed and believed to be a Matrix Level III, IV, or V due to the intent to inflict harm, an abusive or neglectful pattern, degree of injury or the degree of risk must be presented to the CRC, this includes supporting information obtained in the assessment process. Presentations to the team will include the recommendation to substantiate and a proposed treatment plan at the appropriate Matrix Level.

8. The CRC is the determining body to substantiate or to not substantiate a case and the approving body for a treatment plan. Treatment plans based on the matrix and needs determined during assessment may not always be a "match" for the levels (mild, moderate or severe) reported to the Army Central Registry (ACR) on the DD Form 2486. The matrix is used to make a clinical determination based on clinical, assessment-based decisions. For example, an event may result in a "mild" injury for DD Form 2486 reporting purposes; yet, assessment shows a relationship dynamic at a Matrix Level IV or V. Vice versa, a serious injury reported as abuse may prove to be, after assessment and investigation, an accident and not result in a case that is substantiated, but with an offer of support services based on minor risk factors (Matrix Level II).

CHILD ABUSE MATRIX LEVEL I

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: None identified. **Emotional Abuse**: None identified. **Sexual Abuse**: None identified. **Neglect**: None identified. **RISK**: None.	a. To determine credibility of the report. b. To determine the need for FAP services. c. Recognizes many referrals are not credible for FAP, but families would benefit from other military and/or civilian resources.	a. CRC presentation made in summary form with the recommendation to the team to not substantiate. b. Triage for credibility or referral and assessment for FAP and other services. c. Referral to other agencies as indicated. d. Command consultation. e. Follow-up treatment, if indicated. f. Other appropriate interventions, as indicated.	**Command Options Include**: a. Encourage compliance with the Case Review Committee recommendations. b. Command intervention should be supportive of the soldier and family. c. Use unit/community resources as indicated. d. Punitive measures are not indicated. e. Focus should be to maximize the soldier's and family's potential.

CHILD ABUSE MATRIX LEVEL II

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Isolated incident with or without minor physical injury (push, shove, and slap). **Emotional Abuse**: Isolated incident of berating or disparaging remarks. **Sexual Abuse**: * **Neglect:** Isolated incident of placing child(ren) at risk for health or safety concerns. **RISK**: Minimal risk with or without intervention. No history or pattern of abuse or neglect. Willingly seeks assistance or needs that might lead to family violence. Preponderance of worksheet indicators are low.	This level acknowledges that there are allegations of child abuse where an offender acts in a way that is uncharacteristic of his/her general behavior. Intervention at this level is to prevent escalation/repetition of inappropriate behavior, to reinforce family strengths, and to assist the soldier with good career potential. Clinical counseling sessions are intended to address situations related to the incident and determine ongoing services/needs of family members.	a. CRC presentation made in full with the recommendation to the team not to substantiate and to offer services. b. Command and Child Protective Services consultation and one or more of the following are required: 1) Voluntary short-term treatment assistance for the family, couple, individuals(s) as clinically indicated. 2) Refer to other agencies and/or services as appropriate. c. Reassess subsequent incidents of the same or greater risk and/or severity. Modify the treatment plan as indicated by the assessment.	**Command Options Include**: a. Encourage compliance with the Case Review Committee recommendations. b. Use unit/community assistance resources as indicated. c. Commander or 1SG conducts supportive counseling session with soldier.

NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

*Situations in which substantiation of an allegation of sexual abuse is not possible because the available information is indeterminate. May need additional assessment/monitoring.

CHILD ABUSE MATRIX LEVEL III

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Isolated intentional minor physical injury where no medical treatment is required (bruises, scratches, welts, black eye, etc.). **Emotional Abuse**: Isolated intentional incident of berating or disparaging remarks or threats toward the child. **Sexual Abuse**: Isolates sexually inappropriate behaviors which are intentional and non-physical. **Neglect:** Isolated intentional evidence/indication of neglect of health or safety. **RISK**: Minimal risk with intervention. Possible emerging pattern of abuse or neglect. Preponderance of worksheet indicators show a developing trend to increased risk.	a. Determine possible combination of UCMJ actions and rehabilitation. b. Determine critical tasks which may include safety planning, prevention of escalation, treatment, and education. c. Ensure the safety of the child(ren) as the primary goal. (Cases at this level are usually acts of poor judgment which may endanger a child, but are not considered threatening to life and limb.) d. Consider a combination of treatment and prevention services.	a. CRC presentation made in full with a recommendation to the team to substantiate. b. Offender participates in an intensive treatment program recommended for at least 3 months in length. c. Treatment provided for victims and/or family members as clinically indicated. d. Individual Treatment (victim abuser), Couples Treatment, Family Treatment, Psychoeducational Group. e. Notify the commander if the soldier and/or spouse is non-compliant with the recommended treatment plan. f. Establish and document a safety plan to include shelter options. g. Coordinate with the state Child Protective Services where available. h. Reassess subsequent incidents of the same or greater risk and/or severity. Modify the treatment plan as indicated by the assessment. I. Consider referral to the Victim Advocate and/or Victim Assistance Programs. j. Following the completion of treatment, monitor the case for a minimum of 3-6 months.	**Command Options Include**: a. IAW AR 608-18, 1-7 (b), page 3-4, unit commanders will support and comply with CRC recommendations to the maximum extent possible. Provide nonoccurrence with the CRC treatment recommendations in writing through the chain of command to the MTF commander. b. The commander may revoke the pass privileges of the service member to assure the service member remains in the barracks or BOQ when not on duty. c. Command intervention should not be career threatening as long as the soldier completes the recommended treatment. d. The commander may consider non-judicial punishment and/or administrative action.

NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

CHILD ABUSE MATRIX LEVEL IV

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Non-accidental physical injury. Medical treatment may or may not be required. **Emotional Abuse**: Identifiable incidents of berating or disparaging remarks or threats. **Sexual Abuse**: Non-accidental exposure, fondling, etc. No penetration. Medical treatment may be indicated. **Neglect:** Neglect of health and/or safety that places the child(ren) at risk for serious harm. **RISK**: The victim and/or family members are at high risk for continued abuse. Preponderance of worksheet indicators represent a pattern of abusive behavior and a high level of risk.	a. Determine possible combination of UCMJ actions and rehabilitation. b. To be put in-place long term intervention to stop or reduce the abuse. c. Ensure the safety of the victim and family members as the primary goal.	a. CRC presentation made in full with a recommendation to the team to substantiate. b. Provide the offender an intensive treatment program for offenders for at least 6-12 months or longer if clinically indicated. c. Provide treatment for victims, family members, and/or offenders as clinically indicated. d. Individual treatment (victim abuser), couples treatment, family treatment, group (don't place chronically neglectful parents in group), parent aide. e. Notify the commander if the soldier/spouse is non-compliant with the recommended treatment plan. f. Establish and document a safety plan/shelter options. g. Reassess subsequent incidents of the same or greater risk and/or severity. Modify the treatment plan as indicated by the assessment. h. Coordinate with the state Child Protective Services where available. i. Refer to the Victim Advocate and/or Victim Assistance Programs. j. Following the completion of treatment, actively monitor the case for a minimum of 6-12 months.	**Command Options Include**: a. IAW AR 608-18, 1-7 (b), page 3-4, unit commanders will support and comply with CRC recommendations to the maximum extent possible. Provide nonoccurrence with the CRC treatment recommendations in writing through the chain of command to the MTF commander. b. Commander may consider judicial, non-judicial punishment, or other appropriate administrative action. c. Some soldiers at this level may not be candidates for rehabilitation. Command should assess for retention on active duty. d. The case manager will coordinate with command to develop appropriate measures to insure the safety of the victim, the family, and the offender. e. Commander may revoke pass privileges of the service member to assure the service member remains in the barracks or BOQ when not on duty.

NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

CHILD ABUSE MATRIX LEVEL V

ASSESSMENT RESULTS	INTENT OF INTERVENTION	CLINICAL INTERVENTION	COMMAND INTERVENTION
Physical Abuse: Severe physical injury, subsequent Level IV incident, or death. Medical treatment required. **Emotional Abuse**: Serious pattern of berating or disparaging remarks or threats that result in the victim requiring mental health treatment. **Sexual Abuse**: Oral, vaginal, or anal penetration (evaluate for power and/or control). Might involve physical injury, sadomasochism, masturbation, threats, etc. May require medical treatment. **Neglect:** Neglect of health and/or safety that results or may result in serious harm or potential harm. Medical treatment may be required. **RISK**: Victim at **VERY** high risk for continued severe abuse and/or death. Preponderance of worksheet indicators represent chronic abusive behavior.	a. Take action to ensure the safety of the victim and all family members. b. Provide treatment services for the victim and all family members. c. Ensure the offender is offered treatment if indicated	a. CRC presentation made in full with a recommendation to the team to substantiate. b. Provide the offender Family Advocacy Program treatment as indicated. c. Supportive treatment and services for victims and family members to include referral to the Victim Advocate and Victim Assistance Programs. d. Couples treatment due to law enforcement and command restraints. We are probably unlikely to be able to provide tx for sexual abuser at this level. Provide indiv. and/or group for victim and family members. Foster care placement when indicated for all forms of abuse at this level. e. Immediately notify the command of severity of subsequent incident(s). f. Establish and document a safety plan to include foster care placement, shelter options, and coordinate with the commander for appropriate safety measures for all family members. g. Coordinate with the state Child Protective Services where available.	**Command Options Include**: a. IAW AR 608-18, 1-7 (b), page 3-4, unit commanders will support and comply with CRC recommendations to the maximum extent possible. Provide nonoccurrence with the CRC treatment recommendations in writing through the chain of command to the MTF commander. b. Commander should consider judicial, non-judicial punishment, and other appropriate administrative action. c. Consider separation from service. d. The case manager will coordinate with command to develop appropriate measures to insure the safety of the victim, family, and offender. e. The commander should revoke pass privileges of the service member to assure the service member remains in the barracks or BOQ when not on duty.

NOTE: At each level, performance outcome measures should be applied to determine the success of intervention.

CHILD ABUSE MANUAL (CHAM) ASSESSMENT WORKSHEET

For use of this form see MEDCOM Pam 608-1

INSTRUCTIONS. Based on information obtained from Intake, Social History and interviews, Level II provider will complete this worksheet on each child by placing an "X" in the block that most nearly matches the information available. "1" represents none or low and "5" represents high. Not all indicators may be present.

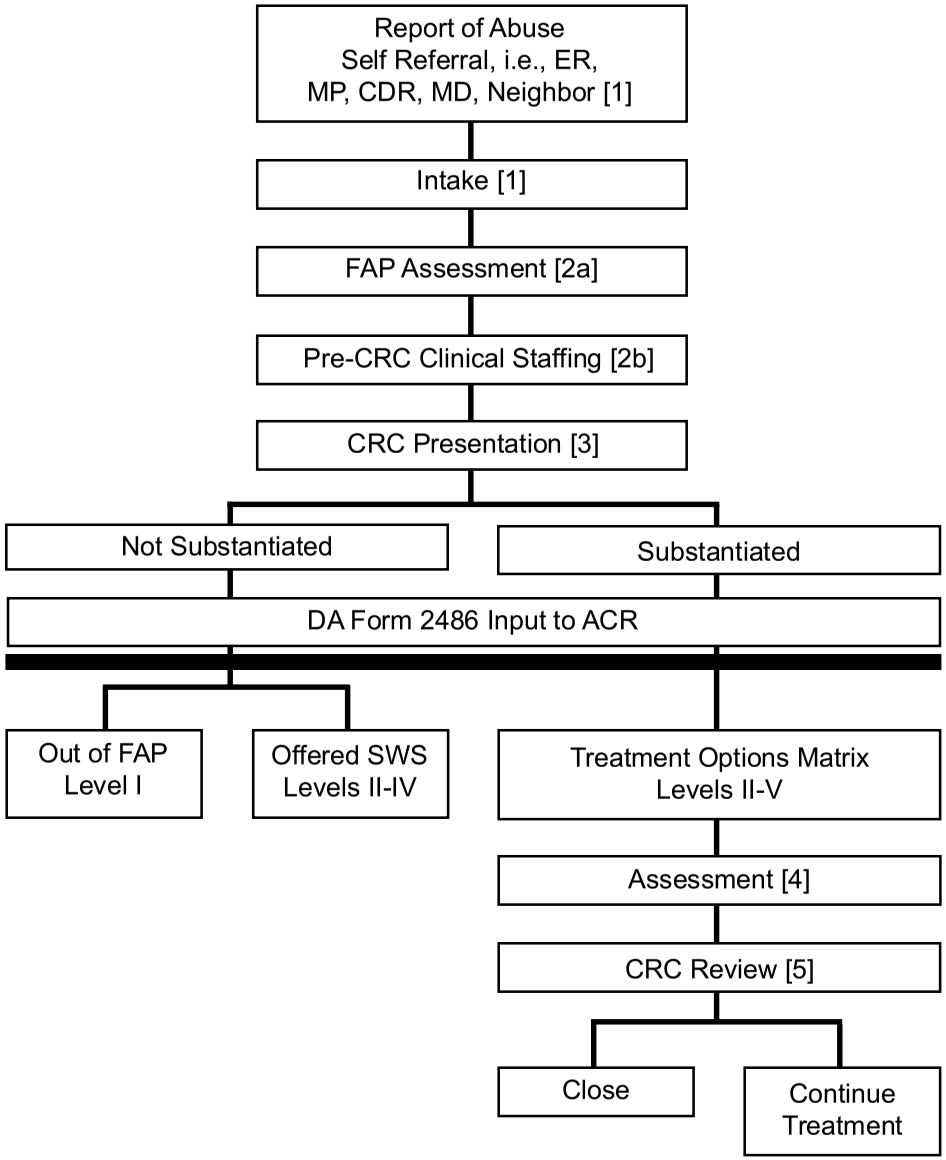
CHARACTERISTICS	INDICATORS	1	2	3	4	5	INDICATORS
1. LEVEL OF MALTREATMENT *(Age relevant)*	Mild.						Severe.
2. FREQUENCY OF ABUSE	None.						High.
3. PSYCHOLOGICAL IMPAIRMENT	None.						Significant.
4. KNOWLEDGE OF CHILD REARING PRACTICES	Knowledgeable.						Extremely deficient.
5. SUBSTANCE ABUSE	None.						Impaired/addictive.
6. PARENT BOND WITH CHILD	Strong.						Weak/poor. None.
7. MARITAL PROBLEMS	Addresses differences.						Emotion Invalidated. Disconnected. Withdrawn. Chronically unresolved problems.
8. EMOTIONAL NEEDS MET	Adequately cared for.						Few needs for attention, affection, and recognition met.
9. CHILD TEMPERAMENT	Emotionally loving and easy to calm.						Rigid, pulling away, hyper vigilant, easily upset, withdrawn.
10. SPECIAL NEEDS CHILD	Diagnosed. Has adequate community and family support						Requires 24 hour attention. No organized support. Obscure diagnosis.
11. DEVELOPMENT CHALLENGES	Parents are flexible. Willing to seek outside help.						Not willing to seek outside help. Parents rigid or fearful of losing control.
12. PREGNANCY	Planned, joyful, without complications.						Unwanted or complicated, with post partum depression.
13. LEVEL OF COMMUNITY INVOLVEMENT	Friends (more than two). Involvement in church or social organizations. Extended family available.						No friends. Never has others over. Does not belong to fraternal groups.
14. STRESSFUL LIFE EVENTS	Low stress levels						High stress level. Change/adaptation required.
15. HISTORY OF ABUSE AND/OR INJURY	None in either family of origin or this family.						Parent abused as child. Prior incidents of abuse in this family (child or spouse).
16. PARENTAL ROLES	Flexible/shared.						Rigid/traditional.
17. IMPULSIVITY	Controlled.						Very impulsive.
18. LOCUS OF CONTROL	Assumes responsibility.						Blames others. External to self.
19. BELIEF IN HIGHER POWER	Spirituality. Faith is a source of comfort.						Religiosity. Stern and rigid practices.
20. ATTITUDE TOWARD EVALUATION	Cooperative and sincere.						Uncooperative or manipulative.
21. WORK PERFORMANCE	Good soldier/worker.						Poor performance.
22. FAMILY STRENGTHS	High.						Low.

AUTHENTICATION

CASE NUMBER:

LEVEL II PROVIDER'S NAME	LEVEL II PROVIDER'S SIGNATURE	DATE

FAP ASSESSMENT FLOW CHART



Assessment **[1]**
- MP Report/Verbal
- PCAN/Spouse Medical
- Risk Assessment Form
- Safety Plan

Decision
- Credible?
- Imminent risk?

Manage It
- Commander/1SG (phone)
- Contact Child Protective Services (CPS) as indicated

Assessment **[2a & b]**
- History Form/Psychosocial Assessment
- Intake Package/Scales/ Instruments/Worksheets
- Clinical Interview

Decision
- Credible?
- Imminent danger?

Potential Risk: Manage It
- Communicate it to the Clinical Supervisor, Hospital Commander, Letter to Unit Commander
- Develop proposed MLP & TP

Assessment **[3]**
- CRC Team Input
- Commander Input
- Other Agency Input
- Substantiate/Unsubstantiate (Admin)

Decision
- Potential Risk-Offender/Victim/ Community/County/Treatment Plan

Manage It
- Communicate Verbally with Unit Commander and Follow-up with Meeting and Form Letter

Status of Assessment **[4]**
- Redo Risk Assessment
- Redo Assessment Worksheet
- Treatment Plan
- Command Input
- Clinical Interview

Decision
- Dangers/Risk

Manage It
- Progress/Recommendations

Communicate It
- Case Review Committee (CRC)

Assessment **[5]**

Decision
- Potential Risk
- Status of Treatment Plan

Manage It
- Communicate it Verbally to Unit Commander in the CRC Meeting
- Letter as Necessary

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16. Parental Roles.

(See Stress)

Flexibilitv speaks to protective factors.

17. Impulsivity.

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18. Locus of Control.

(Speaks to possible protective factors or higher risk).

19. Belief in Higher Power.

(Speaks to issues related to risk).

20. Attitude Toward Evaluation.

(Speaks to issues related to risk).

21. Work Performance.

Krugman, R.D., Lenherr, M., Betz, L., and Fryer, G.E. (1986). The relationship between unemployment and physical abuse of children. Child Abuse and Neglect, 10(3): 415-418.

(Good performance can either work as a protective factor, increasing self esteem or increase risk if high performance is a function of rigidity and over control).

22. Family Strengths.

(Protective Factors).

APPENDIX J: CASE REVIEW COMMITTEE REVIEW PROCESS

- Memorandum for Commanders, MEDCOM RMCs/MEDCENS/MEDDACs, ATTN: Chief, Social Work Service
- Information Paper: FAP

Reference: Chapter 5.4 o.

This section underscores the need to provide specific FAP information to individuals whose cases will be presented at the CRC, as reported child/spouse abuse.

NOTES

DEPARTMENT OF THE ARMY
HEADQUARTERS, U.S. ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

MCHO-CL-H (608-18a) **14 JUL 1998**

MEMORANDUM FOR Commanders, MEDCOM RMCs/MEDCENs/MEDDACs,
ATTN: Chief, Social Work Service

SUBJECT: Family Advocacy Program (FAP) Information Paper

1. References:

a. Army Regulation (AR) 608-18, Army FAP, 1 Sep 95.

b. AR 340-21, Army Privacy Program, 5 Jul ’85.

c. MEDCOM Pamphlet 608-1, FAP, 2 Mar 98

d. Protocol for Child Abuse and Neglect (PCAN), Dec 95.

e. Information Paper, HQ MEDCOM, MCHO-CL-H, 30 Jan 96, subject as above.

2. The Information Paper (Enclosure) replaces the Information Paper at reference e.

3. Effective upon receipt, provide the Information Paper to all clients whose cases will be presented to the Case Review Committee as reported child/spouse abuse.

4. Upon provision to the client allow him/her time for reading, discussion, and answering any questions on the process that the client may have.

5. Attached to the Information Paper is a receipt. Have client sign the receipt after discussion. If the client refuses to sign, the case manager should annotate the receipt “refuses to sign”, date and sign the annotation. File the receipt in the client’s case record at Tab L. This will become an inspection item.

6. This Information Paper is a requirement and supersedes any other in use. You may provide additional information to the client on a local attachment. You may not delete any information.

MCNO-CL-H
SUBJECT: Family Advocacy Program (FAP) Information Paper

7. This Information Paper does not replace the parental advisement letter required by the PCAN. It is an additional requirement.

8. This Information Paper includes information on obtaining a review beyond the local medical treatment facility review. This information is in both reference b and c, but was not in reference e. Also included is the systemization of existing circumstances, reviews are requested by individuals other than the client.

9. This information Paper was staffed with MEDCOM Staff Judge Advocate.

10. Our point of contact is Mrs. Mary W. Behrend, Behavioral Health Division, Office of the Assistant Chief of Staff for Health Policy and Services, DSN 471-6767 or Commercial (210) 221-6767.

Encl
as

for GRIFFIN DAVID LOCKETT LTC, MS
Colonel, MS
Chief, Behavioral Health Division

MCHO-CL-H 7 July 1998

INFORMATION PAPER

SUBJECT: Family Advocacy Program (FAP)

1. Purpose. To define FAP goals and procedures to individuals involved through the medical treatment facility (MTF).

2. FACTS.

a. References:

(1) Department of Defense Instruction (DODI) 6400.1, FAP.

(2) Army Regulation (AR) 608-18, FAP, 1 Sep 95.

(3) AR 340-21, Army Privacy Program, 5 Jul 85.

(4) US Army MEDCOM Pamphlet 608-1, FAP, 2 Mar 98.

b. The FAP is congressionally mandated and directed from the DOD Office of Personnel and Readiness.

c. The Department of the Army proponent is the Community and Family Support Center in the Office of the Assistant Chief of Staff for Installation Management.

d. The FAP is a dual mission program to prevent and to treat child/spouse abuse. At the local installation level, both the Army Community Service (ACS) and the MTF have roles. Command and Community education are the responsibility of the ACS. Treatment and case management are the roles of the MTF, to include Social Work Service (SWS).

e. Within the MTF, SWS provides assessments of and counseling for families/individuals seeking assistance. For families reported as having been involved in an abusive instance, SWS coordinates evaluations, examinations, and gathers information to prepare a case staffing to a multi-disciplinary Case Review Committee (CRC) that evaluates the family’s need for intervention and assistance.

f. The CRC evaluates the preponderance of indicators/information to determine if an abusive instance did occur, what factors (problems) contributed to the events, and develops a treatment plan to address all identified problems for all individuals involved, to include the abuser, the victim, and any child witness to family violence. The objective of the treatment plan is to increase individual and interpersonal family skills and thereby reduce the potential for violence. Every effort will be made to keep the soldier and family informed on case progress.

g. By regulation, a soldier's commander is advised of the CRC process and invited to attend CRC meetings to add any relevant information about the soldier and family in order to facilitate meeting the soldier's and family's needs.

h. By definition, the FAP, is a program to act on behalf of a family; however, should an individual believe that the CRC was inaccurate in determining an abuse status or plan of treatment, he/she may request that the CRC review his/her case a second time.

i. Requests for review are based on the following:

(1) The CRC did not have all relevant information (if the client refuses to provide information during intake and scheduled interviews, and a CRC determination is made that the client believes to be inaccurate, subsequent requests for case review will not be honored).

(2) The CRC did not follow or comply with published policies or procedures.

j. The request to the team must be made in writing through the MTF commander no more than 30 calendar days after the CRC decision. It must state what relevant information was not available and why it was not available, or what published policy or procedure was not met. Only one reevaluation request will be considered for each incident. Treatment will not be suspended, interrupted or postponed pending the outcome of the review.

k. The MTF commander forwards the request to the Chief, SWS. The case is assigned to a new case manager who reviews the case, interviews the individuals involved and resubmits the case to the CRC with any additional/new information obtained. The CRC reevaluates the case with new information and reaches a case determination.

l. The CRC review is documented in the family's case file and the family/individual and the commander are advised in writing of the team's second determination.

m. A review will be conducted only by the CRC which made the determination on the case. If it is not possible for the initiating CRC to review the case, the request will be submitted, with supporting information, directly to the HQ MEDCOM review committee.

n. In the event the client remains dissatisfied with the CRC process after the local review, a written request may be made to the MTF commander to forward the case to HQ MEDCOM, ATTN: MCHO-CL-H, with a request for HQ MEDCOM CRC review.

o. Requests for CRC review of a case determination may also be initiated by a clients effected family member, a commander, or the initiating CRC based on i(1) & (2).

Mary W. Behrend/MCHO-CL-H/DSN 471-6767

APPENDIX K: TREATMENT PLANNING GUIDE

Treatment Planning Guide

Reference: Chapter 5.5 d.
Chapter 6.1 a (2)

This chart is intended to be used as a guide to assist clinicians to develop FAP treatment plans. Treatment plans MUST be assessment driven.

	TREATMENT OPTIONS	OFFENDER SESSIONS	VICTIM SESSIONS	CHILDREN SESSIONS
LEVEL 1	**A. Psychoeducational Information:**			
	1. Communication Skill			
	2. Parent Education (EFMP Child)			
	3. Budget Counseling			
	4. Alcohol Education Awareness			
	5. Stress Management			
	6. Victim Advocate			
	7. Others			
	B. Counseling:			
	1. Individual			
	2. Couple			
	3. Family			
	C. Mandatory County/State Treatment Programs			

	TREATMENT OPTIONS	OFFENDER SESSIONS	VICTIM SESSIONS	CHILDREN SESSIONS
LEVEL 2	**A. Psychoeducational Information:**			
	1. Communication Skill			
	2. Parent Education (EFMP Child)			
	3. Budget Counseling			
	4. Alcohol Education Awareness			
	5. Stress Management			
	6. Victim Advocate			
	7. Others			
	B. Counseling:			
	1. Individual/Adult and Child			
	2. Couple/Marital			
	3. Group-Gender Specific			
	4. Group-Couples			
	5. Group-Age Based Child			
	6. Family			
	C. Mandatory County/State Treatment Programs			

	TREATMENT OPTIONS	OFFENDER SESSIONS	VICTIM SESSIONS	CHILDREN SESSIONS
LEVEL 3	**A. Psychoeducational Information:**			
	1. Communication Skill			
	2. Parent Education (EFMP Child)			
	3. Budget Counseling			
	4. Alcohol Education Awareness			
	5. Stress Management			
	6. Victim Advocate			
	7. Others			
	B. Counseling:			
	1. Individual/Adult and Child			
	2. Couple/Marital			
	3. Group-Gender Specific			
	4. Group-Couples			
	5. Group-Age Based Child			
	6. Family			
	C. Mandatory County/State Treatment Programs			

	TREATMENT OPTIONS	OFFENDER SESSIONS	VICTIM SESSIONS	CHILDREN SESSIONS
LEVEL 4	**A. Psychoeducational Information:**			
	1. Communication Skill			
	2. Parent Education (EFMP Child)			
	3. Budget Counseling			
	4. Alcohol Education Awareness			
	5. Stress Management			
	6. Victim Advocate			
	7. Others			
	B. Counseling:			
	1. Individual/Adult and Child			
	2. Couple/Marital			
	3. Group-Gender Specific			
	4. Group-Couples			
	5. Group-Age Based Child			
	6. Family			
	C. Mandatory County/State Treatment Programs			

	TREATMENT OPTIONS	OFFENDER SESSIONS	VICTIM SESSIONS	CHILDREN SESSIONS
LEVEL 5	**A. Psychoeducational Information:**			
	1. Communication Skill			
	2. Parent Education (EFMP Child)			
	3. Budget Counseling			
	4. Alcohol Education Awareness			
	5. Stress Management			
	6. Victim Advocate			
	7. Others			
	B. Counseling:			
	1. Individual/Adult and Child			
	2. Couple/Marital			
	3. Group-Gender Specific			
	4. Group-Couples			
	5. Group-Age Based Child			
	6. Family			
	C. Mandatory County/State Treatment Programs			

Minimum number of treatment sessions may include one or any combination of listed modalities.

APPENDIX L: RESOURCES

n Annotated Bibliography
n Internet Sites

The annotated bibliography and Internet site listings are intended to serve as a starting point to keep abreast of current information concerning the complex issues associated with children witnessing violence and overlaps between spouse and child abuse. The Internet sites offer a vast amount of information which can be tailored to the users' needs.

ANNOTATED BIBLIOGRAPHY

Title	***Emotional distress in children of high conflict divorce: The impact of conflict and violence***
Authors	C. C. Ayoub, R. M. Deutsh, and A. Maraganore
Journal	*Family and Conciliation Courts Review 37 (3), 297-314*
Year	l999

This article examines the interrelationships between the emotional distress of children who experience "acrimonious" divorce and other parent and child factors, such as, the child's age and gender, and the parent variables of substance abuse and mental illness, the level of conflict and violence in the marriage and post separation relationship, and the stability of the visitation and custody arrangements.

In review of the research literature, this article describes several factors comparing children from divorce with children from intact families. The children from divorce experience problems with psychological adjustment, more social difficulties, lower self concepts and poorer outcomes in school. The literature finds that younger children exhibit lower adjustment to divorce than do older children, but older

children tend to form alliances with one of the parents. The literature reports that boys demonstrate more aggressive behaviors and interpersonal problems than do girls.

Any increase in interparental conflict and duration of the conflict has been found to be associated with increases in behavioral and psychological problems for their children. These findings suggest that the problems associated with the divorce being less of an impact on children than the interparental conflict. There is, however, inconsistency in the literature on how children react to interparental conflict. Some studies find that children exposed to high interparental conflict demonstrate both internalizing (e.g., depression and anxiety) and externalizing problems (e.g., aggression and conduct disorder).

The literature review briefly mentions that health care professionals are concerned with the co-occurrence of spouse abuse and physical child abuse. This article cites that a rate of 40% is found when a conservative definition of child abuse is used (Appel and Holden, l998). Other studies reveal that children who witness spouse abuse have an increased risk of becoming victims of physical abuse also. The studies indicate that several factors such as gender, child's age and mother's emotional health, moderate the degree to which a child is affected by witnessing violence. On the other hand, some researchers found that witnessing domestic violence resulted in serious emotional maladjustment, especially post traumatic stress disorder, regardless of the mediating factors, such as, gender or age.

The findings and implications of this study support earlier research findings. One finding of this study is the association between the child's emotional distress and the level of marital conflict that is not affected by other variables such as age or gender. For example, families with higher marital conflict are more likely to have children with higher levels of emotional distress. Although younger children are more vulnerable to other mediating factors, older children are likely to have experienced continued marital conflict for a longer duration. When coupling the experience of witnessing domestic violence with child maltreatment, there is an increase in emotional distress in the child, at any age. The findings again support earlier research, that denotes an increased risk of child maltreatment in situations where children are exposed to domestic violence. Also, mothers who have a mental health problem or substance abuse problem are more apt to have children with higher levels of emotional distress. The presence of mental disorders or substance abuse by fathers showed a decrease in the child's distress. This seems to be linked to the fact that children are not usually residing with their fathers because the courts usually restricted visitation and/or denied them custody.

The authors discuss other important implications from this study and for future studies. The findings report that marital conflict does impact on the child's emotional well-being and factors such as, witnessing marital violence, experiencing physical abuse, observing frequent verbal conflict between parents and receiving low parental support should not be underestimated. Specifically, the risk of poor adult functioning increases for children exposed to more than one of these risk factors over a period of time.

Other implications are for clinicians to have a working knowledge of all the social and emotional problems that can overlap such as interparental conflict, domestic violence, child maltreatment, mental illness, substance abuse and custody and visitation issues. This would be especially helpful for family courts who make decisions that can support the psychological well being of children.

Title	***Children's witnessing of adult domestic violence***
Author	Jeffery L. Edleson
Journal	*Journal of Interpersonal Violence, 14 (8), 839-870*
Year	August, 1999

This article thoroughly reviews 31 research studies, that met the author's established criteria, concerning the complex influences on children's development and the association to witnessing adult domestic violence. The author was cautious when interpreting the findings. These findings show associations between witnessing of abuse and some other variable (i.e., direct physical abuse of child, child's gender or age, the time lapsed since exposure to violence, etc.) and do not show cause and effect relationships.

This article reviews several examples of ways children experience a violent event, in an attempt to expand common definitions on the various levels of violence. Not only is the child witness to homicide a traumatic event but the "final blow with a fist, the plunge of a knife, or the blast of a shotgun" (Pynoos and Eth, l994, p. 91) is as well. Similarly, the fights children hear and experience, and the aftermath of the violence are common definitions. The following excerpts were used to describe the various ways in which domestic violence is witnessed (pp. 839-840):

Julie, a 4 year-old girl, was the only witness to her divorced mother's fatal stabbing. There was no physical evidence linking the father to the crime. Several months earlier at the time of the divorce, Julie's father had publicly threatened to kill his ex-wife. In describing the event, Julie consistently placed her father at the scene, recounted her father's efforts to clean up prior to leaving. Only after the district attorney saw Julie stabbing a pillow, crying "Daddy pushed mommy down," did he become convinced that the father indeed was the murder (Pynoos and Eth, l984, p. 100).

As (my husband) came back in the house and went in the bedroom and got another bullet and loaded the gun again and started to raise the gun, I really think my daughter saved my life right then...I was holding her behind me, and she came out in front of me and put her arms in the doorway like this (demonstrating with her arms outstretched), so as he raised the gun it came right past her. And I reached out and I took her hands down, and her hands were so strong against that doorway. It was unbelievable the strength that was in her arms. I got her arms down, and I turned and grabbed her in my arms and ran out the door (Syers-McNairy, l990, pp. 105-106).

I wouldn't say anything. I would just sit there. Watch it. I was just, felt like I was just sitting there, listening to a TV show or something. It's like you just sit there to watch it, like a tapestry, you sit there (Pynoos and Eth, l994, p. 122).

I really thought somebody got hurt. It sounded like it. And I almost started to cry. It felt really, I was thinking of calling, calling the cops or something because it was really getting, really big banging and stuff like that (Peled, l993, p. 125).

Other ways that children experience adult domestic violence include threatening a child when "the child is in his or her mother's arms, taking the child hostage to force the mother's return to the home, using a child as a physical weapon against the victim, forcing the child to watch assaults against the mother or

to participate in the abuse, using the child as a spy or interrogating the child about the mother's activities and using the child as a wedge between the mother and the children attempting to get the family back together."

Prevalence of Children Witnessing Domestic Violence

This article examines how often children witness violence and the discrepancies in accurately estimating the prevalence of children witnessing violence. One problem is that parents provide the information and often the information parents or other adults provide, seems to be clouded by their own denial and or misunderstanding of the problem. A review of the literature suggests that parents underestimate the degree to which children are exposed to violence. For example, parents or adults report that "the children were sleeping or outside playing." The author notes that in one community based study, 78% of the children reported witnessing violence, when at least one parent reported that no violence took place or that the children had not witnessed the event.

The author describes that out of 84 studies originally identified, 31 studies met the author's established criteria to extrapolate on the effects of children witnessing domestic violence in comparison to other groups of children. The author's findings were divided into 3 themes: (1) the childhood problems associated with witnessing domestic violence; (2) the moderating factors present in a child's life that appear to increase or decrease these problems; and (3) the evaluation of the weaknesses or gaps in the research methods used in the studies reviewed.

The author urges that a national survey be conducted, since it is clear that a large number of children are exposed to violence. The two most widely cited statistics estimated that "at least 3.3 million yearly are at risk of exposure to parental violence" (Carslon, l984 and Straus, l992).

Weaknesses and Gaps in the Research Methods

Although the author reports gaps and weaknesses in the research methods, he urges that these problems should not cause us to dismiss the findings that are consistently replicated across these studies, using various methods and samples. The problems are reviewed below.

A significant problem in the studies reviewed, failed to differentiate between abused children from those children who are not necessarily themselves abused but who witness violence. Witnessing, includes multiple ways in which a child is exposed to adult domestic violence. Also, some studies do not distinguish between the number of children abused and the number of children both abused and witnessing domestic violence.

Most studies use shelter populations, in which the immediate life situation is not representative of the child's normal surroundings. Another issue is that information is often obtained from the mothers' reports of their child's problems, who may not accurately identify their child's awareness of the violence.

These studies demonstrate only an association between children witnessing violence and some other variable without predicting that one variable caused the other to occur.

The author points out that these studies rely heavily on the Child Behavior Checklist (CBCL), to document childhood developmental problems of children witnessing domestic violence. Edleson suggests an assessment of other measures that can impact children's witnessing violence, such as, the child's

perceived safety, formal and informal support networks (e.g., family members, friends, school and etc.) and visitation arrangements.

Impact of Witnessing Domestic Violence
This article outlines three categories of childhood problems associated with witnessing of domestic violence, that are common findings in the studies reviewed: (a) behavioral and emotional functioning, (b) cognitive functioning and attitudes and (c) longer term issues.

The behavioral and emotional functioning area includes more aggressive, antisocial, fearful, and inhibited behaviors, lower social competencies, more anxiety, depression, trauma symptoms and temperament problems than children who did not witness violence at home.

The cognitive functioning and attitudes category highlights that children's exposure to domestic violence may generate attitudes justifying their use of violence in comparison to other children. Academic abilities were not found to differ between children exposed to domestic violence and other children in most of the studies. One study did find an association.

Long-term developmental problems include adult reports of depression, trauma-related symptoms, low self-esteem, lower social adjustment, as well as, violence in adult intimate relationships. Finally, several studies report a strong association between some form of childhood abuse and later as an adult using adult violence and criminal behavior.

Factors Moderating the Degree of Problems Associated with Witnessing Violence
A number of factors (e.g., abused and witnessing abuse, gender, time since the violent event and parent-child relationship) appear to moderate the degree to which a child is affected by witnessing violence. Upon review of several pertinent studies, the combination of being abused and witnessing violence appears to have a greater impact than for children witnessing violence solely.

Gender factors are also described in the findings, whereby boys exhibit more frequent problems, such as hostility and aggression, whereas girls show more depression and somatic complaints. Preschool children were reported by mothers to show more problems than other ages of children. Another factor is that children seem to exhibit fewer problems when time has lapsed since the immediate crisis, in comparison to a recent event of witnessing violence.

Finally, parent child relationship factors are analyzed. The child's relationship with the abusive fathers was one of affection and/or disappointment over the violent behavior. The relationship between the mother and child was reviewed based on the mother's mental status claiming that the mother's stress level accounted for problems with the child.

Coping Strategies
This article briefly points out that some children develop survival responses to witnessing domestic violence. Currently, there is little research on what specific coping strategies children use to deal with their environment. A few studies defined some of the coping strategies children mostly applied, as "emotion-focused" and "problem-focused" (Lazarus, l980). The emotion focused coping strategies included, "wishing the violence away at the time of the fight, reframing and minimizing the violence, forgiving the father, and refusing to talk about the violence" (Peled, l993, p. 220). The problem focused coping

strategies are described as when the child would physically distance themselves from the violence event, or put themselves into the violent situation.

Conclusions and Implications
Edelson concludes that each child experiences domestic violence in unique ways depending on the variety of factors mentioned above. The author urges professionals to carefully assess the risk factors in every family before assuming that all children who witness abuse develop problems. A few research findings reveal that some children do not show developmental problems and, in fact, show strong coping abilities.

With the increased awareness of the risks of children witnessing abuse some child protection agencies are including witnessing abuse as part of the definition for child maltreatment. This may inadvertently create problems. One issue that emerges is that battered women may be fearful of disclosing if they realize that they could be separated from their children.

Edelson concludes that there has been extensive research concerning how children are affected by their exposure to adult domestic violence, and it is likely that this research will continue. In order to better understand the complex influences of witnessing violence on children's development, studies should identify ways to provide safety to all the victims involved. There is an important connection to witnessing adult domestic violence and related research on areas such as witnessing marital/partner conflict, and witnessing community and media violence.

Title	***The overlap between child maltreatment woman battering***
Author	Jeffery L. Edleson
Report	*Violence against Women, 5 (2), 134-154*
Year	February l999

It is only in recent years, that professionals who work with abused families are focusing more on the overlap between child abuse and spouse abuse in the same families. This article examined 35 studies in order to summarize the information on this overlap. In a majority of the studies, the overlap was found to be in a range of 30% to 60%. Given the shortcomings in the research methods, the author suggests careful interpretations of the findings on co-occurrence of child and spouse abuse. This article describes some of these gaps and inconsistencies which are listed below.

Definitions
Many of the studies reviewed do not use standardized definitions of child abuse or adult domestic violence, or specify the form of abuse or level of severity. In trying to understand the information on co-occurring family violence, the author suggests that researchers become more familiar with the way in which their counterparts understand their professional field of study (e.g., definitions of terms, interventions, etc.). Also, the studies do not specify who the perpetrator is (i.e., whether it a was the child's mother, father, both parents or others). The scant number of comparable studies reveal the failure to distinguish abused from non-abused witnesses of domestic violence, making it difficult to determine what is associated with child abuse and what is solely associated with witnessing domestic violence.

Future studies would benefit from the use of standardized definitions and from improved reporting of the specific forms of maltreatment occurring.

Study Samples
Another gap is that the primary focus of most of the studies addressed child abuse or "woman battering," instead of both. Often, the samples were collected on abused women in shelters, which provides a distorted view of children, in their crisis situation. Looking at children along a continuum of living arrangements and points of times after the violence event would provide a clearer assessment of the child.

Sources of Information
The data collection methods examined in these studies are varied and are often from one source of information such as archival records, current self-reports or retrospective recall of events, which distorts the true level of comparison. For example, reports by battered women or children are apt to depict different information than archival records such as child protection reports. In addition, mothers are reported to underestimate that their children are victims of the violence and children are often not even asked about their perception of the effects on themselves. Other questions are raised about the accuracy of reporting overlaps when researchers use parent reports about whether their abusive spouses were physically abused as children.

Implications
Edleson's review of the 35 studies does show that both children and adults in the same families are victims of the abuse directed at them. The courts, child protections agencies, and domestic violence programs should rethink the framework from which they approach intervention. Researchers must continue to coordinate with direct service providers in an effort to answer some of the questions listed below to obtain a greater understanding of the evolution of violence in these families. The courts should reconsider how to collaborate and intervene with child protection and women's advocates so that everyone can work toward safety for these families.

If one accepts that the majority of the residents in most battered women's shelters are children and 30% to 50% of these children are physically abused (Illinois Coalition Against Domestic Violence, l996, Minnesota Department of Corrections, l993; New Jersey Coalition for Battered Women, l992) then some questions professionals, particularly people who work in shelters, should consider include:
- Are shelters screening for child maltreatment and making appropriate reports to authorities?
- Are the walk-in services in shelters adequately meeting the needs of children if they are being physically abused?
- What are programs providing regarding parenting education for men who abuse both children and spouses?

Similarly, persons working in child protective agencies should consider the following questions:
- Why are abusive males almost "invisible" in child protective agencies (i.e., the service plans frequently focus on what the mother should be doing to enhance child safety, etc.)?
- Where are the service plans for abusive males guiding what they should be doing to enhance safety for family members who they have victimized?

Despite a review of many well-designed studies, the author states that a major barrier to a more complete understanding of the issue on co-occurrence is "the gap in knowledge that this review reveals."

Title	***Co-occurrence of spousal violence and child abuse: Conceptual Implications***
Authors	K. L. Shipman, B. B. R. Rossman, and J. C. West
Journal	*Child Maltreatment 4 (2), 93-102*
Year	1999

The research literature supports that there is an overlap between spouse and child abusive families. It is unclear, however, about the factors that distinguish between families who are spouse abusive and those who are both spouse and child abusive. Of interest to this article, is whether families in the aforementioned groups differ from one another in severity and/or the pattern of negative characteristics present. The questions this study addressed are (a) which familial factors differentiate among families characterized by no violence, spouse abuse, and spouse and child abuse and (b) which child characteristics differentiate among children not exposed to violence, children who witness spouse abuse and children exposed to both spouse and child abuse. The results of this study point out that spouse abusive and spouse and child abusive families differ from one another by the degree of severity. If the position holds, that co-occurrence of abuse increases the likelihood and degree of developmental difficulties in children, then when comparing children who experience multiple types of family violence with peers who only experience one form of abuse, then the behaviors will differ in a qualitative manner. This finding highlights the importance of future research conducting a more detailed assessment of emotional well-being and coping abilities.

The family characteristics measured were completed by the Conflict Tactics Scale (CTS). The mothers were asked to address rate of frequency of verbal reasoning, verbal aggression and physical aggression for self and partner over the past year, and the presence or absence of child abuse. The Brief Symptom Inventory (BSI) provided information on family stressors experienced by the family, socioeconomic status and maternal symptoms. Child characteristics were obtained by mothers completion of the Child Behavior Checklist (CBSL). Other measures included frequency of neighborhood violence and childhood physical punishment ratings reported for mother and partner.

The findings of this study indicate that families experiencing, family factors such as, family stressors, neighborhood violence and fathers' experience of physical punishment during childhood were higher in spouse and child abusive families than in spouse abusive families. In relation to child factors, children exposed to spouse abuse and/or child abuse displayed more significant difficulties with regulating emotional experience, Post Traumatic Stress Disorder symptoms and academic performance than their peers in nonviolent families. On the other hand, the one factor that discriminated between children exposed to spouse abuse and children exposed and abused, was the children's ability to show calm responses under distress with exposed abused children displaying more difficulty.

These findings denote the importance of conducting more research to address the emotional regulation and coping abilities, when attempting to understand any differences between exposed and exposed abused children. The author proposes that clinical intervention should focus on reducing adversities by helping change the "family's broader social context" (e.g., socioeconomic disadvantages, therapeutic assistance for parents and children, training to increase healthy partner and parent-child conflict), as well as, meeting individualized (e.g., anger expression) needs. One final note was to bring these programs into the home.

Title	***Exposed to marital violence: Theory, research, and applied issues***
Authors	G. W. Holden, R. A. Geffner, and E. N. Jouriles
Published	Washington, D. C.: American Psychological Association
Year	l998

This book provides an overview of the theoretical framework, research issues and future research implications about the impact of marital violence on children. It examines children's reactions to witnessing marital violence and identifies variables that contribute to developmental problems or mediate the impact of exposure to violence. The chapters entitled The Impact of Woman Abuse on Children's Social Development: Research and Theoretical Perspectives, Children Exposed to Marital Conflict and Violence: Conceptual and Theoretical Directions and Children as Invisible Victims of Domestic and Community Violence are highlighted below.

This chapter, The Impact of Woman Abuse on Children's Social Development: Research and Theoretical Perspectives, reviews the research literature on how woman battering and other variables are linked to a child's adjustment. This review also details information on how children's development is affected by witnessing abuse (i.e., especially abuse of their mother) within the framework of the social learning theory, trauma theory, and relationships theory. The social learning theory assumes that children identify with their parents. Accordingly, children who learn from the aggressor learn aggressive behavior, while children who learn from the abused mother blame themselves for problems. Trauma theory proposes that repeated violent behavior can result in post traumatic stress disorder, trauma symptoms and "intrusive re-experiencing." Relationship theory can be used to explain that children learn patterns of interactions and develop general expectations of social relationships.

The chapter Children Exposed to Marital Conflict and Violence: Conceptual and Theoretical Directions reinforces the main findings from the research about the correlation of marital conflict and violence with parent-child discipline, parenting practices, interpersonal relationships between family members and child abuse. These findings are significant for showing an association between secure parent child attachments and positive conflict resolution styles, and the stress experienced by the child during marital conflicts. In this chapter, the author addresses the need for future research to distinguish between and among the general predictors of a child's overall adjustment and those that are specifically associated with marital conflict and violence. The author describes a conceptual direction toward broadening perspectives to incorporate what stress and coping strategies children use, when exposed to varying degrees of marital conflict and violence. This direction is incorporated into a model that conceptualizes marital conflict along a continuum that ranges from "constructive" conflict to "destructive" conflict that involves physical violence. Moreover, the author proposes an "emotional security hypothesis," that looks toward understanding a child's reaction to some of the mediating factors.

The chapter Children as Invisible Victims of Domestic and Community Violence combines psychodynamic and systems theory to compare the effects of family and community violence on children's development. An understanding of the current literature on the similarities and differences between family and community violence is an important foundation to understanding how children witness violence and the impact of exposure to violence. Children are viewing multiple forms of violence, and all of these forms appear to affect children's development. Other associations with children witnessing family vio-

lence are the increased risk for continuing the cycle of violence, problem behaviors at school and difficulties with interpersonal relationships. Emphasis is placed on the indirect impacts on children exposed to marital violence, specifically, law enforcement interventions, and how violence affects the parent's ability to care for their children. The author emphasizes the need for all key players to come together to carefully examine all the mediating factors, consistently reported in the research literature, that are impacting children's adjustment, and then educate everyone on alternatives approaches to violence.

Title	***Violence in families: Assessing prevention and treatment programs***
Author	National Research Council and Institute of Medicine
Published	Washington, D.C.: National Academy Press
Year	1998

This book is cited here, despite only glimpsing the information regarding children who witness domestic violence, because it is an extensive review of the research knowledge regarding the development, implementation, and effectiveness of interventions designed to treat and prevent family violence. It is also relevant in view of the number of clinicians and service providers who become frustrated with the lack of coordination among the courts, child protective agencies, and domestic violence councils. It provides an overview of family violence and associated intervention strategies among all key agencies. The rest of the book is devoted to practical recommendations which highlight the continued need for all key players/agencies to form collaborative partnerships with the purposes of doing more sophisticated outcome evaluation, as well as, to improve service strategies provided to families.

This book mentions that children who witness domestic violence in their homes is one area of study that is beginning to emerge in the research literature. Both researchers and clinicians/service providers can assist with the development of service delivery interventions and tools to address the "hard to measure and count risk" for young children who may experience multiple stresses in their families. Another area mentioned was the need for careful interviewing techniques by professionals because children can be further traumatized (e.g., especially with testifying in the courtroom) with detailed questioning. Some research does cast doubt on the accuracy of children's testimony, and other research supports the accuracy of children's memories. Most important, is for interviewers to remember that adults can taint a child's memory when asking detailed questions.

Recently, there are insights regarding how child abuse and spouse abuse or co-occurrence develop in families over time, or how these families may be helped by both informal and formal support systems. It remains unclear as to how the multiple victims in these families support each other, or are assisted or harmed by the support systems. The present study does propose the need for collaboration among all professionals.

Title	***Interviewing child witnesses: A developmental perspective***
Author	K. Saywitz, and L Camparo
Journal	*Child Abuse and Neglect, 22 (8), 825-843*
Published	l998

This article reviews the clinical and research literature, that often is contradictory, on the issue of interviewing child witnesses. The article begins with a discussion of general guidelines on talking to children at an age-appropriate level and ways to minimize the potential for distortions. The final section addresses steps in forensic interviewing.

General Guidelines

Researchers have pinpointed that interviewers should make every effort to tailor the interview to the child's developmental age and interpret the response from a developmental perspective. Thus, it is critical for interviewers to refer to the literature on child development and/or make an informal assessment of a child's developmental functioning, to include coping ability, in advance of any questioning. The guidelines offered in this article are not meant to be exhaustive of this rather complex area of discussion.

Another important element in interviewing children is to assess a child's level of vocabulary development and comprehension of terms during the rapport stage, and match questioning to the child's level of vocabulary. Some suggestions for doing this are as follows: Replace long questions with short ones; replace 3-4 syllable words with 1-2 syllable words; use past tense (e.g., "What happened?") and active voice (e.g., "Did he talk to you?").

The content of the questions need to be associated with the child's reasoning ability. For example, if a child does not tell time, the most appropriate way to ask the questions would be as follows: "What television program was on?"

The most obvious tip is to phrase questions on a continuum and in the least leading way possible. The article cited this example; the question encourages children to elaborate in their own words ("What happened next?"), to questions that draw the child's attention to a particular topic ("Tell me about preschool."), to questions that clarify information previously discussed ("You said Mary was talking. What did she say?"), to leading questions ("Was John there?"), and to strongly worded misleading or accusatory questions ("John hurt you, didn't he?"). Leading questions can be rephrased with "what, who, where" type questions, to avoid further potential for distortions.

The research highlights the importance for the interviewer to be objective and non-judgmental and avoid being condescending or intimidating when interviewing children. The atmosphere needs to have a positive emotional tone regardless of how unbelievable the child's statements may seem. Knowing the consequences of different types of interviewing methods on the accuracy of children's memories is essential for professionals who interview children. The pace and depth of any single interview will depend on many factors and the techniques will be differentially effective in different cases.

Phases of an Interview

This article highlights important interview phases that challenge interviewers, in an attempt to optimize rather than undermine children's communicative competence, to address children's fears of interviews, and to facilitate an "honest exchange of information."

Although definitive studies have not been conducted, this article notes that in order to prepare for developmentally age appropriate questions, the interviewer needs to have a developmental history. An important goal of the interview process is the building of rapport to promote full and honest participation. The surroundings should be free of distractions and should have age appropriate toys and furniture placement. Many authors suggest interviewing children alone, but it is critical to consider any separation anxiety, especially with children 6 years and younger. Clarification of the interviewer's job and purpose is very important to avoid miscommunication and the potential for distrust.

During the rapport building phase many authors suggested assessing the child's understanding of truth. A new method used was to simply show a picture depicting two children with an apple on a table in between them. Children are told that the child on the left called the object a banana and the child on the right called the object an apple. The interviewer asks either "Which child is telling the truth?", or "Which child is telling a lie?" Additionally, reviewing with the child about the process of the interview is important. A number of researchers also suggest a warming up stage before questioning begins such as, having children recall two recent events (e.g., birthday party, celebration, school outing and etc.), or a prepared script to promote expectations about the interview process and offering instructions (e.g., warning a child that some questions may be hard to answer and telling them to say so).

This article describes six steps which are adopted from Saywitz, L, and Elliot, D. (in press), On interviewing children in the forensic context: A developmental approach, Washington, DC: American Psychological Association. These steps are as follows (e.g., these steps are used with older school age children):

Step 1: General Open-ended Questions
"Is there anything you want to tell me?"
"...anything you think I should know?"
"-anything you want to me to tell the judge?"

Step 2: Prompted Elaboration of Initial Narrative
If a narrative follows the open-ended question,
Do not interrupt.
Urge children to elaborate on the facts mentioned.
Use general prompts such as tell me more, what happened next, what else.

Step 3: Categorical "Wh" Questions to Follow-up Children's Leads
Who was there? What were they wearing?
Where were you? What did they say?
What happened next? When?

Step 4: Request Elaboration, Clarification or Justification of Answers to Follow-up Questions
Tell me more. I'm confused. What makes you think so?

Step 5: Specific Open-ended or Short Answer Questions
What color was it? How tall was he?
What kind of...was it?
How did you feel? How did he feel?

Step 6: Elaboration, Clarification, Justification of Answers
Tell me more. I'm confused. What makes you think so?

The author states that the objective of this article was to better inform practitioners on the interviewing practices for which there is some empirical support.

Title	***The impact of domestic violence on children***
Author	Martha J. Markward
Journal	*Families in Society, 78 (2), 66-70*
Year	1997

The impact of domestic violence on children is an important area of concern for all community health professionals who work with both abused children and adults. This article states that the literature regarding how domestic violence affects individual children has progressed beyond descriptive information, but the literature on how spouse abuse in particular situations affects all children is sparse.

This article attempts to explore the "social reality" children create for their behavior on the basis of how children interpret violence when they witness spouse abuse only or when they experience or witness child abuse. Given this premise, the behaviors of children in particular environments provide insights into their interpretations of normal behavior in those situations. This article proposed that it seems plausible that behaviors of children who witness or experience child abuse and witness spouse abuse might appear more distorted or maladaptive than the behaviors of children who witness only spouse abuse.

The literature review of this article suggests that physically abused children are less securely attached, less able to express emotions, and more aggressive than other children. Children who witness spouse abuse display varying degrees in psychological adjustment and their reactions to witnessing violence are similar to those of children who have been physically abused; and the impact of children witnessing or experiencing other types of abuse on their adjustment is less clear. Accordingly, there are gaps in this research area.

This study suggests that if we accept the notion that children may interpret their abuse or the abuse of other children differently from the way they interpret witnessing abuse of their caretaker (i.e. often mothers), then professionals involved in crisis intervention might wish to allow children the opportunity to create a "new social reality" by helping them focus on positive interpretations rather than the negative behavior they witness. For example, professionals might highlight the positive behaviors when asking questions such as "If you were living in a situation in which you did not observe your mother's abuse what would it be like?" The hope is that this type of intervention can provide information about how

children cope with their own abuse. Future research needs to investigate hypothesis which suggest that children's responses to conflict depend on their experiences.

Title	***Research concerning children of battered women: Clinical implications*** in R. Geffner, S. B. Sorenson, and P.K. Lundberg-Love, (Eds.) Violence and sexual abuse at home: Current issues, interventions and research in spousal battering and child maltreatment
Author	H. M. Hughes
Published	New York: Haworth
Year	1996

The author briefly reviews the research literature describing the negative influence battering has on children's adjustment and presents theoretical/conceptual models for understanding how this impact occurs.

Overview and Prevalence

This chapter explains that researchers who have looked at the association between marital violence and children's negative behavioral adjustment are now exploring combinations of factors which could account for the multiple causes for the problems that children experience when witnessing marital violence. This article attempted to convey a sense of the estimated number of children who experience violence in the home, with estimates ranging from 10% - 30% of families (Geffner and Pagelow, l990; Pagelow, l984; Straus and Gelles, l986). Using battered woman's reports regarding where children were during the violence, in 90% of the cases children were reported to be in the same or next room (Hughes, Parkinson, and Vargo, l989; Rosenberg and Rossman, l990).

The finding suggests that behavioral and emotional problems are significantly higher for children of battered women than other children. Some of the problems mentioned were adjustment problems, cognitive skill deficits, lower school achievement, difficulties with problem solving, somatic symptoms and psychopathology.

Variables that Mediate the Impact on Children

This review reports that researchers are looking at more then just the developmental problems associated with exposure to battering. The complexity involves the various moderating child factors and situational factors. Child factors or characteristics of individual children are traits, such as, temperament, self-esteem, cognitive abilities, coping strategies, attributional style, age, and gender. Situational factors include aspects of the marital conflicts such as frequency, intensity, duration, content, resolution, and child's age at the onset, as well as, past experience with violence.

A more in depth review of gender reveals some inconsistencies, yet gender is an important mediator in that frequently more girls than boys have been reported to internalize and externalize problems. Another finding is that spouse and child abuse are both likely to occur in the same family, with estimates in the range of 40%-60% of co-occurrence (Forrstrom-Cohen and Rosenbaum, l985; Rosenbaum and

O'Leary, l981; Straus, Gelles, and Steinmetz, l980). Other findings examine children's exposure to multiple forms of family violence. In these studies the more types of violence children were exposed to, the less well adjusted they appeared to be. More specific findings suggest that the impact on children is more distressing when witnessing physical aggressive marital conflict than verbal marital conflict.

Mechanisms by Which Spouse Abuse Exerts an Impact

Direct mechanisms outlined in this review regarding the impact of battering on children include modeling of aggressiveness and stress in the family. If one accepts the assumption that children learn through modeling, then watching adults be aggressive not only influences children to act that way but it gives them permission to be aggressive. Being exposed to chronic stress by the battering over time, will reduce the quality of the child's adjustment (i.e., experiencing anxiety and depressive symptoms and symptoms similar to Post Traumatic Stress Disorder).

Indirect mechanisms include characteristics of parent-child relationship, and disciplinary practices that are exceedingly negative and inconsistent. The same research findings reveal that the mother's physical and mental health predicted children's adjustment better than the actual abuse between parents. The mother's parenting stress levels is also a significant predictor of the child's adjustment problems. Similarly, a model on attachment theory (i.e., marital conflict undermines the children's emotional security toward healthy adjustment) is presented with evidence that marital conflict causes children to have concerns about their emotional security. Also, ineffective parenting puts children at higher risk for developmental problems such as aggressiveness.

The implications of these mechanisms have important ramifications for clinical intervention strategies.

Goals of Intervention

The goals of treatment are to provide immediate safety and shelter, to help children feel emotionally secure, and to increase their competence and psychological adjustment. More important, is the need to tailor the intervention strategies to the specific client needs. Regarding interventions, focusing on stress and the parent-child relationship, several sources report that cognitive behavioral techniques (e.g., relaxation training, social problem-solving, eliminating irrational beliefs, and learning stress-reducing thought patterns) can be effective with both aggressive symptoms and stress. This review points out that aggressiveness can be treated effectively with teaching problem solving and/or anger control skills, especially with older children.

Interventions also need to concentrate on parenting practices such as discipline. Another direction is to focus on how to empower the mother's overall functioning so they can meet their children's needs. In addition, play therapy was suggested as a means to help children deal with both internalizing and externalizing problems.

Despite some shortcomings, the majority of the studies did not evaluate interventions with children who witnessed spouse abuse. More work needs to be done to determine which types of treatment are most effective with children with particular difficulties and in different circumstances.

Group versus Individual Intervention

Service providers often rely on clinical and theoretical information, since there is little empirical research guiding intervention strategies. Most of the literature points to the use of group treatment with children

of battered women. The goal is to provide children accurate information about violence and pro social skills, and teach them coping strategies.

Individualized treatment is suggested to be more effective with children who have more severe problems. The chapter on individual interventions with children of battered women by Silvern et al. (l995) provides detailed information.

Title	***Children: The unintended victims of marital violence***
Author	Rosenbaum, A. and O'Leary, K. D.
Published	*American Journal of Orthopsychiatry, 51 (4), 692-699*
Year	l981

This article reviews the effects of children witnessing violence between adults in their homes. Emphasis is placed on behavior problems of the children and potential long-term consequences of the "unintended victims." One finding is that several factors appear to mediate the degree to which marital discord and violence between adults contribute to behavioral problems of children. The intertwining factors appear to affect children differently, in that some children appear to develop increased vulnerability to "conduct or personality problems." A finding reported in this study was that the abusive husband is more likely than others to have grown up in homes where adult domestic violence was occurring. This study did not show the same association for an abusive wife. This suggests that male children from violent families of origin may carry this dynamic into their adult interpersonal relationships. However, the author urges future research to investigate all children, to have appropriate comparison groups and to standardize definitions of child behavior problems. Another finding from this study confirmed the relationship between spouse abuse and the occurrence of child abuse. The author urges clinicians to assess for child abuse in families were spouse abuse is occurring.

INTERNET RESOURCES

Minnesota Center Against Violence and Abuse (MINCAVA)
http://www.mincava.umn.edu
386 McNeal Hall
1985 Buford Avenue
University of Minnesota
Saint Paul, MN 55108
(612) 625-4288

This internet resource, through the University of Minnesota, has two separate access points and purposes. One is the MINCAVA clearinghouse which provides links on violence, the Link Research Project, which provides information more specific to child abuse and woman battering.

MINCAVA operates an "Electronic Clearinghouse via the World Wide Web with access to thousands of Gopher Servers, interactive discussion groups, newsgroups and Web sites around the world." This site provides a quick link to a host of other internet sites that focus on violence and family violence. The documents available on this site and other sites are provided in multiple formats in order to be used in a variety of ways (e.g., Adobe Acrobat Reader).

The Link Research Project provides current information on research and intervention with families experiencing both child abuse and "woman battering." One goal of this link is to develop multiple disciplinary models for working with this population and encouraging researchers and practioners to work collaboratively. This project operates as part of MINCAVA and the School of Social Work at the University of Minnesota.

Comments

- MINCAVA provides current information and offers user friendly access points to an **extensive listing of resources**, documents upcoming events and **direct links** to other internet sites which target violence and family violence.
- Documents can be obtained from a variety of different links. Refer to the thorough table of contents for clarification; find under "Table of Contents."
- The Link Research Project focuses on child maltreatment and woman battering.

Publications (Find these links through the MINCAVA site)

- Find under "Papers and Reports" and select from this partial listing of topics: "battered women and their children," "family violence or men who batter" for access to scholarly papers and information.
- Find under "Web Links" 26 topics areas, such as, child abuse, child abuse and violence against women, domestic violence and violence against women. This access point is subdivided in the following way: articles, fact sheets, and other informative resources; institutions and organizations; legal resources and; regional service providers.

Sample Links and Documents (These are direct excerpts from MICAVA "web links" under Domestic Violence and Violence Against Women—articles, fact sheets, and other informative resources)

- Protecting Children in Families Involved in Domestic Violence is a report sponsored by the Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota.
- Other Useful Information on Children and Families-Violence Prevention is a section of the Children's, Youth & Families Consortium's Electronic Clearinghouse. It contains reports, newsletters, and various other resources relating to families and violence.

Publications (Find these samples through The Link Research Project site)

Find under http://www.mincava.umn.edu/link/http://www.mincava.umn.edu/link/and "Current Research"

- Mothers and Children: Understanding the Links Between Woman Battering and Child Abuse is a briefing paper by Jeffery L. Edleson for a strategic planning meeting on Violence Against Women Act.
- Child Witness to Domestic Violence is a brief paper written by Kathryn Conroy, DSW, on the effect of children witnessing their mothers being battered.

Military Family Institute
http://mfi.marywood.edu
Marywood University
2300 Adams Avenue
800-252-2316

The primary mission of the Military Family Institute (MFI) is to conduct research on military families in order to increase readiness and retention in the Armed Forces. Another mission is to implement appropriate collaborations between military and civilian communities to enhance ways to improve family adaptation. These missions are accomplished through designing research in collaboration with the Office of the Secretary of Defense, analyzing and disseminating the research findings, recommending policies, programs and procedures regarding family adaptation, reviewing and summarizing and making recommendations to DoD concerning family research conducted by other individuals or agencies, and conducting conferences, seminars and meetings that will facilitate the identification, coordination and dissemination of military family research.

Comments
- This site is a valuable resource for all aspects of FAP.
- Lists upcoming events and conferences.

Publications
- Access to Military Family Issues: The Research Digest which documents the objectives stated above and provides useful web site connections. Lists current completed research and other studies, found under "Research Projects," and provides several links and options to obtain available documents.

National Clearinghouse on Child Abuse and Neglect Information
http://www.calib.com/nccanch
330 C Street, SW
Washington, DC 20447
(800) 394-3366

This is a clearinghouse which provides current information on prevention, identification, and treatment of child abuse and neglect and other related areas. The clearinghouse database searches more than 27,000 documents related to child welfare issues.

Comments
Offers information on available databases, catalogues, general services, other internet links and publications.

Publications
Find under "Publications," with a submenu find "bibliography," and then find "children who witness violence." Approximately 27 resources are identified and how to locate these documents.

Sample Document (This is an excerpt from this site.)
Williams, E., Weil, M. and Mauney, R. (l998). Children and Domestic Violence: Recognizing Effects and Building Programs. In Harms, T, Ray, A. R., and Rolandelli, P. (Ed.), Preserving Childhood for Children in Shelters, (pp. 23-48). Washington, D.C.: Child Welfare League of America, Inc. This chapter explains the effects of woman battering on children in the household and describes how domestic violence shelters can address the needs of children, depressed, and-or aggressive. They may feel guilt or shame about the abuse if they blame themselves for the violence and may be confused about their feelings regarding their partners. Some children may be injured themselves when they try to protect their mother or get in the way during attacks. In many case of domestic violence, the children are abused as well. Shelter staff should avoid blaming mothers for domestic violence and the abuse of their children and instead praise the mothers and children for surviving the traumatic experience. However, shelter personnel are mandated to report suspected child abuse and neglect. In addition to support service for battered women, shelters should also address the needs of the children, with counseling, court advocacy, skill training, entertainment and developmental activities, safety planning, and case management. The chapter reviews principles of services for children in domestic violence shelters and describes models for community-based post-shelter programs. There are 35 references and 3 figures.

Samples of other documents that are summarized:
- Moffitt, T.E., and Caspi, A. (February l998). Annotation: Implications of Violence Between Intimate Partners for Child Psychologists and Psychiatrists. Journal of Child Psychology and Psychiatry, 39 (2), 137-144.
- Kilpatrick, K.L, and Williams L. M. (April, l998). Potential Mediators of Post Tramautic Stress Disorder in Child Witnesses to Domestic Violence. Child Abuse and Neglect, 22 (4), 319-330.
- Trickett, P.K., and Schellenbach, C. C. (l998). Violence Against Children in the Family and the Community. Washington, D.C.: American Psychological Association.

The Domestic Violence and Incest Resource Centre (DVIRC)
http://home.vicnet.net.au/~dvirc
139 Sydney Rd,
Brunswick Victoria, Australia 3056

This program provides information and resources to everyone, and professional training and technical assistance to the Victorian health and welfare agencies and persons who have experienced domestic violence or sexual assault. It was established to provide consolidated information on domestic violence and child sexual abuse.

Comments
- Appears to offer a range of current information, with easy reading on topics such as child sexual abuse, domestic violence and children who witness domestic violence.
- Offers useful resource listings on available manuals and other publications (e.g., journal articles, videos, books, pamphlets, etc.).
- Provides links to other sites.
- The Minnesota Center Against Violence & Abuse operates this site's electronic clearinghouse.

Sample Document

- Information for Mother and Other People Concerned About Those Who Witness Domestic Violence, DVIRC information pamphlet, September, l997. This pamphlet gives a general overview on ways to help a child who has witnessed domestic violence and ways adult victims, especially mothers can help themselves and their children, and lists other related web sites.

Violence Against Women and Family Violence
http://www.ojp.usdoj.gov/nij/vawprog/

The Violence Against Women and Family Violence (VAWFV) Research and Evaluation program is supported by the Office of Research and Evaluation of the National Institute of Justice (NIJ). This program forges partnerships with federal agencies to carry out a variety of initiatives, such as, conducting field research to test new approaches to intervention with abused women and family violence, evaluating these field test, and working with other federal agencies to promote collaborative research initiatives.

Comments

- Offers a sampling of publications that can be copied directly from this site.
- Provides information on forthcoming conferences and jointly sponsored projects.
- Provides links to other related sites.
- The Minnesota Center Against Violence and Abuse operates this site's electronic clearinghouse.

Publications

Find under "publications" information on children witnessing domestic violence: Edleson, J. (Revised April, l999). Problems Associated with Children's Witnessing of Domestic Violence. University of Minnesota School of Social Work. (*this article is similar to the articles by Edleson cited in the annotated bibliography in Appendix L).

Find under "related links" and under NIJ Reports at the Urban Institute Site to refer to samples of available documents, such as the two listed below:

- Coordinated Community Responses to Domestic Violence in Six Communities: Beyond the Justice System, October, l996. By Sandra J. Clark, Martha R. Burt, Margaret M. Schulte, Karen Maguire.
- Efforts by Child Welfare Agencies to Address Domestic Violence: The Experiences of Five Communities, March l997. By Laudan Y. Aron and Krista K. Olson.

APPENDIX M: VICTIM ADVOCATE

Job Description: Victim Advocate

Reference: Chapter 4.2 a (8)

This section includes a sample job description for a Victim Advocate.

NOTES

JOB DESCRIPTION VICTIM ADVOCATE

INTRODUCTION

This position is located within the Family Advocacy Program (FAP) at the Army Community Service (ACS), _____. The primary purpose of this position is to provide comprehensive assistance and liaison to and for victims of spouse abuse; and to educate personnel on the installation regarding the most effective responses to domestic violence on behalf of victims and at-risk family members.

MAJOR DUTIES AND RESPONSIBILITIES

1. Screens victims of spouse abuse, evaluates their needs, and provides them with information about domestic violence, safe and confidential ways to seek assistance, their rights as Army spouses, and the resources and services available to them. This involves maintaining current information on resources and services, and advising victims before disclosure of the limited confidentiality rule.

2. Coordinates with case manager in developing appropriate plan of assistance/intervention which provides for the safety of the victim and their family members. When FAP case managers are not on duty, this may involve working with law enforcement and/or the sponsoring command. This involves decisions affecting a wide range of problems and services, some of which are quite difficult.

3. Non-voting member of the Case Review Committee.

4. Provides services for victims of spouse abuse and their families to include the following: crisis intervention; assistance in securing medical treatment for injuries; information on legal rights and resources available through both military and civilian programs; education; transportation; pre-trial, trial; and post-trial support; and, follow-up. Assists in conducting support groups for victims. Makes referrals to other helping agencies. Provides follow-up to all identified victims (to include those who have declined services) three months following initial contact to ensure that no further intervention is necessary.

5. Maintains a notebook of contacts and referrals. Ensures that case manager is fully aware of victim's situation and requests necessary entries be made by case managers into the appropriate case record. Ensures confidential handling of all documents or conversations relative to victim care.

6. Advocates for the expressed interest and safety of the victim when providing testimony in the court martial or civilian judicial system.

7. Understands and anticipates the nature of the position requiring some off-duty hour requirements, to include a 24-hour duty rotation.

8. Provides input to FAP Manager in the establishment and implementation of local policies and directives pertaining to the Family Advocacy Victim Advocate Program.

9. Assists with measures designed to determine program effectiveness.

10. Recruits, trains, coordinates, and supervises volunteer victim advocates to provide direct services such as crisis intervention and assistance with legal proceedings.

FACTOR 1. KNOWLEDGE REQUIRED BY THE POSITION

Professional knowledge of social services work, counseling services, psychosocial principles and theories, and group dynamics of family and individual systems such as would be attained through earning a baccalaureate degree from an accredited college or university in the area of sociology, social work, psychology, or education.

Knowledge of the dynamics of domestic violence.

Intensive practical knowledge of community resources and services, crisis intervention, and how individuals in distress may quickly obtain the types of assistance they need.

Knowledge of laws pertaining to family relationships and protection of children and adults. She or he is not required to have formal training in any aspects of law but must be capable of working and interacting with lawyers, court officials, police, etc. Experience with preparing court testimony and victim impact statements is helpful.

Knowledge of military organization, missions, lifestyles, and situations which can contribute to family stress, problems and crisis situations.

Demonstrated ability to communicate effectively with diverse individuals during crisis situations, including persons in the medical, legal, and social service communities. Ability to express oneself orally and in writing in a highly professional manner, to meet and deal with diversified groups, individuals and organizations, and to compose written reports and material clearly, concisely, and effectively per military format.

Familiarity with the dynamics of substance abuse, particularly with regard to recognizing symptoms and understanding the impact upon family dynamics.

Current license and physical ability to operate a motor vehicle.

FACTOR 2. SUPERVISORY CONTROLS

Works under the supervision of the Family Advocacy Program Manager (FAPM), and in her/his absence, the ACS Director acts as the supervisor. Supervision is normally exercised through case staffing, regularly scheduled conferences, and review of client contacts and referrals, reports, and correspondence. The incumbent works with relative independence in the routine activities of the positions such as seeking out the types of community services/resources needed. She/he is expected to exer-

cise good personal judgment in the application of procedures to cases. Actions taken in particular cases must be consistent with the plans of the professional social workers or a counselor who is the case manager. The supervisor maintains a close operational control of decisions and services when the incumbent is dealing with serious problems demanding unusual skill and judgment.

FACTOR 3. GUIDELINES

Guidelines include DoD Directives, Army Regulations, state and local laws pertaining to criminal domestic violence, other materials and professional standards appropriate to the various fields of human services, the ACS and FAP standard operating procedures and direction from the C, SWS. The incumbent should have the ability to interpret these regulations and should be capable of using sound judgment in following them. Issues in the FAP are very sensitive in nature and require a great degree of confidentiality.

FACTOR 4. COMPLEXITY

The Victim Advocate, while receiving some instruction, must analyze many factors in each case so as to seek out those resources which are critically needed and most likely to be responsive. The incumbent must be able to take initiative in responding to cases and effectively understand the problem or interrelationship of problems, work through them with the client to reach workable, satisfactory resolutions. She/he must also be able to prepare and present briefings to all levels of the command structure.

FACTOR 5. SCOPE AND EFFECT

The incumbent assists professional social work and counseling staff in providing assistance to victims of domestic violence. This includes interfacing with both military and civilian medical, legal, social service, and criminal justice systems. In providing education and training on domestic violence, the incumbent impacts on the command at large. Both functions relate directly to the well-being of military personnel and their families and in turn affects their morale and productivity, and the Command's readiness.

FACTOR 6. PERSONAL CONTACTS

The incumbent has contacts with diverse individuals and groups. Contacts include psychologists, unit commanders, clients, physicians, dentists, professional educators, chaplains, social workers, state and local government agencies, probation officers, police officers, lawyers and judges. These contacts are highly sensitive and require discretion, diplomacy and professionalism, and the ability to quickly bring knowledge to bear in a problem situation.

FACTOR 7. PURPOSE OF CONTACTS

The purpose of contacts is to protect victims in crisis, establish, ensure, and carry out effective cooperative relationships with both the military and civilian communities; exchange information; coordinate activities and services; discuss, advise and solve case problems; and to provide education and training to prevent domestic violence.

FACTOR 8. PHYSICAL DEMANDS

The work involves sitting, standing, bending, climbing stairs, walking, and driving. Extensive traveling in the local area to government quarters, victim's shelter, hospitals, courts, lawyer's offices, etc. is necessary. Some lengthy crisis intervention and advocacy endeavors may be stressful and fatiguing. A valid driver's license and ability to lift up to 40 lbs. is required.

FACTOR 9. WORK ENVIRONMENT

Work is performed both in a normal office setting and out in the community including government quarters and private residences. Activity takes place in all social service/law enforcement and medical type facilities. The work schedule is highly flexible and the hours vary according to the needs of the victims. The client population for this position includes individuals who may be upset, anxious, angry, withdrawn, etc.