UNITED STATES MARINE CORPS
MARINE CORPS BASE HAWAI'I
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MARINE CORPS BASE HAWAI'I ORDER 1754.1A

From: Commanding Officer
To: Distribution List

Subj: FAMILY ADVOCACY PROGRAM

Ref: (a) DoD Instruction 6400.01, "Family Advocacy Program (FAP)," May 1, 2019
(b) DoD Instruction 6400.06, "Domestic Abuse Involving DoD Military And Certain Affiliated Personnel," August 21, 2025
(c) DoDM 6400.01, Volume 3, "Family Advocacy Program (FAP): Clinical Case Staff Meeting (CCSM) and Incident Determination Committee (IDC)," August 11, 2016
(d) SECNAVINST 1752.3B
(e) MCO 1754.11A
(f) SECNAVINST 1754.7A
(g) DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014
(h) DoD Instruction 6400.3, "Family Advocacy Command Assistance Team (FACAT)," April 25, 2014
(i) SECNAV M-5210.1
(j) 10 U.S.C. § 47
(k) DoD Instruction 1402.05, "Background Checks on Individuals in DoD Child Care Services Programs," September 11, 2015
(l) 42 U.S.C. § 13031
(m) Manual for Courts-Martial (2019 Edition)
(n) DoD Instruction 1342.24, "Transitional Compensation for Abused Dependents," September 23, 2019
(o) SECNAVINST 1752.5B
(p) MCO 1752.5C
(q) DoD Instruction 6400.05, "New Parent Support Program (NPSP), "June 13, 2012
(r) SECNAVINST 1730.9A

Encl: (1) Definitions
(2) Criteria for IDC Determination of Reports of Child Abuse and Domestic Abuse
(3) Memorandums of Understanding
(4) Family Advocacy Flow Charts for Reporting Child and Domestic Abuse
(5) Child Supervision Matrix

1. Situation. This Order amplifies the policies set forth in the references. It provides specific guidance for the administration of Marine Corps Base Hawai'i (MCBH) Family Advocacy Program (FAP). To define the terminology, concepts, standards, and procedures for commanding officers (CO) and their staff members to effectively respond to incidents of domestic abuse at MCBH.

2. Cancellation. MCBHO 1754.1.

3. Mission. The FAP is designed to assist commanders by providing a Coordinated Community Response (CCR) to domestic and child abuse that will ensure all agencies, individuals, and disciplines involved in the prevention, identification, assessment, treatment, and management of family advocacy matters cooperate and coordinate their efforts to the fullest extent possible to best serve Marines, Sailors, and their families. The goal of the CCR is to prevent abuse, protect and provide safety for victims, to intervene and treat offenders, ensure that offenders are held accountable for their behavior, and to promote a climate in the Marine Corps that does not tolerate domestic and child abuse.

4. Execution

a. Commander's Intent. Domestic and child abuse will not be tolerated aboard MCBH. As part of the tradition of "taking care of our own," it is the responsibility of each Navy and Marine Corps Service Member to ensure the safety, health, and well-being of his/her family members and that of his/her fellow Service Members. Acts of family violence or neglect are in direct conflict with the high standards of professional and personal discipline required of members of the Armed Services.

b. Concept of Operations

(1) The primary goal of this program is to ensure the safety of victims of abuse and to prevent future incidents of domestic abuse.

(2) This program must receive command emphasis and support at all levels throughout MCBH and all tenant commands aboard the installation to be effective.

(3) Cases of intimate partner/child abuse occur throughout all grades/ranks and must be addressed without regard for grade or position.

(4) The three keys to changing social and military behavior regarding domestic abuse are educational programs, command monitoring, and a defined policy that addresses incidents on a case-by-case basis.

(5) The implementation of this program requires a coordinated community effort, defined as the CCR between:

(a) COs of subordinate and tenant commands.

(b) FAP Manager (FAPM).

(c) Director, Marine and Family Programs (MFP).

(d) Provost Marshal Office (PMO)/Criminal Investigation Division (CID).

(e) CO, Naval Health Clinic Hawai'i (NHCH).

(f) Staff Judge Advocate (SJA).

(g) Director, Substance Assessment Counseling Center (SACC).

(h) Command Inspector General (CIG).

(i) Supervisory Special Agent, Naval Criminal Investigative Service (NCIS).

(j) Director, Child, Youth and Teen Programs.

(k) Base Chaplain.

(l) Victim's Legal Counsel.

(m) Off-base Civilian Agencies:

1. Honolulu Police Department (HPD).

2. Child Welfare Services (CWS).

3. Social Service Organizations.

4. Judicial Branch.

(6) The elements of a successful program that address all aspects of intimate partner and child abuse and neglect include, but are not limited to, the following:

(a) Establishing and implementing a reporting protocol for domestic violence, and child abuse and neglect that is available 24-hours-a-day and tailored to the specific needs of MCBH.

(b) Establishing clear standards for personal behavior and holding offenders accountable.

(c) Creating an atmosphere which encourages victims of abuse to come forward and seek assistance.

(d) Establishing a climate that confronts the beliefs, values, and behaviors that contribute to child abuse, and domestic abuse.

(e) Facilitating the ongoing education of Marines on how to prevent incidents of child abuse and domestic abuse, while also encouraging victims and witnesses to report these incidents when they occur.

(7) The primary focus of this program is to address allegations of spouse/child abuse and neglect. References (a) through (e) provide detailed information about the Marine Corps FAP and standards. Familiarity with the references and the enclosures by all military and civilian personnel assigned

to MCBH is essential for an effective response. Terms used in this Order are defined in enclosure (1).

c. Organizational Structure. The major components of the FAP are the Installation CO, the COs of subordinate and tenant commands, the FAPM, the Family Advocacy Committee (FAC), the Incident Determination Committee (IDC), and the Clinical Case Staff Meeting (CCSM).

(1) Installation CO

(a) Ensures that all personnel involved with the CCR to child abuse and domestic abuse receive training and comply with their defined roles, as outlined in references (a) thorough (e).

(b) Establishes and monitors an installation FAC for the prevention, reporting, investigation and treatment of child abuse and domestic abuse, in accordance with reference (a). The goal of the FAC is to oversee the operation of the FAP to ensure CCR to domestic violence.

(c) Publish written policy addressing domestic and child abuse.

(d) Establish an IDC to review reports of child and domestic abuse.

(e) Ensure availability of a 24-hour reporting and emergency response system capable of providing immediate protection to victims of child abuse, sexual assault, and domestic abuse on the installation.

(f) As appropriate, establish Memorandums of Understanding with CWS, civilian law enforcement, and other civilian agencies adjoining MCBH to assist in the CCR.

(g) Ensure that FAP provides training on the prevention of and response to child abuse and domestic abuse to commanders within 90 days of assuming command and annually to the total force.

(h) In collaboration with the FAPM, may request a Family Advocacy Command Assistance Team (FACAT) through the Commandant of the Marine Corps when alleged child sexual abuse by a care provider in a Department of War (DoW)-sanctioned-activity has been reported and at least one of the following apply:

1. Additional personnel are needed.

2. The victims are from different military services or other DoW components, or there are multiple care providers who are the subjects of the report, and they are from different military services or other DoW components.

3. Significant issues in responding to the allegations have arisen between the military services or other DoW components and other Federal agencies or civilian authorities.

4. The situation has potential for widespread public interest that could negatively impact performance of the DoW mission.

(2) COs of Subordinate and Tenant Commands

(a) Hold military offenders accountable, in accordance with reference (e).

(b) Issue and enforce Military Protective Orders (MPO) when necessary to ensure the protection and safety of victims, as outlined in reference (e).

1. The MPO may include conditions on the liberty of the Service Member such as an order to remain away from family quarters unless accompanied by a command representative, or to refrain from contacting named persons at any location or by any means. When a MPO is issued to a Service Member, forward copies to PMO and the FAP.

2. Secure safe housing for the victim as needed. Per MCBHO 11000.22A, section 3-6,9; Military Protection/Temporary Restraining Orders/No contact orders, unit commanders may authorize E-5s and below who have been displaced from their home in accordance with a military protective order/temporary restraining order/no-contact order to reside in the barracks, space permitting. E-6s and above should not be place in the barracks, absent extenuating circumstances.

3. Before allowing the Service Member to return to quarters (government or civilian), ensure an assessment has been completed at FAP. The unit must notify the spouse of when the Service Member will be allowed to return to the quarters at the end of the workday. If the spouse cannot be contacted, the unit will contact FAP to pass the above information.

(c) Receive training on the prevention and response to child abuse and domestic abuse within 90 days of assuming command, and annually thereafter, per reference (c).

(d) Ensure completion of FAP IDC training prior to participation in IDC, in accordance with reference (c) and (e).

(e) Appoint a primary and secondary officer to receive training and participate in the IDC, as detailed in reference (e). Secondary appointees participate in the IDC only in the event that the primary appointee is unavailable. This requirement only pertains to those commanders who are convening authorities.

(f) Participate in the IDC.

(g) Support CCSM treatment recommendations, in accordance with references (a) and (e).

(h) Notify the installation FAPM when orders are pending to reassign Service Members and/or family members with open FAP cases.

(i) Ensure all Marines attend annual educational/awareness briefings on the prevention of child abuse and domestic abuse.

(j) Report to FAP any suspected and alleged incidents of child abuse and neglect and domestic abuse occurring on MCBH or involving military personnel or their families within their command, as required of all mandated reporters in reference (a).

(3) FAPM

(a) The FAPM has overall responsibility for the daily operation of the FAP in accordance with references above.

(b) The FAPM serves as MCBH's subject matter expert in the area of domestic abuse and child abuse and neglect.

(c) Identify and recommend through the chain of command resources necessary to accomplish FAP mission, including the FAC.

(4) FAC

(a) The purpose of the FAC is to operationally function as a CCR that provides policy and program level oversight for the FAP. The FAC is responsible for ensuring the development and implementation of this Order and an annual FAP plan. The FAC is also responsible for ensuring a 24-hour-a-day mechanism is established for receiving reports for alleged domestic abuse and/or child abuse, the deployment of the FACAT when appropriate, and the collaboration between FAP and subordinate and tenant commands for both the treatment and prevention of domestic abuse and child abuse.

(b) The permanent membership of the FAC will consists of the following members:

1. Installation CO, Chair of the FAC.

2. FAPM.

3. Base Sergeant Major.

4. M&FP Director.

5. FAP Prevention Specialist

6. SJA.

7. PMO, CID, or NCIS.

8. Chaplain.

9. Medical Treatment Facility Representative.

10. Other representatives as deemed appropriate by the FAPM.

(c) Permanent FAC members will be appointed in writing by the Installation CO.

(d) The FAC will meet at least quarterly. Minutes will be

maintained that address all content areas required by section 5-3(d) of reference (e).

(5) IDC

(a) The purpose of the IDC is to decide which referrals for suspected child abuse or unrestricted domestic abuse meet the DoW criteria found in enclosure (2) that defines such abuse, requiring entry into the FAP Central Registry. Enclosure (5) also includes MCBH's Child Supervision Requirements that clarify standards regarding the supervision of children as defined by the DoW criteria. This decision is known as the Incident Status Determination (ISD).

(b) The IDC will be a multi-disciplinary team appointed in writing by the Installation CO. All IDC voting members must be IDC trained in accordance with guidance in reference (e). Membership includes the following:

1. IDC Chairperson. The CO, MCBH must choose a Senior Military Officer with equivalent, but not more than one pay-grade lower, to serve as the IDC Chairperson. MCBH can also request a waiver for its Marine civilian Chief of Staff to serve as the IDC Chairperson.

2. Base Sergeant Major.

3. A military officer or staff non-commissioned officer from the PMO, or CID, and/or a NCIS investigator.

4. A judge advocate from SJA Office.

5. The FAPM.

6. Unit CO. The unit CO (squadron or battalion level) of the active duty alleged offender or active duty victim, or the active duty sponsor in cases of child abuse, should participate in the IDC and is a voting member. In cases of dual military, both COs are voting members.

7. A designated health care provider from the installation Military Treatment Facility (MTF) or another MTF supporting the installation, with the requisite medical training and expertise to offer medical opinion on domestic abuse and child abuse injuries.

(c) The IDC shall meet, at minimum, monthly.

(d) Deliberations

1. Relevant information. The IDC shall only discuss that information related and pertinent to the specific allegation(s) presented, and the criteria each type of alleged abuse requires as set forth in references (a), (d), and (e).

2. The FAPM shall introduce the case. Ensure ISDs are made on an incident by first identifying each type of alleged abuse. The CO of the sponsor shall open the discussion of the incident by presenting the information the command has received about the incident. When a law

enforcement response or criminal investigation has occurred with respect to the incident, the PMO/CID or NCIS representative shall present information for criteria relevant to the incident. Each IDC member and authorized guest may present additional information relevant to determining whether the incident met the appropriate criteria defined in enclosure (2).

3. In cases with diverging accounts, at the discretion of the Chairperson, the IDC may consider readily available historical information related to abuse, power and control, as well as witness reports when making a credibility determination.

4. Separate allegation numbers will be created for each victim and each incident of abuse.

5. The IDC shall make ISDs within 60 days of the initial report of child or domestic abuse.

6. Each voting member shall vote "meets" or "does not meet" criteria for each part A, B, and if applicable C for each allegation of abuse.

7. The IDC deliberations and each member's vote is confidential.

(e) Record of deliberations shall be kept in accordance of reference (e), section 5-10 (f), by the FAPM. Unit COs will receive a disposition letter on each case brought before IDC. These letters contain privacy-sensitive information. As such, these letters shall be addressed to the appropriate CO, and FAP clinicians/case managers shall inform the family member or other person who is the alleged abuser, victim, or parent of a victim of the ISD determination. Unless otherwise required, no other information regarding the IDC and ISD decision process shall be disclosed.

(f) Review of an IDC Decision

1. Information regarding the review process shall be provided to the alleged abuser, victim, or parent on behalf of a child victim, in a statement of rights during a FAP assessment as well as in the IDC disposition letter.

2. The alleged abuser, victim, parent on behalf of a child victim, CO, or initiating IDC member may request, in writing, a reconsideration of the ISD within 60 calendar days of the notification of the ISD based on the following criteria: (a) the IDC did not have all the relevant information when it made its finding; (b) evidence that the IDC did not follow policy published in this Order or its references; or (c) not guilty or guilty finding after a military or civilian trial.

3. All requests must be submitted in written format and contain specific justification for the reconsideration. Only one reconsideration request will be considered for each incident. Treatment will not be suspended, interrupted, or postponed pending the outcome of the review.

a. Marine (or Service Member) Requestor. The written request for ISD reconsideration is made to the installation FAPM with a copy to the requestor's chain of command.

b. All Others. The written request for ISD reconsideration is made to the installation FAPM.

4. The FAPM shall present the ISD reconsideration request to the IDC to vote on whether to approve or deny the request. If the reconsideration request is denied, the requestor may submit the reconsideration request to HQMC MF FAP at hqmcfap@usmc.mil within 60 calendar days of notification of ISD reconsideration request denial. HQMC MF FAP will determine if an ISD reconsideration is warranted.

(6) CCSM

(a) The purpose of the CCSM is to clinically consult about the assessment and ongoing case management of interventions with families having allegations of abuse. Safety planning, supportive services and clinical treatment are the core areas of the CCSM. The CCSM operates independently from the IDC and does not need to wait for an ISD in order to make treatment and referral recommendations. Additionally, the CCSM will:

1. Facilitate supportive services and appropriate treatment for eligible victims of child or domestic abuse.

2. Provide coordinated case management, including risk assessment and ongoing monitoring of child abuse and domestic abuse victims' safety, between military and civilian agencies consistent with reference (b).

3. Recommend specific protective measures to the CO regarding an alleged offender. Such measures may include, but are not limited to, an MPO, weapons removal, restrictions, escort assignment, and debarment from the installation.

4. Recommend clinical interventions and rehabilitation appropriate treatment for alleged offenders who are eligible for treatment.

5. Recommend case transfer and closure decisions.

(b) CCSM Attendees

1. The FAPM or a clinical supervisor shall chair the CCSM.

2. Attendance at CCSM is limited to those with clinical expertise in child abuse and domestic abuse and on a case-relevant basis only. The FAPM shall exercise discretion in inviting other military or civilian medical, mental health, or clinical social services providers who may add value to the clinical case discussions.

(c) Agenda. The agenda of CCSMs shall include:

1. A review of newly reported child abuse and domestic abuse incidents.

2. Open cases, including open cases transferred from another installation. Open cases shall be reviewed:

a. At least monthly for incidents of child sexual abuse.

b. At least monthly for cases deemed high risk.

c. At least monthly for cases that involve children in out-of-home placements.

d. At least quarterly for all other incidents.

3. Open cases recommended for termination of services and case closure.

(d) CCSM Discussions. People attending the CCSM shall provide clinical consultation to the FAP case manager as needed for each incident to ensure thorough discussion of:

1. The safety plan and protective measures in place.

2. The severity of harm.

3. The results of risk assessments and psychosocial history and the assignment of a risk level.

4. Clinical interventions to address the needs of each of the family members, including victim(s) and alleged offender.

5. The success of such intervention and supportive services in protecting and assisting the victim, potential changes to or enhancement of such intervention and supportive services, and the appropriateness of terminating interventions when clinically indicated.

6. The success of such intervention and supportive services in assisting the alleged offender in changing his or her behavior, potential changes to or enhancement of such intervention and supportive services and the appropriateness of terminating interventions when clinically indicated.

7. Coordination of military and civilian service providers for such assessments, supportive services, treatment, and clinical intervention.

8. Coordination with the chain-of-command and other community or collateral contacts, such as CWS, schools, law enforcement, Victim Advocates, New Parent Support Program, etc.

9. CWS recommendations including out-of-home placement or reunification.

(e) Record of CCSM Discussions. Notes of CCSM discussions shall be documented in the FAP record. Letter of recommended services and progress will be sent to the Service Member's CO for acknowledgment and support.

(f) Confidentiality of CCSM Discussions. Information discussed during CCSM is confidential and is protected from disclosure under reference (g) and shall not be disclosed except as authorized by procedures set forth in references (g), (j), or (m). The FAPM, Case Manager, or other service provider may only disclose the result of the CCSM discussion pertaining to the individual receiving the clinical services.

(7) Installation response to Problematic Sexualized Behavior in Children and Youth (PSB-CY)

(a) Per references (a) and (c), the FAC will designate and Multi-disciplinary Team (MDT) to respond to reports of PSB-CY using a trauma-informed CCR model. The FAPM serves as the chair in accordance with PS 23 in Paragraph 3.3.b.(1) of reference (c).

(b) The FAC must require that all installation agencies involved in the MDT to PSB-CY implement a trauma-informed parent engagement strategy for both impacted and exhibiting children and youth. The MDT must include how each agency involved in the CCR for PSB-CY will engage parents about the steps of the process and provide them with the information and skills necessary to support developmentally appropriate sexual behaviors in their child(ren) or youth(s).

(c) The FAP serves as the subject matter expert on PSB-CY for the installation and should receive all reports or allegations of PSB-CY. FAP must complete the following in response:

1. Within 24 hours, FAP will communicate all reports of PSB-CY to the appropriate law enforcement agency.

2. Within 24 hours after a trauma-informed assessment of any children or youth involved in PSB-CY, FAP will:

a. Communicate all suspected incidents of child abuse and neglect in the families and home to CWS and appropriate law enforcement agency.

b. Ensure the safety of all children potentially impacted by PSB-CY and any other children living in the home of the child or youth exhibiting PSB-CY.

(d) FAP shall provide the clinical assessment, intervention services, advocacy services and supportive services, counseling or clinical treatment, and the ongoing case management and risk assessment for all children and youth impacted by or exhibiting PSB-CY, in accordance with references (a) and (c).

(e) The FAC must seek to establish formal MOUs, as appropriate, with counterparts in the local civilian community to improve coordination on trauma-informed child advocacy, assessment and treatment for all children and youth impacted by PSB-CY.

(8) Confidentiality

(a) Due to the sensitive nature of allegations of abuse and neglect, information regarding specific FAP cases will only be released to a Service Member's chain of command on a strict need to know basis. Commanding officers and every member of the IDC must ensure that the release of FAP information is strictly limited to personnel within the member's chain of command with a need to know and to those personnel responsible for taking action on FAP cases at the unit level.

(b) During the initial assessment process, Family Advocacy Clinicians will advise clients on the following:

1. Assessment sessions and matters discussed during sessions are confidential.

2. Confidentiality is limited in that, from time-to-time, the clinician is obligated to provide information to the client's chain of command regarding safety concerns, and the conduct and disposition of FAP cases and to report new incidents of child or domestic abuse.

(c) Privileged communication similar to the clergy-penitent and the attorney-client relationship does not apply to FAP cases.

5. Administration and Logistics

a. COs of Subordinate and Tenant Commands

(1) Incorporate intimate partner/child abuse prevention education within unit programs. All Service Members should receive intimate partner/child abuse prevention training on an annual basis.

(2) Incorporate the contents of this Order into all Officer-of-the-Day (OOD), Staff Duty Noncommissioned Officer (SDNCO), and Duty Noncommissioned Officer (DNCO) turnover folders. Reference this Order in all OOD/SDNCO/DNCO orders, as appropriate.

b. Director, MFP

(1) Coordinate the management of the installation FAP with other programs servicing military families to avoid duplication of effort.

(2) Ensure accreditation and quality assurance standards are maintained for FAP.

(3) Ensure that programs have established Standard Operating Procedures for the identification, reporting, and evaluation of adult and child abuse in accordance with this Order and its references.

c. FAPM

(1) Conduct FAP operations in accordance provided by references in this Order.

(2) Ensure counselors conduct assessments with both the alleged victim and offender as soon as possible after CID/NCIS complete their investigations.

(3) Ensure all unit COs, Executive Officers, and Sergeants Major receive a telephonic report from the Victim Advocate of initial information. The case manager will then recommend case disposition, based on his or her initial assessment interview.

(4) Ensure a determination letter is available to the unit CO within 3 working days following IDC.

(5) Follow the reporting procedures for child abuse and all unrestricted domestic abuse cases, including reporting to COs, law enforcement, and CWS when appropriate.

d. CO, NHCH

(1) NHCH will provide treatment for non-emergency cases during working hours.

(a) Refer to appropriate medical treatment facility for cases determined to be beyond the scope of practice for the NHCH staff during normal working hours.

(b) Provide appropriate medical follow-up treatment as required.

(c) After daily clinic closure, member, sponsor, or other personnel should call 911 if an emergency, or if non-emergent, medical case should be obtained at a military treatment hospital.

(2) Incorporate this Order into the procedures at the NHCH for those personnel standing duty.

(3) Assign in writing primary and alternate representatives to the FAC and IDC.

e. PMO

(1) Assign in writing officers, SNCOs, or appropriate civilian employees to serve as primary and alternate members of the FAC and IDC.

(2) Ensure FAC and IDC representatives are familiar with their roles and attend required trainings.

(3) Respond to all reported incidents of intimate partner/child abuse or neglect and cross-report/make notifications per enclosure (4).

(4) Investigate cases of alleged intimate partner/child abuse or neglect and refer to NCIS, as appropriate.

(5) Send completed reports to the CO of Service Member(s) involved, the FAP, the Senior Trial Counsel, and the SJA. Send completed reports to the Special Assistant United States Attorney if a civilian offender is identified.

(6) Provide notification of incidents by telephone. Follow up with copies of blotter reports to the FAP as soon as possible, or the next workday following an incident of domestic or child abuse or neglect.

(7) Incorporate this Order into procedures for all military police and CID personnel.

(8) Require all military police and CID personnel to attend training provided by FAP on identifying and reporting domestic and child abuse or neglect, at least annually.

f. SJA

(1) Assign in writing primary and alternate representatives to the FAC and IDC.

(2) Ensure FAC and IDC representatives are familiar with their roles and attend required trainings.

(3) Provide oversight and guidance regarding legal and policy matters to the FAPM to ensure compliance with the references.

g. Director, SACC. Collaborate with FAP Clinicians on cases where SACC has some involvement.

h. CIG

(1) Assign in writing primary and alternate representatives to the FAC.

(2) Ensure FAC representatives are familiar with their roles and attend required training.

i. Supervisory Special Agent, NCIS

(1) Assign in writing primary and alternate representatives to the FAC.

(2) Ensure FAC and IDC representatives are familiar with their roles and ensure NCIS agent investigating the alleged child abuse or domestic abuse case attends the corresponding IDC meeting.

j. Base Chaplain

(1) Assign in writing primary and alternate representatives to the FAC.

(2) Collaborate with FAP Clinicians on cases in which the chaplain has had some personal involvement without violating privileged and/or confidential communications per reference (r).

(3) Ensure FAC representatives are familiar with their roles and attend required training.

k. Records created as a result of this Order shall be managed according to National Archives and Records Administration approved dispositions per SECNAV M-5210.1 and SECNAV Notice 5210 to ensure proper maintenance, use, and accessibility and preservation, regardless of format or medium.

1. Privacy Act. Any misuse or unauthorized disclosure of Personally Identifiable Information (PII) may result in both civil and criminal penalties. The Department of the Navy (DON) recognizes that the privacy of an individual is a personal and fundamental right that shall be respected and protected. The DON's need to collect, use, maintain, or disseminate PII about individuals for purposes of discharging its statutory responsibilities will be balanced against the individuals' right to be protected against unwarranted invasion of privacy. All collection, use, maintenance, or dissemination of PII will be in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a) and implemented per SECNAVINST 5211.5F.

6. Command and Signal

a. Command. This Order is applicable to Armed Forces and civilian personnel aboard MCBH, unless otherwise prohibited or permitted by regulation of higher authority.

b. Signal. This Order is effective the date signed.

J. W. BEAVEN

DISTRIBUTION: A

Definitions

Alleged Abuser. An individual reported to the FAP for allegedly having committed child abuse or domestic abuse.

Child. An unmarried person under 18 years of age for whom a parent, guardian, foster parent, caregiver, employee of a residential facility, or any staff person providing out-of-home care is legally responsible. The term means a biological child, adopted child, stepchild, foster child, or ward. The term also includes a sponsor's family member (except the sponsor's spouse) of any age who is incapable of self-support because of a mental or physical incapacity, and for whom treatment in a DoW medical treatment program is authorized.

Child Abuse. The physical or sexual abuse, emotional abuse, or neglect of a child by a parent, guardian, foster parent, or by a caregiver, whether the caregiver is intrafamilial or extrafamilial, under circumstances indicating the child's welfare is harmed or threatened. Such acts by a sibling, other family member, or other person shall be deemed to be child abuse only when the individual is providing care under express or implied agreement with the parent, guardian, or foster parent.

Domestic Abuse. Defined in reference (b).

Domestic Violence. Defined in reference (b).

Family Advocacy Committee (FAC). The policy-making, coordinating, recommending, and overseeing body for the installation FAP.

Family Advocacy Command Assistance Team (FACAT). A multidisciplinary team composed of specially trained and experienced individuals who are on-call to provide advice and assistance on cases of child sexual abuse that involve DoW-sanctioned activities.

Family Advocacy Program (FAP). A program of coordinated efforts designed to prevent and intervene in cases of family violence, and to promote healthy family life through prevention, direct services (including identification and reporting, assessment, treatment, rehabilitation, and follow-up), administration, evaluation, and training.

FAP Manager (FAPM). The individual designated by the installation CO or garrison commander in accordance with DoW Component implementing guidance to manage the installation FAP, supervise FAP staff, and coordinate all FAP activities with other activities.

Incident Determination Committee (IDC). A multidisciplinary team of designated individuals working at the installation level, tasked with the evaluation of reports of child abuse and domestic abuse to the FAP to determine whether they meet the relevant criteria for alleged child abuse and domestic abuse for entry into the Service FAP Central Registry of child abuse and domestic abuse reports. Formerly known as the Case Review Committee, or CRC.

Incident Status. The IDC determination of whether or not the reported incident meets the relevant criteria for alleged child abuse or domestic abuse for entry into the Service FAP central registry of child abuse and domestic abuse reports.

New Parent Support Program (NPSP). Defined in Reference (s).

Out-of-Home Care. The responsibility of care for and supervision of a child in a setting outside the child's home by an individual placed in a caretaker role sanctioned by a Military Service or Defense Agency or authorized by the Service or Defense Agency as a provider of care. Examples include a child development center, school, recreation program, family child care, and child care activities that may be conducted as a part of a chaplain's program or as part of another morale, welfare, or recreation program.

Problematic Sexual Behavior in Children and Youth (PSB-CY). Behaviors initiated by children and youth under the age of 18 that involve sexual body parts (genitals, anus, buttocks, or breasts) in a manner that deviates from normative or typical sexual behavior and are developmentally inappropriate or potentially harmful to the individual initiating the behavior, the individual(s) impacted by the behavior, or others.

Restricted Report. A report of an incident of domestic abuse by an adult victim who is eligible to receive military medical treatment, including a civilian or contractor who is eligible to receive military healthcare outside the continental United States on a reimbursable basis, to a domestic abuse victim advocate or healthcare provider without initiating the investigative process or notification to the victim's or alleged offender's commander.

Unrestricted Report. A report of an incident of domestic abuse by any person, including an adult victim, that uses current reporting channels, e.g. the chain of command, military or civilian law enforcement or criminal investigative organization, and the FAP for clinical intervention.

Criteria for IDC Determination of Reports of Child Abuse and Domestic Abuse

1. Child Physical Abuse. The non-accidental use of physical force on the part of a child's caregiver.

a. Child Physical Abuse Part A. Physical force includes, but is not limited to at least one of the following:

(1) Hitting with open hand or slapping, including spanking.

(2) Dropping.

(3) Pushing or shoving.

(4) Grabbing or yanking limbs or body.

(5) Poking.

(6) Hair-pulling.

(7) Scratching.

(8) Pinching.

(9) Restraining or squeezing.

(10) Shaking.

(11) Throwing.

(12) Biting.

(13) Kicking.

(14) Hitting with fist.

(15) Hitting with a stick, strap, belt, electrical cord, or other object.

(16) Scalding or burning.

(17) Poisoning.

(18) Stabbing.

(19) Applying force to throat.

(20) Strangling or cutting off air supply.

(21) Holding under water.

(22) Brandishing or using a weapon.

b. Child Physical Abuse Part B. Significant impact on the child involving ANY of the following:

(1) A more than inconsequential physical injury, involving any of the following:

(a) Any injury to the face or head.

(b) Any injury to a child under two years of age.

(c) A more-than-superficial bruise. The bruise was a color other than very light red or had a total area exceeding that of the victim's hand or was tender to a light touch.

(d) A more-than-superficial cut or scratch. The cut or scratch was bleeding and required pressure to stop the bleeding.

(e) Bleeding internally or from mouth or ears.

(f) A welt (a bump or ridge raised on the skin).

(g) Loss of consciousness.

(h) A burn.

(i) Loss of functioning, including but not limited to a sprain, broken bone, detached retina, or a loose or chipped tooth.

(j) Damage to an internal organ.

(k) Disfigurement, including but not limited to scarring.

(l) Swelling lasting at least 24 hours.

(m) Pain felt in the course of normal activities AND at least 24 hours after the physical injury was suffered. If the child is unable to report orally or in writing about pain or is inaccessible to clinical authorities for assessment of pain, the criterion of harm is met if the nature of the injury would typically result in such a level of pain.

(n) Death.

(2) Reasonable potential for more than inconsequential physical injury, given the:

(a) Inherent dangerousness of the act.

(b) Degree of force used.

(c) Physical environment in which the acts occurred.

(3) A more than inconsequential fear reaction: fear (verbalized or displayed) of bodily injury to self or others, AND at least one of the following signs of fear or anxiety lasting at least 48 hours:

(a) Persistent intrusive recollections of the incident, including recollections as evidenced in the child's play.

(b) Marked negative reactions to cues related to the incident, including the presence of the alleged offender, as evidenced by:

1. Avoidance of cues.

2. Subjective or overt distress to cues.

3. Physiological hyperarousal to cues.

(c) Acting or feeling as if incident is recurring.

(d) Marked symptoms of increased arousal, including any of the following:

1. Difficulty falling or staying asleep.

2. Irritability or outbursts of anger.

3. Difficulty concentrating.

4. Hypervigilance (i.e., acting overly sensitive to sounds and sights in the environment; scanning the environment expecting danger; feeling keyed up and on edge).

(e) Exaggerated startle response.

c. Part C: Exclusion From Child Physical Abuse Part A. Any non-accidental act of physical force shall NOT be considered to meet the criteria for Part A if it is determined to be:

(1) An act committed to protect the caregiver from imminent physical harm. The act must include ALL of the following:

(a) The act occurred while the child was in the act of using physical force. "In the act" begins with the initiation of motoric behavior that typically would result in an act of physical force, such as charging at the caregiver to hit him or her, and ends when the use of force is no longer imminent.

(b) The sole function of the act was to stop the child's use of physical force, and did not include punishment for the child's use of physical force.

(c) The act used only that force that was minimally sufficient to stop the child's use of physical force.

(2) An act committed during developmentally appropriate physical play with the child, including, but not limited to, horseplay, wrestling, and tackle football.

(3) An act committed to protect the child or another person from imminent physical harm, including, but not limited to, grabbing the child to prevent the child from being hit by a car, taking a weapon from a suicidal child, or physically intervening to prevent the child from inflicting injury on another person. However, this does not include non-accidental use of

physical force as punishment for the child's behavior that may have subjected the child or another person to the risk of imminent harm.

2. Child Sexual Abuse. Sexual activity by a caregiver with a child for the purpose of sexual gratification of the child, the alleged offender, or any other person.

a. Child Sexual Abuse Part A

(1) Sexual Exploitation Without Direct Contact. Forcing, tricking, enticing, threatening, or pressuring a child to participate in an act for the sexual gratification of the child, the alleged offender, or any other person without direct physical contact between the child and the alleged offender. Sexual gratification means providing sexual arousal or pleasure or appealing to prurient interest but does NOT require overt evidence of arousal such as an erection, vaginal lubrication, ejaculation, or orgasm. Sexual exploitation acts include, but are not limited to:

(a) Exposing the child's genitals or anus or, if the child is a female, the child's breasts.

(b) Exposing the alleged offender's genitals or anus or, if the alleged offender is a female, the alleged offender's breasts, to the child.

(c) Having the child masturbate or watch any other person masturbate.

(d) Having the child participate in sexual activity with a third person, including child prostitution.

(e) Having the child pose, undress, or perform in a sexual fashion, including posing or performing for child pornography.

(f) Exposing the child to child pornography, adult pornography, or a live sexual performance.

(g) Engaging in voyeurism ("peeping") or other prurient watching of a child's genitals or anus or, if the child is a female, the child's breasts without the child's knowledge.

(2) Rape or Intercourse. The caregiver's use of force, emotional manipulation, trickery, threatening, or taking advantage of the child's youth or naïveté to engage in penetration of the vagina, however slight:

(a) By the penis; or

(b) By a hand or finger or any object with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

(3) Sodomy. The caregiver's engaging in any of the following:

(a) Placing the alleged offender's sexual organ in the mouth or anus of a child, however slight the penetration; or

(b) Taking into the alleged offender's mouth or anus the sexual organ of a child, however slight the penetration.

(4) Molestation. Physical contact of a sexual nature not involving rape, intercourse, or sodomy between the child and the caregiver, including, but not limited to any of the following:

(a) The fondling or stroking of the genitals or buttocks, directly or through clothing, with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

(b) The fondling or stroking of a female's breast, directly or through clothing, with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

(c) The attempted penile penetration of the vagina, anus, or mouth.

(d) The attempted penetration of the vagina, with a hand or finger or any object with the intent to abuse, humiliate, harass, or degrade the child, or to arouse or gratify the sexual desire of the alleged offender, the child, or any other person.

b. Child Sexual Abuse Part B. Any act of child sexual abuse that meets the criteria of Part A shall be considered to have a significant impact on the child, which is the criterion for part B. No voting is required for Part B.

c. Part C: Exclusion From Child Sexual Abuse. There are NO exclusions from any act of child sexual abuse. No voting is required for Part C.

3. Child Emotional Abuse. A non-accidental act or acts, including the following and any other act not listed of similar severity, but excluding an act that meets the criteria of child physical abuse or child sexual abuse:

a. Child Emotional Abuse Part A

(1) Berating, disparaging, degrading, scapegoating, or humiliating the child, or other similar behavior directed toward the child.

(2) Threatening the child, including but not limited to indicating or implying future physical abuse, abandonment, or sexual abuse.

(3) Harming or indicating that the caregiver will harm a person or thing that the child cares about, such as:

(a) A loved one, including but not limited to a relative or friend of the child.

(b) A pet.

(c) Real or tangible property.

(4) Abandoning or indicating that the caregiver will abandon a person or thing that the child cares about, such as:

(a) A loved one, including but not limited to a relative or friend of the child.

(b) A pet.

(c) Real or tangible property.

(5) Restricting the child's movement by:

(a) Fastening the child's arms or legs together,

(b) Binding the child to a chair, bed, or other object, or

(c) Confining a child to an enclosed area, such as a closet.

(6) Coercing the child to inflict pain on himself or herself, including, but not limited to:

(a) Ordering the child to kneel on split peas, rice, or similar substance for long periods.

(b) Ordering the child to ingest a highly spiced food, spice, or herb.

(7) Disciplining the child through non-physical means or with the non-accidental use of force that does not meet the criteria of child physical abuse, when such discipline is excessive because there is disproportion between the:

(a) Frequency of punishment and the infrequency of the child's bad behavior.

(b) Severity of punishment and the undesirability of the child's bad behavior.

(c) Duration of punishment and the undesirability of the child's bad behavior.

b. Child Emotional Abuse Part B. Significant impact on the child involving ANY of the following:

(1) Psychological harm, including either:

(a) More than inconsequential fear reaction.

(b) Significant psychological distress related to the act, including one or more psychiatric disorders at or near diagnostic thresholds as defined by the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.

(2) Reasonable potential for psychological harm, including either when:

(a) The act or pattern of acts creates reasonable potential for the development of a psychiatric disorder, at or near diagnostic threshold, related to or exacerbated by the act(s) when taken into consideration with the child's level of functioning and any risk and resilience factors present; or

(b) The act, or pattern of acts, carries a reasonable potential for significant disruption of the child's physical, psychological, cognitive, or social development by substantially worsening the child's developmental level and trajectory that was evident before the alleged emotional abuse.

(3) Stress-related somatic symptoms related to or exacerbated by the act or pattern of acts significantly interfere with normal functioning, including aches and pains, migraines, gastrointestinal problems, or other stress-related physical ailments.

c. Part C: Exclusion From Child Emotional Abuse. The following shall NOT be considered to meet the criteria for Part A:

(1) Any generally accepted care giving practice such as:

(a) Confining a small child in a child car seat or safety harness, or

(b) Swaddling an infant.

(2) Any generally accepted disciplinary practice proportionate to the seriousness of the child's behavior that involves:

(a) Restriction of a child's normal privileges (e.g., "grounding" a child), or

(b) Restricting a child to his or her room for a period of time.

4. Child Neglect. The negligent treatment of a child through egregious acts or omissions below the lower bounds of normal care giving, which shows a striking disregard for the child's well-being, under circumstances indicating the child's welfare has been harmed or threatened by the deprivation of age-appropriate care. Defiance of base guidance may be cause for referral to FAP for services, but it is not necessarily neglectful unless the alleged act or omission meets the criteria for Part A and Part B.

a. Child Neglect Part A. Any of the following:

(1) Abandonment. This includes the absence of the caregiver with no intent to return or the absence of the caregiver from the home for more than 24 hours without having arranged for an appropriate surrogate caregiver. Any act of child abandonment that meets the criteria of Part A child neglect shall be considered to have a significant impact on the child, which is the criterion for Part B. No voting is required for Part B for abandonment.

(2) Lack of Supervision. Egregious absence or inattention, taking into account the child's age and level of functioning.

(3) Exposure to Physical Hazards. Inattention to the child's safety by exposing the child to physical dangers or home hazards including, but not limited to:

(a) Exposed electrical wiring.

(b) Broken glass.

(c) Non-secured, loaded firearms in the home.

(d) Illegal drugs in home.

(e) Dangerous or unhygienic pet.

(f) Asking the child to perform dangerous activities.

(g) Driving a vehicle while intoxicated, with the child in the vehicle.

(h) Hazardous chemicals.

(i) Unhygienic living conditions dangerous to health.

(j) Caregivers known to be abusive.

(k) An act of domestic violence close enough to the child to have created a risk of injury to the child.

(4) Educational Neglect. When education is compulsory by law, any of the following:

(a) Knowingly allowing the child to have extended or frequent absences from school.

(b) Neglecting to enroll the child in appropriate home schooling or public or private education.

(c) Preventing the child from attending school for other than justifiable reasons.

(5) Neglect of healthcare. Refusal or failure to provide appropriate healthcare, including but not limited to failure to obtain appropriate professionally indicated medical, mental health, or dental services, procedures, or medications, although the caregiver was financially able to do so or was offered other means to do so. It includes withholding of medically indicated treatment for a child with life-threatening conditions.

(6) Deprivation of Necessities. This is defined as the failure to provide age-appropriate nourishment, shelter, and clothing to the child. It includes non-organic failure to thrive as determined by a competent medical authority.

b. Child Neglect Part B. Significant impact on the child involving ANY of the following:

(1) More-than-inconsequential physical injury including heat exhaustion or heat stroke.

(2) Reasonable potential for more than inconsequential physical injury given the:

(a) Act(s) or omission(s); and

(b) The child's physical environment.

(3) Psychological harm, as set forth in paragraph 3b(1) of this enclosure.

(4) Reasonable potential for psychological harm.

(5) Stress-related somatic symptoms.

c. Part C: Exclusion From Child Neglect. The following shall NOT be considered to meet the relevant criteria for Part A:

(1) Unattended Older Child in a Vehicle. A caregiver's leaving a child age 10 or older unattended in a vehicle for a brief period of time in a safe area DOES NOT meet the Part A criterion for lack of supervision.

(2) Unforeseen Lack of Supervision or Exposure to Physical Hazards. When lack of supervision or exposure to physical hazards occurs, but a person who is not the caregiver is directly responsible for such lack of supervision or exposure to physical hazards, such lack of supervision or exposure to physical hazards does not meet the Part A criterion IF the IDC concludes that a reasonably competent caregiver would not have foreseen such lack of supervision or exposure to physical hazards by such other person.

(3) First Time Exclusion. The Part A criteria for lack of supervision or exposure to physical hazards are not met if ALL of the following criteria are met:

(a) The impact on the child meets the criteria for potential harm, but NOT for actual harm.

(b) The caregiver has no other significant risk factors for neglect (e.g., low self-esteem, high impulsivity, lack of social support, high daily stress, substance abuse diagnosis).

(c) Two-thirds of the voting members determine the neglect to have barely met criteria.

(d) There has been no previous incident of problematic care giving, as evidenced by both of the following:

1. The caregiver has not come to the attention of any community helper (including, but not limited to, teachers, security forces, medical professionals, civilian authorities) for potential child abuse or extreme parenting practices.

2. The caregiver has not been reported to the FAP or a civilian CPS agency previously for allegations of child abuse or child neglect.

5. Intimate Partner Physical Abuse. The non-accidental use of physical force against a current or former intimate partner.

a. Intimate Partner Physical Abuse Part A. Such physical force includes but is not limited to at least one of the acts set forth in paragraph 1a of this enclosure.

b. Intimate Partner Physical Abuse Part B. Significant impact on the intimate partner involving ANY of the following:

(1) Any physical injury, including, but not limited to:

(a) Pain that lasts at least four hours.

(b) A bruise.

(c) A cut.

(d) A sprain.

(e) A broken bone.

(f) Loss of consciousness.

(g) Death.

(2) Reasonable potential for more than inconsequential physical injury given:

(a) The inherent dangerousness of the act.

(b) The degree of force used.

(c) The physical environment in which the acts occurred.

(3) More than inconsequential fear reaction as set forth in paragraph 1b(3) of this enclosure but excluding "intrusive recollections as evidenced in the child's play."

c. Part C: Exclusion From Intimate Partner Physical Abuse. Any non-accidental use of physical force act that meets any of the following situations shall NOT be considered to meet the criterion for Part A. These exclusions do not include subsequent non-accidental use of physical force against the intimate partner that was not protective.

(1) The act was committed to protect the alleged offender from imminent physical harm from the intimate partner who was in the act of using physical force. The act must include ALL of the following:

(a) The act occurred while the intimate partner was in the act of using physical force. "In the act" begins with the initiation of motoric

behavior that typically would result in an act of physical force, such as charging at the alleged offender to hit him or her, and ends when the use of force is no longer imminent.

(b) The sole function of the act was to stop the intimate partner's use of physical force.

(c) The act used only that force that was minimally sufficient to stop the intimate partner's use of physical force.

(2) The act was committed to protect the alleged offender from imminent physical harm from the intimate partner who had previously threatened the alleged offender with more than inconsequential physical injury. This requires that:

(a) The act followed the intimate partner's verbal or non-verbal threat to imminently inflict more than inconsequential physical injury on the alleged offender; AND

(b) The IDC determined that there was at least one previous incident of the intimate partner inflicting more than inconsequential physical injury on the alleged offender. "More than inconsequential physical injury" shall have the meaning set forth in paragraph 1b(1) of this enclosure but excluding "any injury to a child under two years of age."

(3) The act was committed to protect the intimate partner or another person from imminent physical harm, including, but not limited to:

(a) Grabbing or pushing the intimate partner to prevent him or her from being hit by a vehicle.

(b) Taking a weapon away from a suicidal intimate partner.

(c) Stopping the intimate partner from inflicting physical abuse on a child as set forth in paragraph 1a of this enclosure.

(4) The act was committed during physical play with the intimate partner, including, but not limited to, horseplay, wrestling, and tackle football.

6. Intimate Partner Sexual Abuse. A sexual act with the intimate partner without the consent of the intimate partner or physical contact of a sexual nature against the expressed wishes of the intimate partner. Corroboration of the report of the intimate partner is NOT required to meet the Part A criteria for intimate partner sexual abuse. A sexual act is:

a. Contact between the penis and the vulva, or the penis and the anus, involving penetration, however slight;

b. Contact between the mouth and the penis, vulva, or anus; or

c. Penetration of the anal or genital opening by a hand, finger, or other object.

d. Intimate Partner Sexual Abuse Part A. Any of the following:

(1) The use of physical force to compel the intimate partner to engage in a sex act against his or her will, whether or not the sex act is completed.

(2) The use of a physically aggressive act in paragraph 1a of this enclosure or use of one's body, size, or strength, or an emotionally aggressive act in paragraph 7a of this enclosure, to coerce the intimate partner to engage in a sex act, whether or not the sex act is completed.

(3) An attempted or completed sex act involving an intimate partner who is unable to provide consent. The intimate partner is unable to understand the nature or conditions of the act, to decline participation, or to communicate unwillingness to engage in the sexual act because of illness, disability, being asleep, being under the influence of alcohol or other drugs, or other reasons.

(4) Physical contact of a sexual nature, including but not limited to, kissing, groping, rubbing, or fondling, directly or through clothing, of the intimate partner that does not meet the criteria of paragraphs 6d(1) through 6d(3) of this enclosure but is against the expressed wishes of the intimate partner.

e. Intimate Partner Sexual Abuse Part B. Any act that meets the criteria for Part A intimate partner sexual abuse shall be considered to have a significant impact on the intimate partner, which is the criterion for part B. No voting is required for Part B for intimate partner sexual abuse.

f. Part C: Exclusion From Intimate Partner Sexual Abuse. There are NO exclusions from any act of spouse sexual abuse or from any act of intimate partner sexual abuse that meets the criteria for Part A.

7. Intimate Partner Emotional Abuse. A non-accidental act or acts, excluding physical abuse or sexual abuse, or threat adversely affecting the psychological well-being of a current or former intimate partner.

a. Intimate Partner Emotional Abuse Part A. Including, but not limited to any one or more of the following:

(1) Interrogating the intimate partner.

(2) Berating, disparaging, or humiliating the intimate partner or using other similar behavior against the intimate partner.

(3) Isolating the intimate partner from his or her family, friends, or social support resources.

(4) Interfering with the intimate partner's adaptation to American culture or the military subculture.

(5) Restricting the intimate partner's access to or use of economic resources despite an obviously grave economic situation, when such restriction does not reasonably obstruct the intimate partner from recklessly incurring debts for which the alleged offender would be responsible for repayment.

(6) Restricting the intimate partner's access to or use of appropriate military services and benefits, including, but not limited to, taking away the intimate partner's military identification card.

(7) Obstructing the intimate partner from obtaining medical, mental health, or dental services.

(8) Restricting the intimate partner's ability to come and go freely when such restriction is not intended to prevent the intimate partner from committing:

(a) An act or acts injurious to the intimate partner.

(b) An act or acts that may injure another person.

(9) Trying to make the intimate partner believe that he or she is mentally ill, and/or trying to make others think that the intimate partner is mentally ill.

(10) Threatening to harm the intimate partner directly or indirectly, including, but not limited to, by threatening to:

(a) Inflict physical abuse or sexual abuse on the intimate partner.

(b) Harm the intimate partner's children, pets, or people that the intimate partner cares about.

(c) Damage or destroy the intimate partner's property.

(11) Harming the intimate partner's children, pets or property.

(12) Stalking the intimate partner.

(13) Obstructing the intimate partner's access to protective assistance, including but not limited to assistance from:

(a) A military domestic violence VA or the FAP.

(b) The military command.

(c) A military or civilian law enforcement agency.

(d) An attorney.

(e) A civilian court of competent jurisdiction.

(f) A civilian domestic violence program of shelter, support, or other assistance.

b. Intimate Partner Emotional Abuse Part B. Significant impact on the intimate partner involving ANY of the following:

(1) Psychological harm, including ANY of the following:

(a) More than inconsequential fear reaction (fear, verbalized or displayed) as set forth in paragraph 1b(3) of this enclosure, but excluding "intrusive recollections as evidenced in the child's play;"

(b) Significant psychological distress as set forth in paragraph 3b(1)(b) of this enclosure;

1. Fear of an emotionally abusive act that significantly interferes with the intimate partner's ability to carry out any of five major life activities: employment, education, religious faith, obtaining necessary medical or mental health services or following prescribed treatment, or contact with family or friends;

2. Stress-related somatic symptoms as set forth in paragraph 3b(3) of this enclosure.

(2) Part C: Exclusion From Intimate Partner Emotional Abuse. There are NO exclusions from any act of intimate partner emotional abuse that meets the criteria for Part A.

8. Neglect of Spouse. A type of domestic abuse in which the alleged offender withholds necessary care or assistance for his or her current spouse who is incapable of self-care physically, psychologically, or culturally, although the caregiver is financially able to do so or has been offered other means to do so.

a. Neglect of Spouse Part A. The IDC must determine that ALL of the following conditions are present:

(1) The alleged offender withholds, or withholds the spouse's access to, any of the following:

(a) Appropriate, medically indicated healthcare, including but not limited to appropriate medical, mental health, or dental care;

(b) Appropriate nourishment, shelter, clothing, or hygiene; or

(c) Care-giving for more than 24 hours without having arranged for an appropriate surrogate caregiver.

(2) The alleged offender is able to provide care, or access to care, specified in paragraph 4h(1)(a) of this enclosure or has been offered assistance to do so.

(3) The spouse is incapable of self-care due to substantial limitations in one or more of the following areas:

(a) Physical, including but not limited to quadriplegia,

(b) Psychological or intellectual, including but not limited to vegetative depression, very low intelligence, or psychosis, or

(c) Cultural, including but not limited to the inability to communicate in English or the inability to manage activities of rudimentary daily living in American culture.

b. Neglect of Spouse Part B. Deprivation-related significant impact involves either of the following:

(1) More-than-inconsequential physical injury, as set forth in paragraph 1b(1) of this enclosure, but excluding "any injury to a child under two years of age" and including heat exhaustion or heat stroke.

(2) Reasonable potential for more than inconsequential physical injury, given:

(a) The reason(s) the spouse is incapable of self-care;

(b) The care required for the spouse's condition(s); and

(c) The more-than-inconsequential injury that the spouse could suffer if appropriate access to care is withheld.

c. Part C: Exclusion from Neglect of Spouse. There are NO exclusions from any act of spouse neglect that meet the criteria for Part A.

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH VA 22042

IN REPLY REFER TO
7220
Ser M3/18UM30036

18 June 2018

MEMORANDUM OF UNDERSTANDING (MOU)
BETWEEN
THE NAVY BUREAU OF MEDICINE AND SURGERY (BUMED),
MARINE AND FAMILY PROGRAMS DIVISION (MF),
AND
MARINE CORPS HEALTH SERVICES (HS)

Subj: PSYCHOLOGICAL HEALTH SERVICES FOR ACTIVE DUTY MARINES AND THEIR FAMILY MEMBERS

Ref: (a) DoD Directive 5136.01 (Assistant Secretary of Defense for Health Affairs)
(b) DOD Instruction 1010.04 Problematic Substance Use by DOD Personnel
(c) BUMED Instruction 5353.4B Standards for Provision of Substance Related Disorder Treatment Services
(d) SECNAVINST 1850.4E (Department of the Navy Disability Evaluation Manual)
(e) MCO 1754.14 (Marine Corps Community Counseling Program)
(f) MCO 5300.17A (Marine Corps Substance Abuse Program)
(g) MCO 1754.11 (Marine Corps Family Advocacy and General Counseling Program)
(h) DoD Instruction 6490.08 (Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members)
(i) DoD Instruction 6025.18R (DoD Health Information Privacy Regulation)
(j) SECNAVINST 5211.5E (Department of the Navy Privacy Program)
(k) Diagnostic and Statistical Manual of Mental Disorders, Current Edition
(l) American Society of Addiction Medicine, Patient Placement Criteria for Treatment of Substance Related Disorders, Current Edition

1. General

a. Purpose. To define the full continuum of care offered on Marine Corps installations to Marines, Sailors attached to Marine Corps units, and their family members; establish clear lines of communication between all entities involved in these services; and leverage and augment existing systems while delineating the responsibilities of all parties. Clear communication will ensure a comprehensive system of care that is coordinated and transparent to all who use it. Delineation of roles and processes will assist Marines, attached Sailors, and their family members to navigate through the entire psychological health care system. This MOU covers

ENCLOSURE (3)

responsibilities related to psychological health and problematic substance use care (both medical and non-medical), administration, reporting requirements, and communication processes.

b. Background

(1) The demand for psychological health services for Marines, attached Sailors, and their families has increased dramatically over the past two decades. This rising need has been addressed through a variety of programs and resources which have expanded in response to increasing demands. Programs include resources at Military Treatment Facilities (MTFs), a variety of initiatives managed by Headquarters Marine Corps (HQMC), Manpower and Reserve Affairs (M&RA), Marine and Family Programs Division (MF), and medical and behavioral health embedded assets.

(2) It is imperative that the Navy Bureau of Medicine and Surgery (BUMED) M3 (Healthcare Operations), HQMC MF, and Marine Corps Health Services (HS), (collectively referred to as "the Parties") maintain a comprehensive system of psychological health care to include substance use disorder services for Marines, attached Sailors, and their family members, from education and prevention, through all levels of care, including aftercare and/or continuing care. This system should take into account the contributions of all available agencies, including leadership, peers, chaplains, and other psychological health resources on the installation as well as those off base. Respect for the patient/client autonomy as an underlying principle is paramount in our system of care, taking into account the role of the Marine, attached Sailor or family member in deciding whether to seek or participate in care.

(3) This delineation of responsibilities must also be in accordance with existing regulations covering both medical and non-medical services. Reference (a) places the responsibility for DoD medical and dental programs under the Defense Health Program (DHP), as administered by the Assistant Secretary of Defense for Health Affairs (ASDHA). In accordance with references (b) and (c), certain levels of care must be performed under (ASDHA) and the service medical departments. In the case of the Navy and Marine Corps, medical care falls under the authority of BUMED. Medical care cannot be funded through other venues or by entities not under the cognizance of (ASDHA). However, Department of the Navy policy supports the funding and provision of Marine Corps non-medical counseling services as a Morale, Welfare, and Recreation "Category A" Warfighter and Family Services activity. As implemented in the Marine Corps, these non-medical counseling services are separate but complementary to Defense Health Programs.

(4) This agreement will summarily address how BUMED, MF, and HS will cooperate in providing services, explicitly define the

responsibilities of all parties, and most importantly, establish how BUMED and MF will work together to ensure the highest quality of care, and appropriate access to care is provided to Marines, attached Sailors, and their families. This MOU is applicable to the care provided on all Marine Corps installations.

2. Scope of Practice. Improved processes will ensure Marines, attached Sailors, and family members move throughout the care continuum and across installations with clear communication between professionals at each level of care.

3. Responsibilities. BUMED and MF will participate in a comprehensive system of psychological health and substance use disorder care, maintaining the necessary accreditations and certifications to carry out their delineated responsibilities, as described below.

a. BUMED. Responsible for the treatment of all potentially disabling psychiatric diagnoses described in reference (d), all pharmacologic care, and all treatment of substance use disorders classified as "moderate" (depending on the criterion) or "severe" as per the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (reference (k)).

(1) Provide diagnostic services and outpatient treatment for all psychological diagnoses listed in the current edition of the DSM that could potentially be considered "disabling" under existing regulations. Reference (d) recognizes the majority of mental health diagnoses as potentially disabling. The only exceptions are listed in reference (d). All other mental health conditions, including affective disorders, anxiety disorders (including PTSD), somatoform and dissociative disorders, organic mental disorders and eating disorders can only be treated in a medical setting under existing regulations. This is true regardless of the severity of the condition, and includes both pharmacologic and non-pharmacologic treatment. This standard applies to the treatment of both active duty service members and dependents.

(2) Provide all treatment for individuals determined to be at moderate to severe risk of self- or other-directed violence (e.g. suicide).

(3) Provide all inpatient care, partial hospitalization, and intensive outpatient care for psychological health diagnoses, even those not listed as potential disabilities under reference (d).

(4) Provide outpatient and intensive outpatient care for dual diagnosis cases (provided the non-substance related disorder falls within the potentially disabling psychiatric diagnoses described below).

(5) Provide all medication assisted treatment (MAT) for substance-related conditions.

(6) Provide all inpatient, residential, partial hospital, intensive outpatient, and continuing care (aftercare) for substance-related conditions (and non-substance-related addictive conditions), initially requiring American Society of Addiction Medicine (ASAM) patient placement criteria (reference (l)) level 2.5 or higher, consistent with the precept of "no wrong door", as long as within the scope of services offered through the respective clinic. Marines, attached Sailors, and family members remain at the original treating clinic through the entire course of treatment and aftercare as clinically appropriate.

(7) Provide diagnostic screening and assessments for the purpose of determining appropriate referrals.

b. MF. Non-medical counseling services will be provided through installation Marine Corps Community Services (MCCS) for all Marines, attached Sailors, and their family members.

(1) Provide diagnostic screening and assessment for the purpose of determining appropriate referrals.

(2) Provide outpatient counseling for diagnoses that are sub-clinical in nature and not potentially disabling under reference (d), such as personality disorders for which there is no elevated risk of harm, and adjustment disorders under six months in duration.

(3) Provide non-medical counseling, per reference (e), which addresses general conditions of living, life skills, improving relationships at home and at work, stress management, adjustment issues, marital problems, parenting, and grief and loss, even when the individual is suffering from a potentially disabling diagnosis, as long as the potentially disabling diagnosis is not the primary focus of care.

(4) Provide services deemed to be educational or preventive in nature.

(5) Provide family and couple counseling services, per reference (e), as long as the treatment of a potentially disabling diagnosis, as described in reference (d), is not the primary focus of clinical attention. This family and couple therapy can be conducted in a non-medical setting, even when one of the participants carries a potentially disabling diagnosis, as long as this medical disorder is not the primary focus of care.

(6) Provide early intervention, outpatient, intensive outpatient, and aftercare for substance-related conditions

(and non-substance-related addictive conditions) requiring ASAM patient placement criteria level 0.5-2.1, consistent with the precept of "no wrong door", per reference (f). Marines remain with MCCS substance use disorder counseling services throughout service provision as clinically appropriate.

(7) Provide counseling services for child abuse and domestic violence per reference (g).

4. Other Considerations

a. For cases in which the appropriate level of care is unclear, or when there are concerns by one of the Parties, or their representatives, that the transfer of care would be harmful to the client or would negatively disrupt care, designated MCCS representatives at the local level and the MTF will discuss the case and come to an agreement as to the most appropriate course of action. These discussions and the decision will be documented in the applicable records (i.e., in the DoD electronic health record (EHR) if the service member is seen at the MTF, and in the appropriate Marine Corps record if the Marine, attached Sailor, or family member is seen by an installation MCCS counseling provider). If the appropriate level of care cannot be determined by these designated representatives, the issue will be referred to the next level of leadership over the involved activities for resolution. It is anticipated that there will be very few cases for which the appropriate care site is unclear. Instances in which additional discussion may be necessary include:

(1) Cases in which it is unclear whether the individual meets diagnostic criteria for a potentially disabling psychiatric diagnosis.

(2) Cases in which a Marine, attached Sailor, or a family member is refusing a level of care at a recommended site and there is a concern that he or she will avoid services altogether if compelled to receive care at the recommended site. In such cases, it is still unauthorized for medical care to be provided outside of a provider's scope of practice. However, if there is no threat of harm, an MCCS provider can continue to meet with such individuals, with the goal being to prepare and encourage them to participate in the recommended level of care.

b. Care cannot be provided by both BUMED and MF for the same diagnosis. If a Marine, attached Sailor, or family member carries a diagnosis that requires treatment in a medical setting (as per the criteria in paragraph 3), that same diagnosis cannot be treated in a non-medical setting. There are exceptions to this rule, including the following:

(1) It is permissible for an MTF to provide medical consultation for Marines, attached Sailors, and family members participating in outpatient care at the installation MCCS Substance Abuse Counseling Centers (SACCs), as noted in paragraph (2) below.

(2) A MTF provider can prescribe medications for a substance use disorder that falls under the purview of care provided by installation MCCS SACCs (i.e., mild and in some cases moderate substance use disorders), if medication is indicated. Similarly, the MTF can provide psychopharmacologic treatment for diagnoses that are not potentially disabling, that are being treated through installation MCCS.

(3) This stipulation also does not preclude MCCS from providing psycho-educational resources (such as stress and anger management) and other adjunctive services for individuals with a potentially disabling diagnosis.

c. Medical consultative services for select clients who present with medical issues beyond the scope of practice for the SACC Licensed Independent Practitioners will be referred to the installation MTF for appropriate care or case consultation.

5. Communication. The Parties will communicate regularly at the headquarters level, and BUMED and MCCS representatives will also communicate regularly at the installation level. There will be three "tiers" of communication: a Flag Officer/General Officer level group that will meet as required, an "HQ Action Officer" group that will meet quarterly, and groups at the installation level that will communicate at least monthly.

a. In exercising oversight of this system of care, BUMED and MF representatives will examine all applicable data, including information on the numbers of service members seen at BUMED and MCCS facilities, referral patterns, diagnoses, problems encountered at each facility, access to care (for both initial and ongoing appointments), workload trends, network referrals and any other systems issues that arise.

b. Nothing in this MOU is intended to preclude local representatives from establishing their own communication/cooperative processes, based on individual circumstances at the local level. Personnel at each installation are encouraged to cooperate in whatever fashion is deemed most beneficial to the person seeking care and to unit commanders. Specifically:

c. BUMED will:

(1) Provide representatives from BUMED, M3, to participate in meetings with MF and HS representatives to monitor the flow of

patients through the system of care, and identify any problems or issues in the care provided to Marines, attached Sailors, and their family members. Through these quarterly meetings, MF and BUMED representatives will develop a Quality Assurance/Process Improvement (QA/PI) Program to review and provide oversight on issues related to the broad spectrum of psychological health services at each installation, and collaborate on all "systems" issues related to care delivery, ensuring high quality of care and appropriate access to care. This QA/PI Program will include records review to ensure that referrals are being made appropriately, that timely evaluation and follow-up is provided, and that responses are sent to the referring provider. These meetings will occur at least quarterly.

(2) Ensure that BUMED personnel are cooperatively engaged with their MCCS counterparts at the installation level.

(3) Command notification requirements involving mental health and substance-related care are governed by reference (h). The provisions of references (c) and (h) apply to all BUMED functions and BUMED providers covered under this MOU. These requirements found in reference (h) do not apply to the minimum amount of information necessary to satisfy the purpose of the disclosure. In general, this shall consist of the diagnosis; a description of the treatment prescribed or planned (including medication prescribed); impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations for the safety of self or others; and (2) ways the command can support or assist the Service member's treatment.

d. MF will:

(1) Provide representatives from the headquarters level to participate in quarterly meetings with BUMED and HS representatives, as described in item 5a.

(2) Ensure that MCCS personnel are cooperatively engaged with their BUMED counterparts at the installation level.

6. Resources. Approval of this agreement does not constitute approval of additional resources. Any funding or billet requirements that cannot be accommodated within the existing budgets of BUMED, MF, or HS must be separately addressed through normal budget processes or other special programs.

7. Health Insurance Portability and Accountability Act (HIPAA)/Privacy Act. All Parties understand and will adhere to reference (i), section C3.4, as well as reference (j), as applicable.

8. Effective Period. The effective period of this support agreement is five years from the date of last signature. It may be continued

without change during that period, but requires annual review for modification, if required, by all Parties.

9. Modification, Change or Amendment. Any modification, changes, or amendments to this agreement must be in writing and are contingent upon approval from all Parties.

10. Termination. This agreement may be cancelled at any time by mutual consent of the Parties. The agreement may also be terminated by either party upon giving 90 days written notice to the other parties. In case of mobilization or other emergency, the agreement may be terminated immediately upon written notice by any party, or remain in force only within the Parties' capabilities.

11. Concurrence. This written statement embodies the entire agreement between the Parties regarding this affiliation, and no other agreements exist between the Parties for this support except as stated herein. All parties to this agreement concur with the level of support and resource commitments that are documented herein.

12. Points of Contact. Dr. Linda Love, HQMC MF, Behavioral Health Branch Head, MFC, 703-784-9526, CAPT Ingrid Pauli, USPHS, Director of Psychological Health BUMED M33, 703-681-9098.

15 JUN 18
B. GILLINGHAM Date
RADM, MC, USN
Deputy Chief, Readiness and Health
Navy Bureau of Medicine and Surgery

31 May 2018
M. C. BALOCKI Date
Senior Executive
Director
Marine and Family Programs Division

05 Jun 2018
G. SHAFFER Date
RDML, DC, USN
The Medical Officer of the Marine Corps
Marine Corps Health Services

FAMILY ADVOCACY PROGRAM CHILD ABUSE/NEGLECT FLOW CHART

1. Incidents/allegations of domestic abuse reported to MPD.

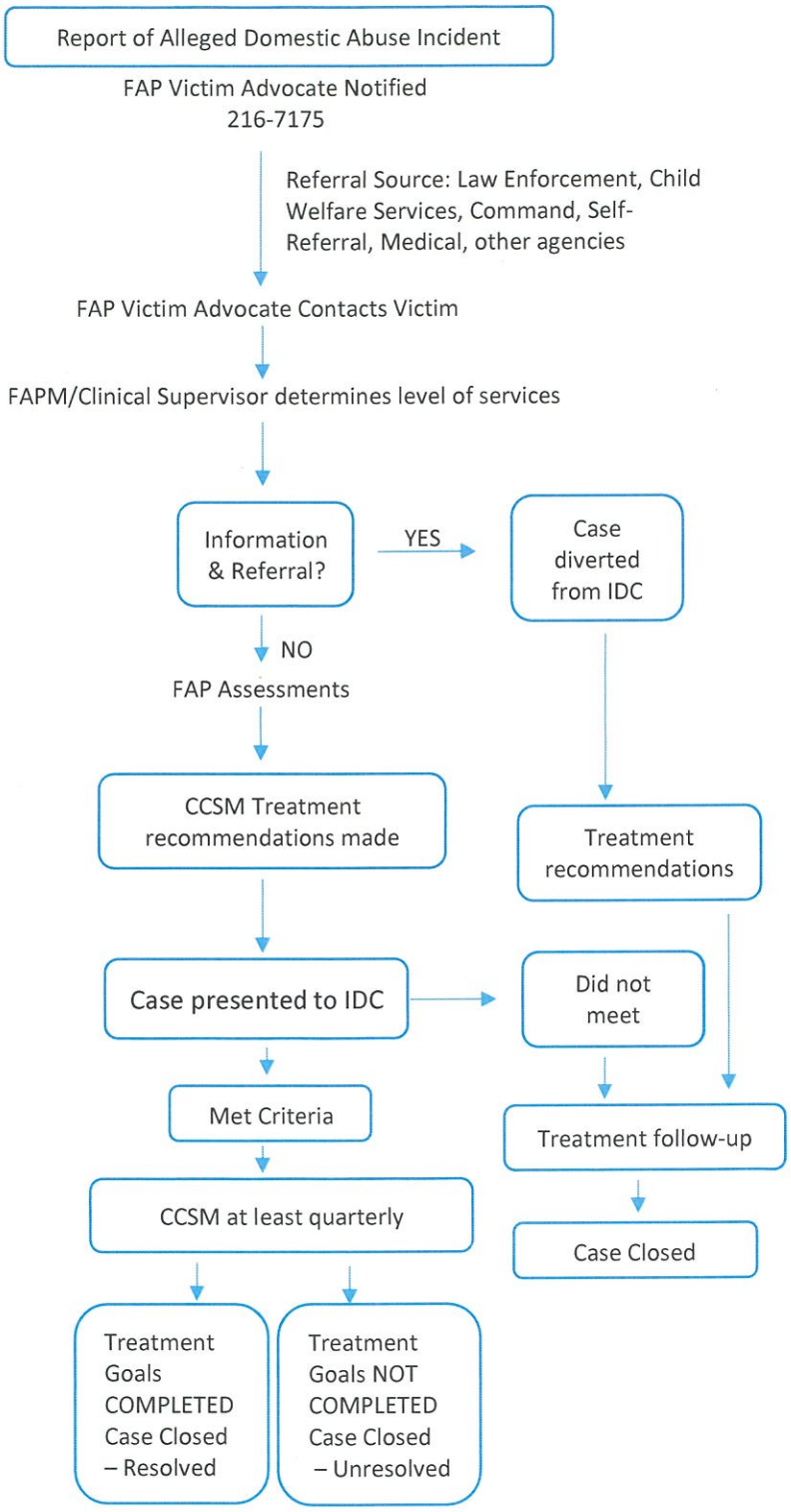
2. PMO will notify Family Advocacy Program (FAP) Victim Advocate (VA) ASAP. The MP's will contact the VA, and the VA will contact the victim. VAs can also be contacted at 24 hour hotline: (808) 216-7175.

3. Victim Advocate contact victim via telephone for safety assessment.

4. 48 Hour "cooling off" period issued and couple separated.

5. VAs will contact command if Military Protective Orders (MPO) needs to be issued.

6. FAP can be notified at any time during this process for consultation and assistance, 496-7780/8803.



FAMILY ADVOCACY PROGRAM CHILD ABUSE/NEGLECT FLOW CHART

1. Child Welfare Services (CWS) must be notified by whoever has first-hand information of **all** child abuse/neglect incidents or allegations (CWS will decide their level of involvement).

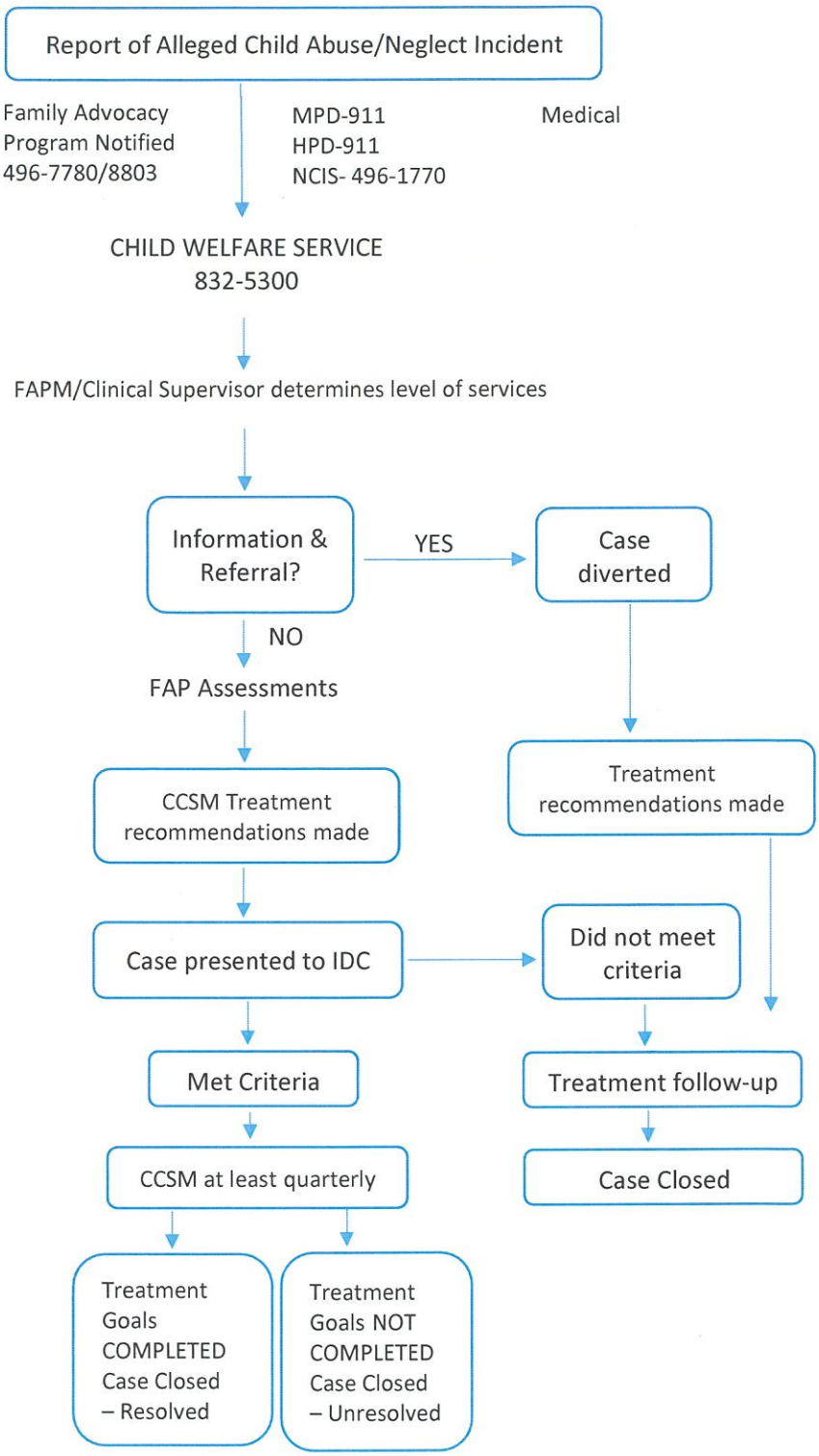
2. Medical exam for child as appropriate.

3. Command to be notified if MPO needs to be issued.

4. If child sexual abuse, CWS/NCIS interview child at the Children's Justice Center, 586-0822.

5. If needed, VA can provide information and support to the non-offending parent and family members. The MPs will contact the VA and the VA will contact the family members. VA can also be contacted through the VA Hotline, 808-216-7175.

6. FAP can be notified at any time during this process for consultation and assistance, 496-7780/8803.



Age of Child	Required Supervision	Left Alone in Quarters	Left Alone Overnight	Outside Unattended or using MCBH facilities	Left in Car Unattended	Child Sit Siblings	Child Sit Others
Newborn- 5 years old	Direct Supervision Required.	**NO**	**NO**	**NO**	**NO**	**NO**	**NO**
6-9 years old	Direct Supervision Required	**NO**	**NO**	**YES** With immediate access (visual sight and hearing distance) to adult supervision. Children six years old may not walk alone to and from school or school bus stop. Children seven years old and older may walk unaccompanied to and from school or school bus stop with a buddy. Parents need to buddy partner or use older siblings, so child is not alone.	**NO**	**NO**	**NO**
10-11 years old	Indirect Supervision Required. This is a transitional time, and children are accepting more responsibility however they continue to require indirect supervision. Sponsor should know child's location and activities. Emergency contact available.	**YES** Ten years old for up to 1 hour. Eleven year olds up to 3 hours (occasionally, not daily). Must have access to indirect supervision (neighbor, checking with sponsor by phone).	**NO**	**YES** With ready access to adult supervision. Sponsor checks on the child or has the child check in with the sponsor, parent, or caregiver hourly. Ready access can be accomplished with cell phone. Must be 30 minutes or less to respond to the child in crisis. Child should take into consideration due to child's maturity and any limitations or special needs.	**YES** Not more than ten minutes and the keys MUST be removed and the parking brake applied.	**YES** Eleven year olds may sit siblings 6 years and older for up to 1 hour. Ten year olds may not sit siblings. Child's maturity and knowledge of emergency protocols should be considered.	**NO**
12-13 years old	Indirect Supervision Required. Children are approaching the adolescent years when there is need for increased responsibility should be carefully evaluated.	**YES** For up to six hours with ready access to adult supervision and interment contact with a supervisor.	**NO**	**YES** With access to adult supervisor. Sponsor checks on the child or has the child check in person or by the phone every 2 hours. Parent must know child's location and activity and respond to the child within 1 hour. Parents should take into consideration the child's maturity and any limitations or special needs.	**YES**	**YES** Limit up to 6 hours. Not overnight.	**YES** Limit up to 6 hours. Not overnight.
14-15 years olds	Children continue to need to know how to access sponsor and guidance for emergency situations. Sponsors are responsible for their actions.	**YES** No longer than 9 hours with ready access to adult supervision.	**NO**	**YES** With access to adult supervision by phone or designated caregiver within 2 hours. Contact must be made every 3 hours.	**YES**	**YES**	**YES** May sit up to 9 hours, not overnight.
16-17 years old	Sponsors are responsible for their children and their actions as long as Family Member status is maintained.	**YES** No More than two consecutive overnight periods with access to adult supervision.	**YES** Indirect Supervision	**YES** Time is left up to the Sponsor's discretion.	**YES**	**YES**	**YES**

To report concerns that may constitute child neglect, please call PMO (808) 496-2123.

Updated November 4, 2025