



***Serving Veterans and  
Military Families Affected by  
Substance Use Disorders and  
Child Maltreatment***

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For Families Affected by Substance Use**

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# ***Air Force Medical Operations Agency***

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*Coaching and Partnering for Improved Performance*

## **Serving Veterans and Military Families Affected by Substance Use Disorders and Child Maltreatment**



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# ***Family Advocacy Program***

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- **In accordance with Department of Defense Instruction 6400.01 February 13, 2015, it is DoD policy to:**
  - **Promote early identification, reporting, and coordinated, comprehensive intervention, assessment and support to victims of child abuse and domestic abuse**
  - **Provide assessment, rehabilitation, and treatment, including comprehensive abuser intervention**
- **All DoD installations where active duty families are assigned have a Family Advocacy Program (FAP) and a substance abuse program**
- **FAP and substance abuse programs have reciprocal reporting requirements under certain conditions**



# *Eligibility for FAP*

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- **Active duty (AD) Air Force, Army, Navy and Marines and their immediate family members who are eligible for care in the military hospital are eligible for FAP services**
- **Activated Guard and Reserve members and their family members who are eligible for care in the military hospital**
  - **Must live near an installation with a FAP to take advantage of these services**
- **Military retirees can receive voluntary prevention and treatment services on a “space-available” basis – No commander involvement**
  - **Coast Guard families and Military Public Health Officers’ families receive initial safety planning at referral**
    - **Victims and alleged offenders are referred off base for treatment and/or follow-on care**



# ***FAP Prevention Services***

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- **New Parent Support Program (NPSP)**
  - **Evidence-based screening tool identifies families with the highest need for prevention intervention**
  - **Home visitation services provided by registered nurses or licensed clinical providers**
  - **To expectant parents and parents of children under three y/o**
    - **Supportive services related to education on pregnancy, infant/child growth and development, safety and care**
    - **Visits at least twice per month to deliver anticipatory guidance with the goals of**
      - **Decreasing risk factors for child maltreatment**
      - **Increasing protective factors**
      - **Teaching positive parenting practices**



# ***FAP Prevention Services***

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**Family Advocacy has a strong prevention component:**

- **Education about domestic abuse and child maltreatment in briefings across the installation and in special emphasis months:**
  - **April: Child Abuse Prevention Month / Month of the Military Child**
  - **Feb: Dating Violence Prevention Month**
  - **Oct: Domestic Violence Awareness Month**
- **Prevention Specialists also teach skill building in classes/groups:**
  - **Parenting Classes**
  - **Stress and Anger Management Classes**
  - **Couples Communication and/or Relationship Enhancement**
  - **Divorce Recovery Support**

**\*Prevention programs offered may vary across installations**





# ***Maltreatment Intervention***

- **When FAP receives an allegation of child maltreatment, initial notifications are made immediately:**
  - **Military Criminal Investigative Office (MCIO) - OSI, CID, NCIS**
  - **Military Police**
  - **Child Protective Services**
  - **Active duty member's commander or first sergeant**
- **DOD requires FAP to establish MOUs with child protection agencies**
  - **Reciprocal reporting**
  - **Information sharing for safety planning**
  - **Collaboration on intervention plans**
    - **FAP prevention and treatment services are free to active duty military families**
- **FAP is mandated to call Child Protective Services (CPS) for all suspected reports of child abuse and neglect**



# ***Maltreatment Intervention***

- **Parents receive psychosocial assessments with licensed clinicians**
  - **FAP interviews the child only if CPS doesn't**
  - **Commanders direct AD members to FAP for assessment**
  - **AD members who “lawyer-up” may refuse to discuss allegations**
  - **Commanders cannot direct family members to FAP**
    - **FAP must then rely on interview information from CPS**
  - **Commanders cannot make an AD member take a child to a medical appointment**
    - **FAP relies on CPS or the courts to gain the cooperation of uncooperative parents in child maltreatment cases**
- **The military generally cannot remove children from parents' custody and relies on CPS when removal is necessary**
  - **There are, however, some exceptions that apply in overseas locations where CPS access is not authorized**





# ***Maltreatment Intervention***

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**Temporary removal of children at high risk:**

**In the Navy the installation commander can order temporary removal of the child from the home without parental consent when:**

- **There is substantial reason to believe the life and/or health of the child is in real and present danger and**
- **There is no protecting and responsible adult in the home and**
- **The child is located in an overseas location, or in an area under the sole jurisdiction of U.S. military forces**



# ***Maltreatment Intervention***

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**Temporary removal of children at high risk:**

**In the Army the treating physician will make the initial determination to request removal of a child in consultation with the hospital commander and the legal consultant.**

**The hospital commander will ensure that the military police and the soldier's commander are notified. In CONUS locations, close collaboration with CPS is required.**

**In overseas locations, when parental approval for placement is not given, Family Advocacy will recommend to the installation commander that the child should be returned to CONUS using the early return of dependents policy.**

**If the child requires medical protective custody, the hospital commander will initiate. SOFA rules apply overseas and sometimes host nation CPS or the courts will be involved.**

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# ***Maltreatment Intervention***

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**Temporary removal of children at high risk:**

**In the Marines a Pacific Order is in place that allows military police or a commanding officer to temporarily remove a minor child from the home when police determine that exigent circumstances require such removal due to abandonment or child abuse in which the child is in imminent danger of death or serious bodily harm.**

**The order reads, " The Federal government does not possess a child welfare agency equivalent to that of a child protective services agency in a state. III Marine Expeditionary Force (MEF) and Marine Corps Installations Pacific (MCIPAC) units and organizations also require procedures to provide for the protection of minor (i.e., under 18 years of age} children with Status Of Forces Agreement (SOFA) status when reasonable grounds exist to believe that they may be abused or neglected and may require protective placement and medical examinations".**



# ***Maltreatment Intervention***

- **Incident Determination Committee (IDC):** Reviews all reports of child maltreatment and domestic abuse on an installation and makes an incident status determination about whether the incident “Met Criteria” for physical, emotional, or sexual abuse or neglect
  - **In Air Force IDC is called the Central Registry Board**
  - **Army is currently using the Case Review Committee model but is transitioning to the IDC**
- **Team applies an automated decision tree algorithm containing the DOD definitions to each incident and the application then tells the team if the incident “Met Criteria.”**
  - **Voting is by a show of hands**
  - **Chaired by the 2<sup>nd</sup> in command of the installation**
  - **Members: Family Advocacy clinician, lawyer, MCIO, military police, senior enlisted officer, AD member’s commander**



# *Active Duty Members*

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## ■ **By Service Branch**

- **Air Force Members are called**
  - **Airmen**
- **Army Members are called**
  - **Soldiers**
- **Marine Corps Members are called**
  - **Marines**
- **Navy Members are called**
  - **Sailors**



# ***Air Force FAP***

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- **FAP is located in the hospital or medical clinic**
  - **Family Advocacy Officer (FAO) leads the entire team**
  - **All FAP clinicians are masters-level social workers (LCSW)**
- **Commanders are required to direct Airmen who are offenders of child/partner maltreatment to complete FAP treatment recommendations**
- **There is no requirement to administratively separate a child sexual abuse offender until after a military or civilian conviction**
- **All Airmen involved in an alcohol-related incident must be referred to ADAPT (DWI, DV, child abuse, arrest, etc.)**
- **If during FAP assessment or treatment a provider suspects the Airman of alcohol or drug abuse an ADAPT referral is required**



# ***Air Force Substance Abuse Program***

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## **Alcohol and Drug Abuse Prevention (ADAPT)**

- **Located in the Mental Health Clinic of the hospital providing prevention education and out-patient treatment**
- **Providers who suspect family maltreatment in the course of assessing or treating substance abuse must refer to FAP**
- **ADAPT primarily treats Airmen**
  - **Adult family members can voluntarily attend educational or treatment program in locations where the Mental Health Clinic sees civilians - ADAPT does not treat minors**
- **Airmen under age 21 drinking alcohol must be referred to ADAPT**
- **Illegal drug use by Airmen must be referred to ADAPT**
  - **Normally are separated from the AF, final decision made by the commander with consult from AF attorneys**





# Army FAP

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- **Prevention Services are located in Army Community Service Center**
    - **Family Advocacy Program Manager (FAPM) is responsible for overall management of FAP and is housed with prevention staff**
  - **Assessment & treatment Services are located in the hospital**
    - **Clinical team is led by Family Advocacy Clinical Chief (FAPC)**
    - **All clinicians are masters-level and licensed for independent practice**
  - **Army commanders have discretion about whether to mandate FAP treatment recommendations for Soldiers who are offenders**
  - **All FAP referrals that include allegations that alcohol was involved in the incident must be referred to ASAP**
  - **If during FAP assessment or treatment a providers suspects the Soldier is abusing alcohol or drugs an ASAP referral is required**
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# ***Army Substance Abuse Program***

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## **Alcohol and Substance Abuse Program (ASAP)**

- **Currently transitioning back to the hospital, providing prevention education and out-patient treatment**
- **Providers who discover family maltreatment in the course of assessing or treating substance abuse must refer to FAP**
- **ASAP treats Soldiers only**
- **Soldiers under age 21 drinking alcohol must be referred to ASAP**
- **Illegal drug use by Soldiers must be referred to a Medical Review Officer and ASAP, commander has final decision about whether to separate the Soldier from the Army**
- **2<sup>nd</sup> DUI/DWI in a military career requires separation from Army**
- **2<sup>nd</sup> substance-related incident within 12 months of completing ASAP requires separation from Army**



# *Marine Corps FAP*

- **The FAP is located in Behavioral Health programs, in Marine Corps Community Service Centers**
  - **The FAP team is led by the Family Advocacy Program Manager (FAPM)**
  - **All clinicians are masters-level and licensed for independent practice**
- **There is no requirement for commanders to mandate a Marine into FAP treatment, however they are encouraged to endorse the treatment plan recommended by FAP**
- **There is no mandate to initiate administrative separation of a Marine for child sexual abuse or adult sexual assault prior to a military or civilian conviction**
- **Providers in all Behavioral Health programs are required to refer all allegations/suspicious of child or partner maltreatment to the FAP**



# ***Marine Corps Substance Abuse Program***

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## **Substance Abuse Program located in the Substance Abuse Counseling Centers (SACC)**

- **Operate under the Behavior Health umbrella in the Marine Corps Community Services Center or nearby clinic with Behavior Health oversight, providing prevention education and out-patient treatment**
- **The SACC does not treat civilians or minors – referred off base**
- **Reservists and retirees are seen space-A or referred off base**
- **The Marine Corps has a requirement to begin mandatory out processing for illicit drug use**
- **Providers in all Behavioral Health programs are required to refer all Marines suspected of substance abuse to the SACC**
- **The decision of when to separate a Marine for alcohol abuse resides with the commander**



# *Navy FAP*

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- **FAP is located in the Fleet and Family Support Center**
    - **The Family Advocacy Representative (FAR) leads the team**
    - **All clinicians are masters-level and licensed for independent practice**
  - **The commander does not have the legal authority to direct Sailors to complete FAP treatment recommendations, however, Navy commanders consistently support treatment for Sailors whose case meets criteria at IDC**
  - **Administrative separation process will be initiated on Sailors who are offenders of child sexual abuse incidents that meet criteria at IDC**
  - **FAP refers all Sailors suspected of substance abuse to NADAP**



# ***Navy Substance Abuse Program***

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## **Naval Alcohol and Drug Abuse Prevention Program (NADAP)**

- **Located in the hospital or nearby clinic with hospital oversight, providing prevention education and out-patient treatment**
- **Sailors who are drinking under age 21 or suspected of using illicit drugs require referral to NCIS and NADAP**
- **NADAP treats Sailors and Navy Reserve members, civilians and minors are referred off base**
- **Any illicit drug use requires discipline as appropriate and administrative separation processing initiated**
- **All hospital personnel, including NADAP staff, are required to report suspected child maltreatment to FAP**
- **Alcohol treatment failures are administratively separated**
  - **Command may authorize senior-level Sailors be treated a second time if more than 3 yrs lapsed since previous incident and successful completion**



# *Working Together*

- **DoD Child Maltreatment and Substance Abuse Programs’ mission is to keep military families safe and AD members free from substance abuse or dependence**
  - **We welcome referrals from “outside the gate”**
- **AF and Army FAP records, Navy, Air Force and Army substance abuse records are HIPAA protected**
- **Marine and Navy FAP records and Marine substance abuse records are privacy act protected**
  - **There may be limits to what personally identifiable information or protected health information DOD programs can share with civilian programs**
  - **We want to collaborate in the best interest of military families**

**Google the installation name and the program name for local contact information**





# Questions?

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# Contact Info

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# **Collaborating at the Local Level to Serve Veterans and their Families**



**SID GARDNER  
CHILDREN AND FAMILY FUTURES  
STRONG FAMILIES, STRONG CHILDREN PARTNERSHIP**

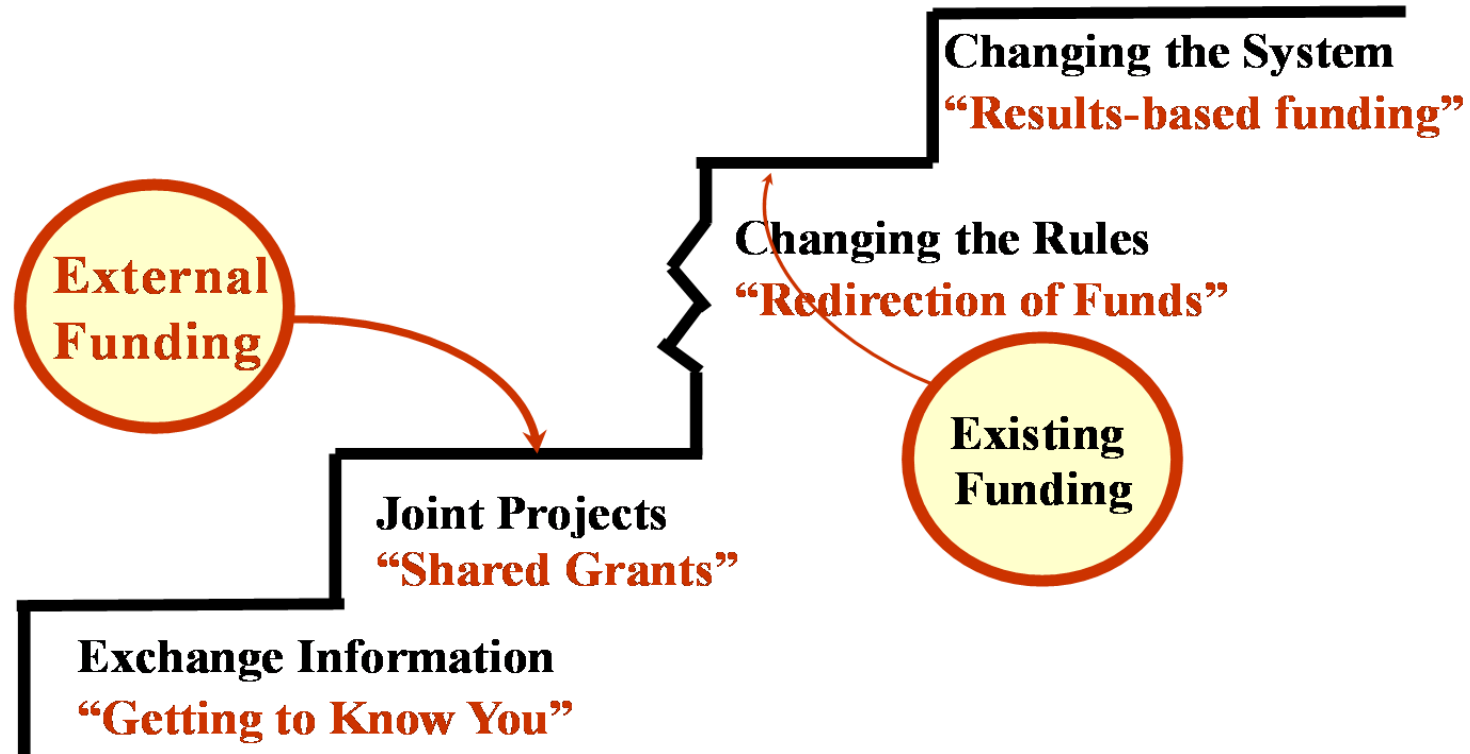
**AUGUST 2016**

# Overview



- **How can veterans' agencies collaborate to achieve better results and wider funding?**
- **The numbers: how many children and veterans?**
- **The need**
- **The networks: the potential for collaboration**
- **Obstacles to collaboration**
- **A checklist of collaborative tasks**

# Four Levels of Collaboration



# What are the key issues?



- **Numbers**: How many veterans and children of recent veterans are there?
- **Needs**: What services and supports do these families need, given the parents' needs and children's ineligibility for most VA services?
- **Networks**: How can we build lasting, effective networks at the local level that respond to the needs of these veterans and their families?

# The Numbers



- **Over 2 million active duty service members were deployed to Iraq and Afghanistan since 2001**
- **An estimated 40% of them are now veterans separated from service, living in their communities**
- **Approximately 1/3 of those separated veterans are married, over half have children, averaging 2 each**
- **There is no current figure for the total number of children of veterans of recent conflicts or the children of veterans affected by family disorders such as PTSD and substance abuse**
- **As a result, these are “invisible children,” who need services but have no status in the services system**



# Best Available Numbers in Orange County



- **131,000 total veterans**
- **Estimated annual increase in veterans coming to OC: 6,500**
- **6,200 children of post 9/11 veterans**
- **Served by the VA for health needs: ?**
- **Total homeless veterans: 16,375 \***
- **Total unemployed veterans: ?**
- **Total veterans attending college: est. 10,000**

\*estimate based on USC/OCCF veterans study

# The Need



- **Approximately 30-35% of separated veterans exhibit symptoms of PTSD and/or substance abuse**
- **These are problems that affect the entire family, with an impact on children's cognitive learning, emotional stability, behavior, and the likelihood that these children will adopt risky behaviors**
- **These children need early identification and screening, substance abuse prevention services, and mental health services aimed at social and emotional stability**

# Eligibility and Access to Services: Why Do We Need to Collaborate?



- **Separated veterans have access to VA services**
- **Approximately 1/3 of them access VA health services; about 1/4 of them in rural areas access non-VA mental health services; 45% of them receive health services from non-VA sources**
- **Children of veterans are not eligible for services unless their parent is seriously disabled or homeless**
- **As a result, *the VA cannot meet the needs of these families with its own resources***

# The Question: A Matter of Values, not Resources



- **Should children of veterans who served their country be harmed or placed at risk by their parents' deployment and subsequent problems?**
- **If the answer is No—then developing services that respond to the needs of these children is one of the most important tasks of caring for veterans and their families**

# What Does A Local Collaborative Need to Succeed?



- **Active involvement by all agencies that serve children, youth, and families**
- **A “box on the form” identifying veteran status in agency caseloads**
- **An accurate and updated inventory of local public and private services available to veterans and their families—for both “veterans’ programs” and programs that *should* serve veterans and their families**
- **Estimates of the total number of veterans and families needing help:**
  - **“You can’t coordinate what you can’t count”**

# Two Key Ingredients of Collaboration



- **Accountability for results:**
  - How do we measure what the collaborative achieves that we can't achieve in our own agency?
- **Trust in shared resources and outcomes:**
  - Shifting from competing for resources to writing better proposals because we can show that we're working together

# Four Challenges Collaboratives Need to Overcome



- **Missing players**
- **The tendency to talk about activities rather than clients—“what we did last month” vs how the veterans are doing—who’s getting help and how do we measure progress?**
- **“Projectitis:” defining progress as launching and funding projects rather than looking at the whole system that serves veterans**
  - “Invading Normandy—and digging in on the beach”
- **Pursuing grants vs “fair share funding”—are veterans and their families receiving priority in other agencies’ caseloads?**
  - \$400 billion in federal funding for child-serving programs

# A Checklist of Collaborative Tasks



- **Is an inventory of services kept current?**
  - Does it have information about capacity and funding—or just phone numbers?
- **Are referrals to non-veterans' agencies tracked?**
  - “We sent them over” Then what?
- **Are local colleges and universities engaged in training, surveys of needs, or evaluations of impact?**
- **Are veterans' advocates and providers active in pending health decisions about who gets expanded coverage and for what services?**
- **Cuts: are programs for veterans and their families exempt from ongoing cutbacks?**



# Collaborative Challenges for Local Collaboratives



- **Accountability for results: Do we want to develop an annual “report card” of key indicators for veterans and their families?**
  - Similar to the Conditions of Children report—a track record of 21 years
  - Not just measuring what we do—measuring whether veterans are doing better
- **Do we want to develop a resources inventory on total funding for veterans programs in the County?**
  - Can we address long-term sustainable funding that goes beyond grant funding? Can the County count total spending for veterans?
- **Will existing grants and coalitions be able to achieve either of these?**

# We've Got a Mission...



- **Do we have agreement on how we can measure our progress to know whether we carried out the mission successfully?**
- **Do we know what resources we need—or what resources we have now—to carry out the mission?**
- **If the answers are No—then how can we carry out the mission?**

# Resources



- **Slide show available at [www.cffutures.org](http://www.cffutures.org)**
- **Other resources available at**
  - <http://www.samhsa.gov/MilitaryFamilies/tacenter/>
  - <http://www.zerotothree.org/about-us/funded-projects/military-families/>
  - <http://www.justiceforvets.org/>
  - <http://www.oefoif.va.gov/>
  - <http://iava.org/>
  - <http://navso.org>

# Contact Information



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