



## DoD INSTRUCTION 6400.10

# DoD COORDINATED COMMUNITY RESPONSE TO PROBLEMATIC SEXUAL BEHAVIOR IN CHILDREN AND YOUTH

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**Originating Component:** Office of the Under Secretary of Defense for Personnel and Readiness

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**Purpose:** In accordance with the authority in DoD Directive 5124.02 and DoD Instruction (DoDI) 6400.01, this issuance establishes policy, assigns responsibilities, and prescribes procedures for the DoD coordinated community response (CCR) for preventing and responding to problematic sexual behavior in children and youth (PSB-CY), as defined in DoDI 6400.01.

## TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION .....	4
1.1. Applicability. ....	4
1.2. Policy. ....	4
SECTION 2: RESPONSIBILITIES .....	6
2.1. Under Secretary of Defense for Personnel and Readiness (USD(P&R)). ....	6
2.2. Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD(M&RA)). ....	6
2.3. DASD(MC&FP). ....	6
2.4. Assistant Secretary of Defense for Health Affairs (ASD(HA)). ....	7
2.5. Director, Defense Health Agency. ....	7
2.6. Director, DoDEA. ....	8
2.7. Under Secretary of Defense for Intelligence and Security. ....	8
2.8. Secretaries of the Military Departments. ....	8
SECTION 3: CHILDREN AND YOUTH WITH PSB .....	10
SECTION 4: ESTABLISHMENT OF THE PSB-CY MDT .....	11
4.1. Installation PSB-CY MDT .....	11
4.2. Installation Family Advocacy Committee. ....	11
4.3. Core PSB-CY MDT .....	11
4.4. Expanded PSB-CY MDT .....	12
4.5. PSB-CY MDT Roles and Responsibilities. ....	12
4.6. PSB-CY MDT Case Review .....	13
SECTION 5: CHILD-FOCUSED ADVOCACY FOR PARENTS AND LEGAL GUARDIANS .....	15
5.1. Child-focused Advocacy .....	15
5.2. Roles and Responsibilities. ....	15
SECTION 6: PSB-CY MDT ORGANIZATIONAL RESPONSIBILITIES AND PROCEDURES FOR RESPONDING TO PSB-CY .....	17
6.1. FAP. ....	17
6.2. FAP Clinical Provider. ....	17
6.3. CDP/YP .....	18
6.4. DoDEA. ....	19
6.5. Military LEAs. ....	20
6.6. MCIOs .....	20
6.7. HCPs. ....	21
SECTION 7: PSB-CY PARENT(S) AND LEGAL GUARDIAN(S) ENGAGEMENT AND CASE MANAGEMENT .....	22
7.1. Active Parent(s) and Legal Guardian(s) Involvement. ....	22
7.2. Intake and Assessments. ....	22
7.3. FAP Clinical Providers and Case Managers. ....	22
7.4. FAP Clinical Intervention Plans. ....	23
7.5. FAP Clinical Safety and Supervision Plans. ....	23
7.6. FAP Clinical Interventions. ....	24
7.7. Medical Evaluations and Acute Examinations. ....	24
7.8. Disclosure. ....	25
7.9. Forensic Interviews. ....	25

SECTION 8: PSB-CY PREVENTION STANDARDS ..... 27

    8.1. General..... 27

    8.2. Standard Elements for PSB-CY Prevention. .... 27

        a. Primary Prevention..... 27

        b. Secondary Prevention. .... 28

        c. Tertiary Prevention..... 28

GLOSSARY ..... 30

    G.1. Acronyms..... 30

    G.2. Definitions..... 31

REFERENCES ..... 35

## SECTION 1: GENERAL ISSUANCE INFORMATION

### 1.1. APPLICABILITY.

a. This issuance applies to:

(1) OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this issuance as the “DoD Components”).

(2) All Service members and their families and, when authorized by law or the Secretary of the Military Department concerned, other designated populations, such as civilian personnel.

b. This issuance:

(1) Does not apply to adult victims of sexual assault who are covered pursuant to Volume 1 of DoDI 6495.02.

(2) Is not intended to change or otherwise modify regulations, including DoD directives and instructions, concerned with determining misconduct by individuals and the criminal, civil, or administrative actions available to address such misconduct.

(3) Does not create any rights enforceable by any person, organization, or other entity in an administrative proceeding or at law or equity. Failure on the part of personnel to comply with any aspect of these guidelines will not create any rights or privileges in any persons or entity and will not operate to provide a defense or other remedy in any proceeding arising under this protocol.

c. Nothing in this issuance will infringe on the Office of Inspector General of the Department of Defense’s statutory independence and authority as articulated in the Inspector General Act of 1978, as amended, in the Appendix of Title 5, United States Code. In the event of any conflict between this issuance and the Inspector General Act of 1978, the Inspector General Act of 1978 takes precedence.

### 1.2. POLICY.

DoD will prevent and respond to PSB-CY by:

a. Establishing the Family Advocacy Program (FAP) as the reporting point of contact to receive and review all referrals of PSB-CY occurring on military installations and received by covered entities, through a multi-faceted, multidisciplinary team (MDT) pursuant to Section 1089 of Public Law 115-232.

- b. Promoting public awareness of PSB-CY and its impacts on individuals, families, communities, and readiness.
- c. Supporting trauma-informed parent engagement strategies for both the child impacted by such behavior and the child exhibiting such behavior.
- d. Referring identified children and youth exhibiting PSB to evidence-informed services.
- e. Establishing a trauma-informed CCR to PSB-CY.
- f. Adopting trauma-informed intervention, supportive services, and treatment models.
- g. Establishing an installation MDT designated to respond to PSB-CY and tasked with:
  - (1) Monitoring the risk to and safety of all children and youth involved in an incident of PSB (whether exhibiting or impacted by the behavior).
  - (2) Making recommendations for intervention, supportive services, and case management.
  - (3) Coordinating parent and legal guardian engagement.
- h. Establishing an advocate role providing child-focused advocacy for parents and legal guardians to facilitate access to a range of military and community-based resources.
- i. Establishing cultural competency in cultural norms, ethnicity, religion, socioeconomic status, disability, gender, gender identity and expression, and sexual orientation in providing PSB-CY prevention, outreach, and response supports.
- j. Requiring all DoD personnel who are covered professionals as defined in Section 20341 of Title 34, United States Code and Section 575 of Public Law 114-328 to report PSB-CY incidents that include suspected child abuse and neglect to the appropriate Child Protective Services (CPS) agency, law enforcement agency (LEA), and FAP. The aforementioned DoD personnel have an on-going obligation to disclose protected health information to the MDT and its members to enable the MDT to review and recommend treatment, counseling, or other appropriate interventions for the complainants and respondents.
- k. PSB-CY incidents are managed by the MDT and do not go to the installation determination committee for incident status determination as described in Volume 3 of DoD Manual (DoDM) 6400.01 to guard against the conflation of adult initiated behavior and child initiated behavior.

## **SECTION 2: RESPONSIBILITIES**

### **2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)).**

The USD(P&R):

- a. Establishes and oversees DoD-wide policies and programs for preventing and responding to PSB-CY.
- b. Collaborates with the Secretaries of the Military Departments to establish procedures and programs in accordance with this issuance.
- c. Budgets and allocates funds and other resources to meet the policy objectives of this issuance.

### **2.2. ASSISTANT SECRETARY OF DEFENSE FOR MANPOWER AND RESERVE AFFAIRS (ASD(M&RA)).**

Under the authority, direction, and control of the USD(P&R), the ASD(M&RA) provides policy, direction, and oversight to the Office of Military Family Readiness Policy and Family Advocacy Program (FAP) through the Deputy Assistant Secretary of Defense for Military Community and Family Policy (DASD(MC&FP)).

### **2.3. DASD(MC&FP).**

Under the authority, direction, and control of the ASD(M&RA), the DASD(MC&FP):

- a. Monitors compliance with this issuance and periodically evaluates the DoD response to PSB-CY in coordination with the organizations identified in Paragraph 2.3.c.
- b. Monitors and oversees implementation of the FAPs of the Military Services to enhance the management and effective delivery of services.
- c. Issues standardized guidance to the Secretaries of the Military Departments for developing a coordinated approach to preventing and responding to PSB-CY. These guidelines will be designed to meet local needs after consultation with DoD Education Activity (DoDEA), health care providers (HCPs), military and family readiness programs, military community support programs, military law enforcement (LE), and military criminal investigative organizations (MCIOs) serving DoD personnel and their families.
- d. Provides:
  - (1) Operational support, staffing tools, funds, and other resources to ensure adequately trained personnel are available to administer all required programs.

(2) Guidance and technical assistance to the DoD Components in addressing PSB-CY and in identifying and resolving inter-component issues and concerns related to the prevention of and response to PSB-CY.

e. Supports:

(1) Funding requests to create and update FAP automation necessary to meet data collection and monitoring requirements.

(2) DoD and Military Department research for identifying program challenges and developing best practices in preventing and responding to PSB-CY.

f. Collaborates with Federal and State agencies that address PSB-CY and serves on related Federal committees and advisory groups.

g. Adheres to all requirements with regard to the status-of-forces agreements and other partner nation agreements in addressing PSB-CY in military families and sponsored civilians in locations outside of the continental United States.

h. Ensures any personally identifiable information collected, maintained, used, or circulated when preventing or responding to PSB-CY is collected, maintained, used, or circulated in accordance with DoDI 5400.11, DoD 5400.11-R, DoDI 8580.02, and DoDM 6025.18.

i. Submits reports to congressional committees, as requested.

#### **2.4. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)).**

Under the authority, direction, and control of the USD(P&R), the ASD(HA) develops policy guidance, competencies, and education requirements for HCPs that address the provision of health care services related to PSB-CY and health care support to the CCR to PSB-CY.

#### **2.5. DIRECTOR, DEFENSE HEALTH AGENCY.**

Under the authority, direction, and control of the USD(P&R) through the ASD(HA), the Director, Defense Health Agency:

a. Provides:

(1) Oversight of military medical treatment facility (MTF) compliance with the policies and procedures in this issuance.

(2) Annual education and training to all HCPs on the policies and procedures in this issuance.

(3) Sufficiently trained pediatric forensic health care examiners (FHEs), in accordance with DoDI 6310.09, to support pediatric forensic health exams, where appropriate.

(4) Behavioral health care support to the PSB-CY MDT as part of the CCR.

(5) Consultation and assistance with the release of protected health information in the MDT environment that ensures consistency with applicable laws and regulations.

b. Develops procedural and clinical practice guidelines and provides assessment instruments for HCPs that address PSB-CY.

## **2.6. DIRECTOR, DODEA.**

Under the authority, direction, and control of the USD(P&R), through the ASD(M&RA), the Director, DoDEA:

a. Develops procedures to ensure compliance with the requirements of this issuance.

b. Oversees implementation of DoDEA Administrative Instructions 1443.02 and 2051.02 as they relate to PSB-CY.

c. Programs, budgets, and allocates sufficient funds and other resources to meet the policy objectives of this issuance.

## **2.7. UNDER SECRETARY OF DEFENSE FOR INTELLIGENCE AND SECURITY.**

The Under Secretary of Defense for Intelligence and Security:

a. Develops and recommends policy and training standards for LE activities in the DoD Components in accordance with DoDI 5525.15.

b. Serves as the OSD staff point of contact for issues related to LE activities in the DoD Components that are associated with PSB-CY and the policies and procedures in this issuance.

## **2.8. SECRETARIES OF THE MILITARY DEPARTMENTS.**

The Secretaries of the Military Departments:

a. Establish policies and:

(1) Programs consistent with the procedures outlined in Sections 3 and 5 of this issuance and ensure implementation, monitoring, and evaluation at all levels of military command.

(2) Procedures for Military LEAs and their respective MCIO in support of PSB-CY and ensure proper coordination with Federal, State, and local LEAs.

b. Budget and allocate funds and other resources to meet the policy objectives of this issuance.

c. Provide:

(1) Public awareness and prevention efforts in alignment with DoD campaigns and initiatives.

(2) Annual education and training to key personnel (e.g., command, Child Development Program/Youth Program (CDP/YP), LE) on the policies and procedures in this issuance.

d. Support and provide continued training and skills development for FAP clinical providers, case managers, New Parent Support home visitors and advocates providing child-focused advocacy for parents so such personnel may maintain professional licenses or certifications and comply with occupational standards of competence, as required.

e. Submit any proposed policy change that may expand FAP's scope of responsibility and mission to OSD FAP for review.

### **SECTION 3: CHILDREN AND YOUTH WITH PSB**

#### **3.1. Children and youth who engage in PSB:**

a. Are fundamentally different from adults who have sexually abused children and require a different set of guidelines with respect to response, safety planning, assessment, evaluation, and interventions.

b. Should be screened and evaluated in the context of other emotional or behavioral issues and family functioning by clinical providers who have received specialized training working with children and youths in:

- (1) Child development, including normal sexual development and behavior in children.
- (2) Childhood mental health and behavioral problems.
- (3) Current research literature and empirically supported intervention and treatment for childhood behavioral and mental health problems.
- (4) Cultural, environmental, and family factors that affect child and youth behaviors.

3.2. For children and youth involved in incidents where the alleged behaviors reach a criminal threshold, the appropriate adjudication will be determined by the appropriate civilian justice systems, to include State juvenile justice systems, designed and equipped to determine the appropriate disposition for the alleged juvenile misconduct.

## **SECTION 4: ESTABLISHMENT OF THE PSB-CY MDT**

### **4.1. INSTALLATION PSB-CY MDT.**

The Installation PSB-CY MDT coordinates a comprehensive, multidisciplinary, trauma-informed response to the needs of children, youth, and families involved in incidents of PSB-CY. Installation PSB-CY MDTs will:

a. Promote:

(1) Effective and coordinated case management based on open communication, collaborative decision making and information sharing that is supported by relevant laws, regulations, and statutes.

(2) Constructive parent(s) and family engagement strategies.

b. Provide support services to promote trauma recovery for all involved children, youth, and families.

c. Regularly and systematically review all open cases until closure, to ensure continuity of care.

### **4.2. INSTALLATION FAMILY ADVOCACY COMMITTEE.**

The installation family advocacy committee develops and coordinates written guidance in accordance with Service implementing policy that establishes the PSB-CY MDT and identifies core and expanded ad hoc members. To the greatest extent possible, all forms of written guidance will use person-first language when referring to children with PSB to maintain consistency with a developmentally appropriate focus and reflect best practices. This written guidance is reviewed annually, and upon change in policy, practice, or leadership.

### **4.3. CORE PSB-CY MDT.**

The core PSB-CY MDT includes representatives from:

a. FAP, as chair.

b. Military LE (e.g., MCIO) relevant to the case.

c. CDP/YP, when CDP/YP is the referral source or if the child or youth's PSB occurred in a CDP/YP-sponsored setting.

d. DoDEA, when DoDEA is the referral source or if the child or youth's PSB occurred in a DoDEA-sponsored setting.

#### **4.4. EXPANDED PSB-CY MDT.**

a. Depending on the involvement of other DoD and civilian entities, the core PSB-CY MDT may be expanded on a case-by-case basis to include representatives such as:

(1) CDP/YP, when CDP/YP is not the referral source and the PSB did not occur in a CDP/YP-sponsored setting but the children or youth are enrolled in CDP/YP programs.

(2) DoDEA, when DoDEA is not the referral source and the PSB did not occur in a DoDEA-sponsored setting but the children or youth are enrolled in DoDEA schools.

(3) Military and family life counselors, when supporting DoDEA schools or CDP/YP sponsored settings.

(4) Staff judge advocate or another attorney from the servicing legal office.

(5) Civilian CPS.

(6) Children's advocacy center.

(7) MTF, such as HCP, or FHE.

(8) Child-focused advocate for parents.

(9) Public affairs office, when community safety is an issue or media interest is anticipated.

(10) School liaison office, when the exhibiting or impacted child or youth attends public school.

(11) Parents and legal guardians as ad hoc attendees at the discretion of the MDT Chair who will consider personally identifiable information and protected health information disclosures when determining parental or legal guardian attendance.

#### **4.5. PSB-CY MDT ROLES AND RESPONSIBILITIES.**

PSB-CY MDTs will:

a. Develop written protocols and guidelines for PSB-CY MDT case review in accordance with Service implementing guidance. Protocols and guidelines will include:

(1) Frequency of meetings for new and ongoing cases.

(2) Process for adding cases to and deleting cases from the agenda.

(3) Notification procedures for meetings.

(4) PSB-CY MDT information sharing protocols, confidentiality guidelines and documents that are in compliance with all relevant laws, regulations, and statutes, and professional standards of practice.

(5) PSB-CY MDT confidentiality guidelines that are reviewed and acknowledged in writing by each member in attendance at the beginning of each meeting.

b. Confirm a safety and supervision plan is in place for all children and youth exhibiting PSB in all relevant settings such as CDP/YPs and DoDEA schools.

c. Facilitate information gathering including intake, screening, assessments, medical appointments, forensic interviews, and clinical service plans to maximize coordination and avoid duplication.

d. Coordinate:

(1) A trauma-informed, developmentally appropriate, evidence-informed assessment and response plan for the exhibiting child or youth.

(2) Child-focused advocacy for parents as described in Paragraph 5.1. of this issuance for all directly involved children or youth as requested by the parent(s) or legal guardian(s).

(3) Supportive services for the impacted child and family at the request of the parent(s) or legal guardian(s).

(4) Services that are accessible and tailored to meet the individual and unique needs of children and families regarding culture, development, and special needs throughout all aspects of the CCR.

e. Review all open problematic cases in accordance with Volume 1 of DoDM 6400.01, until FAP-related services are completed or discontinued, any juvenile or criminal court involvement has ended, and community risk factors have been addressed.

#### **4.6. PSB-CY MDT CASE REVIEW.**

Case review is an informed decision-making process with input from all PSB-CY MDT organizations actively involved in the case under review.

a. The case review process will:

(1) Discuss:

(a) Plan, and monitor the current status and progress of the PSB-CY MDT response.

(b) Child protection and other safety and supervision needs and develop strategies to address those needs.

(c) Emotional support and FAP clinical intervention needs of all children and families involved as well as strategies for accessing or providing services to meet those needs.

(2) Review:

(a) Parent(s) engagement strategies and adjust any action taken by team member organizations to promote the participation of parents and legal guardians in recommended services.

(b) Medical evaluations and forensic health care examinations with parental consent or minor consent as determined by State law and in accordance with all other relevant laws, regulations, and statutes.

(c) Available forensic interview outcomes when relevant and appropriate.

b. At all times, prevention, outreach, and response will reflect and accommodate diversity in cultural norms, ethnicity, religion, socioeconomic status, disability, gender, gender identity and expression, and sexual orientation.

## **SECTION 5: CHILD-FOCUSED ADVOCACY FOR PARENTS AND LEGAL GUARDIANS**

### **5.1. CHILD-FOCUSED ADVOCACY.**

The primary goal of child-focused advocacy is to empower parents and legal guardians to take an active and informed role in establishing safety and stability for their child(ren) and family and to participate in recommended services. Parents or legal guardians may be unable to process PSB information at certain times, particularly when in crisis. They may be addressing immediate safety concerns, coping with the emotional impact of the initial PSB notification, and understanding how to access support through a complex CCR system.

a. FAP personnel providing child-focused advocacy for parents and legal guardians:

(1) Facilitate access to a range of military and community-based resources.

(2) Explain services available through FAP.

(3) Describe the PSB-CY MDT approach to coordinating a response to referrals of PSB-CY.

b. More than one FAP personnel providing child-focused advocacy can be assigned to complex cases involving siblings, more than one impacted child, or an exhibiting child when requested by the parent(s) or legal guardian(s) with ongoing support from the primary FAP clinical provider and notification of the MDT.

c. Domestic abuse victim advocates (DAVAs), FAP case managers, or FAP clinicians may provide child-focused advocacy for parents and legal guardian(s) of children and youth impacted by or exhibiting PSB, in accordance with Military Department implementing guidance.

(1) Non-clinical case managers and DAVAs in this role support the safety and well-being of children and youth, and the stability of the family through the provision of non-clinical support services to parents or legal guardians.

(2) Providing direct services to children is outside the scope of child-focused advocacy for parents and legal guardians when performed by non-clinical case managers and DAVAs.

### **5.2. ROLES AND RESPONSIBILITIES.**

The child-focused advocate for parents and legal guardians will:

a. Reinforce the central role the parent(s) or legal guardian(s) plays in the ongoing safety and recovery of their child or youth.

b. Represent the unique needs of the parent(s) or legal guardian(s) and create appropriate support strategies to improve parent or legal guardian coping skills, promote seamless

coordination of services, and convey to the PSB-CY MDT parent or legal guardian concerns as requested by the parent(s) or legal guardian(s), when appropriate.

c. Serve as a liaison between the parent(s) or legal guardian(s) and the MDT and provide information to the parent(s) or legal guardian(s) at regular and ongoing intervals.

d. Inform the parent(s) or legal guardian(s) of any changes to the response protocol if, during the course of services, child abuse or neglect on the part of the parent(s) or legal guardian(s) is suspected, or a criminal investigation is initiated.

e. Communicate regularly with FAP clinical providers who are providing services to parents, guardians, or children involved in PSB-CY incidents on any obstacles or challenges to accessing or participating in recommended services.

f. Inform parents or legal guardians of relevant crime victim support when the civilian justice system is involved.

## **SECTION 6: PSB-CY MDT ORGANIZATIONAL RESPONSIBILITIES AND PROCEDURES FOR RESPONDING TO PSB-CY**

### **6.1. FAP.**

Pursuant to DoDI 6400.01, and Volume 1 of DoDM 6400.01, the FAP will:

a. Review all initial referrals to FAP of child and youth sexual behavior with the referral source, when appropriate, to determine if the incident involves PSB based on established standardized tools.

b. Activate the core and expanded, when appropriate, PSB-CY MDT on all referrals involving PSB-CY.

c. Facilitate:

(1) The MDT and document the actions of the MDT.

(2) Requests for Family Advocacy Command Assistance Team support for incidents of PSB-CY involving multiple children when warranted in accordance with DoDI 6400.03.

d. Train all PSB-CY MDT members in PSB-CY at appointment and annually on the operation of the PSB-CY MDT, and the roles and responsibilities of each member organization on the PSB-CY MDT in accordance with DoD policy and Service implementing policy and guidance.

e. Coordinate child-focused advocacy for parents, clinical screening and assessment, and clinical services for all children and youth involved in a case as requested or required.

f. Establish a MDT review of all open PSB-CY cases until case closure in accordance with Volume 1 of DoDM 6400.01, and Service implementing policy and guidance.

g. Notify the PSB-CY MDT:

(1) If a parent(s) or legal guardian declines services.

(2) Upon case termination and closure and provide a reason for the closure.

### **6.2. FAP CLINICAL PROVIDER.**

The FAP clinical provider will:

a. Provide or coordinate:

(1) Access to clinical services to include psychoeducational support, assessment, and clinical intervention for directly impacted and exhibiting children, youth, and their families.

(2) Specialized medical assessments and evaluations when recommended and beyond the scope of FAP clinical intervention.

b. Provide updates to the PSB-CY MDT on the status of supportive and clinical intervention in a manner consistent with ethical and professional standards of practice, and in accordance with relevant laws, regulations, and statutes.

c. Create or coordinate:

(1) Safety plans for all directly impacted children and youth and families at the request of parents or legal guardians when not created or coordinated by other FAP personnel such as those serving as child-focused advocates for parents.

(2) Supervision plans for children and youth exhibiting PSB and their families.

### **6.3. CDP/YP.**

The CDP/YP will:

a. Respond to all initial referrals of sexual behavior involving child(ren) and youth in accordance with DoDI 6060.04.

b. Review all initial referrals of sexual behavior involving child(ren) or youth to determine if the incident involves non-normative sexual behavior based on established standardized tools.

c. Refer all non-normative sexual behavior involving child(ren) or youth to FAP for review, assessment, and potential activation of the PSB-CY MDT response.

d. Consult with FAP, as needed, on non-normative sexual behavior that is concerning but not problematic based on established standardized tools to determine if additional services or referrals are warranted.

e. Appoint a PSB-CY trained CDP/YP member, as indicated in DoDI 6060.04, to represent the CDP/YP on the PSB-CY MDT. As a member of the PSB-CY MDT, the CDP/YP member will provide input on:

(1) CDP/YP-based support needs of all children, youth, and families involved in CDP/YP and recommend strategies for meeting those needs within the CDP/YP setting.

(2) The responses of the children, youth, parents, and legal guardians to the notification of PSB and identify the engagement needs for parent(s) and legal guardian(s).

(3) Any immediate or subsequent action taken by CDP/YP to address the behavior.

(4) Ongoing cultural factors and special needs relevant to the case.

(5) Current CDP/YP-based safety and supervision plans.

f. Coordinate and implement CDP/YP:

- (1) Safety and supervision plans.
- (2) Behavior intervention plans.

#### **6.4. DODEA.**

The DoDEA will:

- a. Respond to all initial referrals of sexual behavior involving child(ren) and youth in accordance with DoDEA Administrative Instructions 1443.02 and 2051.02.
- b. Review all initial referrals of sexual behavior involving child(ren) or youth to determine if the incident involves non-normative sexual behavior based on established standardized tools.
- c. Consult with FAP, as needed, on non-normative sexual behavior that is concerning but not problematic based on established standardized tools to determine if additional services or referrals are warranted.
- d. Refer all non-normative sexual behavior involving child(ren) or youth to FAP for review, assessment, and potential activation of the PSB-CY MDT response.
- e. Appoint a PSB-CY trained DoDEA staff member to represent DoDEA on the PSB-CY MDT. As a member of the PSB-CY MDT, the DoDEA member will provide input on:
  - (1) Social-emotional support needs of all children and families involved and recommend strategies for meeting those needs.
  - (2) Parent engagement strategies and any barriers to engagement.
  - (3) Any immediate or subsequent action taken by DoDEA to address the behavior.
  - (4) Ongoing cultural factors or special needs relevant to the case.
  - (5) Current DoDEA based safety and supervision plans.
- f. Provide or coordinate specialized school-based assessments and evaluations in accordance with Section 1232 of Title 20, United States Code.
- g. Coordinate and implement school-based:
  - (1) Safety and supervision plans.
  - (2) Behavior intervention plans.

## **6.5. MILITARY LEAS.**

Military LEAs will:

- a. Provide initial response to incidents involving sexual behavior that deviates from normative or typical behavior between children and youth that occur on military installations and notify the applicable MCIO.
- b. Ensure immediate safety for all children and youth involved.
- c. Gather initial information and make required notifications in accordance with military LE response procedures and applicable Service policies.
- d. Notify FAP of all reports involving sexual behavior between children and youth.

## **6.6. MCIOS.**

MCIOs will:

- a. Notify:
  - (1) FAP of all reports involving sexual behavior between children and youth within 24 hours.
  - (2) Command in accordance with MCIO procedures and Service policies.
- b. Determine:
  - (1) If the report warrants a criminal investigation.
  - (2) The jurisdiction and investigative lead agency. Coordinate with Federal, State, or local LEAs as needed.
- c. Ensure parents and legal guardians are informed on the investigative process, status of the investigation, and support services offered through FAP.
- d. When warranted, conduct an investigation, or collateral or joint investigation, with other LEAs and investigative agencies.
- e. Provide updates to the PSB-CY MDT on the investigative status of case(s) in a manner consistent with legal, ethical, and professional standards of practice.
- f. When the civilian justice system is involved, work with local prosecutors to the greatest extent possible until case closure or adjudication.

## **6.7. HCPS.**

HCPs will:

- a. Notify FAP of all referrals involving PSB between children and youth.
- b. Provide:
  - (1) Specialized medical evaluations and refer to FHE when indicated, in accordance with DoDI 6310.09.
  - (2) Updates on medical findings and recommendations to the PSB-CY MDT in a manner consistent with relevant laws, regulations, and statutes, and ethical and professional standards of practice.
- c. Evaluate, document, diagnose, and address medical conditions resulting from PSB.
- d. Screen the child or youth for any developmental, emotional, or behavioral problems needing further evaluation and treatment and make referrals as necessary.
- e. Refer the child or youth for clinical services to address trauma-related issues, if not provided by another member or expanded member of the PSB-CY MDT.

## **SECTION 7: PSB-CY PARENT(S) AND LEGAL GUARDIAN(S) ENGAGEMENT AND CASE MANAGEMENT**

### **7.1. ACTIVE PARENT(S) AND LEGAL GUARDIAN(S) INVOLVEMENT.**

Helping children and youth with PSB requires active engagement of the family to:

- a. Improve and strengthen the parent(s) or legal guardian(s) and child relationship.
- b. Inform parents and legal guardians on what to expect at each step in the CCR.
- c. Empower parents and legal guardians with the skills and resources needed to successfully navigate through recommended or required CCR processes.
- d. Update parents and legal guardians regularly on the PSB-CY MDT recommendations and when any changes or modifications are made to the intervention plan.
- e. Implement parenting strategies that prevent and reduce behavior problems in general.
- f. Address sexual education topics with their children and youth that support normative sexual development, healthy interpersonal boundaries, and a developmentally appropriate understanding of consent.
- g. Develop and use community- and home-based prevention strategies and skills.
- h. Apply safety, monitoring, and supervision rules about sexual behavior in the home and in the children and youth's social or school environment.

### **7.2. INTAKE AND ASSESSMENTS.**

Assessments of children and youth who engage in PSB will be multidimensional, combining multiple sources of information to the greatest extent possible such as through record reviews, self-referrals, and parent and legal guardian referrals using available evidence-informed strategies, evaluation tools, and risk assessment instruments.

### **7.3. FAP CLINICAL PROVIDERS AND CASE MANAGERS.**

FAP clinical providers and case managers will:

- a. Consider:
  - (1) Community safety and the prevention of additional PSB as core principles of the assessment process.

(2) The State’s juvenile age of jurisdiction and how that status may influence the nature, scope, or validity of the child or youth’s assessment.

b. Take reasonable steps to afford the child or youth and their parent(s) or legal guardian(s) the opportunity to give informed consent about participating in the assessment process and to decline participation, if they so choose. These steps include, but are not limited to:

(1) Explaining the nature and purpose of the assessment.

(2) Outlining potential benefits, risks, and limitations of the assessment procedures.

(3) Explaining the potential implications of participating or declining to participate in the assessment.

(4) Explaining the limits of confidentiality, such as persons or entities to whom the findings will be provided, and under what circumstances information will be released to the PSB-CY MDT, LE, command, or other individuals or entities.

#### **7.4. FAP CLINICAL INTERVENTION PLANS.**

Clinical intervention plans inform intervention targets and strategies, duration, and placement decisions.

a. FAP clinical providers:

(1) Who are providing direct clinical intervention to children or youth involved in PSB-CY will develop and implement individualized, written clinical intervention plans for each child or youth outlining clear and specific intervention goals and objectives consistent with the results of a current or recent assessment and other relevant information.

(2) Will identify and document factors that may potentially impact engagement and responsiveness to interventions. These may include, but are not limited to, previous trauma exposure, co-occurring diagnosis, cultural considerations, developmental delays, language barriers, and strategies to overcome barriers to positive parenting and effective child and youth supervision.

b. Clinical intervention plans will be reviewed with the FAP clinical supervisor and updated routinely, but at least quarterly.

#### **7.5. FAP CLINICAL SAFETY AND SUPERVISION PLANS.**

Clinical providers will develop clinical safety and supervision plans that support any existing CDP/YP, DoDEA, and Child Focused Advocacy for Parents safety and supervision plans to the greatest extent possible to enhance the capacity of parents and/or legal guardians to effectively supervise and monitor their child or youth’s behavior, and intervene as appropriate.

## **7.6. FAP CLINICAL INTERVENTIONS.**

### **a. Clinical interventions will:**

- (1) Focus on risk and protective factors supported by current research.
- (2) Promote safety while facilitating prosocial and developmentally appropriate skill development.
- (3) Use evidence-informed interventions that match the presenting risk factors.
- (4) Include the child or youth and their parent(s) or legal guardian(s) in the development of intervention goals and objectives to the greatest extent possible.
- (5) Address risk and protective factors across the child or youth's social environment (e.g., family, peers, school).
- (6) Allow the child or youth to practice skills and use social supports in their social environment outside of the clinical setting to the greatest extent possible.
- (7) Tailor approaches to match individual characteristics and circumstances of the child or youth (e.g., developmental status, learning style, gender, culture).
- (8) Address sexually non-normative behavior as well as other challenging behaviors.

### **b. FAP clinical providers:**

- (1) Who are providing direct clinical services to child(ren) or youth will use empirically supported clinical interventions. Current recommended clinical intervention models include trauma-informed and developmentally appropriate cognitive-behavioral, skills-oriented, multisystemic, socioecological interventions that are family-focused and target dynamic risk factors, mitigate risk, and enhance protective factors in the child or youth's family and social environment.
- (2) Will familiarize themselves with the research available in relation to specific subpopulations (e.g., adolescent females, developmentally delayed children or youth, children or youth with co-occurring mental health issues) and consult with specialists in these areas when conducting assessments and developing clinical service plans.

## **7.7. MEDICAL EVALUATIONS AND ACUTE EXAMINATIONS.**

a. Medical evaluations are conducted by HCPs with specific training in child sexual abuse that meets at least one of the following training standards:

- (1) Child abuse pediatrics subspecialty eligibility or certification.

(2) Physicians without child abuse pediatrics subspecialty eligibility or certification, advanced practice nurses, or physician assistants with a minimum of 16 hours of formal training in the medical evaluation of child sexual abuse.

(3) FHE in accordance with DoDI 6310.09, to support pediatric forensic health examinations when appropriate.

b. All providers must be licensed to practice and in current good standing by their corresponding State board of practice regulations.

c. Civilian pediatric sexual abuse centers that have a memorandum of agreement or memorandum of understanding with a local MTF in accordance with DoDI 6310.09 may be used for care.

## **7.8. DISCLOSURE.**

When developing recommendations regarding disclosure of information, FAP clinical providers will consider:

a. Laws, regulations, and statutes guiding release of personally identifiable information and protected health information as referenced in Paragraph 2.3.h. of this issuance.

b. Reason disclosure is being considered.

c. Person to whom disclosure is being considered.

d. Harm that disclosure is thought to avert.

e. Harm that disclosure may cause.

f. Additional information to increase the usefulness and decrease the potential harm when disclosure occurs.

## **7.9. FORENSIC INTERVIEWS.**

Forensic interviews may be recommended by the MCIO and will be conducted in a manner that is developmentally and culturally sensitive, unbiased, fact-finding and in accordance with relevant laws, regulations, and statutes.

a. Forensic interviews will adhere to research-based forensic interview guidelines for children and youth and are conducted by selected, supervised, and appropriately trained professionals. At a minimum, any professional conducting forensic interviews must have initial and ongoing formal forensic interview training by an approved source. State laws may dictate who can conduct forensic interviews.

b. FAP clinicians who are trained in forensic interviewing and requested by the MCIO to forensically interview any child or youth in a given case cannot be assigned as the clinical

service provider or case manager for that same child or youth or family given the focus of the forensic interview is on the investigative process and not on the clinical needs of the child or youth.

c. Forensic interviewers must complete training that includes these elements:

(1) Minimum of 32 hours of instruction and practice.

(2) Evidence-informed interview protocol.

(3) Pre- and post-testing that reflects understanding of the principles of interviewing in a manner that is developmentally and culturally sensitive, unbiased, fact-finding, and in accordance with relevant laws, regulations, and statutes.

(4) Content that includes:

(a) Child development.

(b) Question design.

(c) Implementation of protocol.

(d) Dynamics of abuse.

(e) Disclosure process.

(f) Cultural competency.

(g) Suggestibility.

(5) Practice component with a standardized review process.

## SECTION 8: PSB-CY PREVENTION STANDARDS

### 8.1. GENERAL.

PSB-CY can be prevented through evidence- and trauma-informed parent(s), or legal guardian(s) and child engagement that considers the child(ren)'s varying social and emotional development. PSB-CY prevention includes:

- a. Establishing Service implementing policy for the primary, secondary, and tertiary prevention of PSB-CY that are based on current evidence and best practices.
- b. Ensuring PSB-CY prevention activities are coordinated with stakeholders across the military family readiness system, DoDEA, and community-based partners.
- c. Encouraging a multisectoral approach to family engagement to address risk and protective factors for PSB-CY in the home environment, school, and community.

### 8.2. STANDARD ELEMENTS FOR PSB-CY PREVENTION.

#### a. Primary Prevention.

Primary prevention for PSB-CY will reflect the DoD policy on integrated primary prevention in accordance with DoDI 6400.09 and will address the community, family, and individual risk and protective factors associated with children and youth exhibiting or impacted by PSB through:

(1) New Parent Support Program education and home visitation for expecting or new parents, and parents of children ages 0 to 3 years, about healthy child sexual development across their ages and stages, so parents can understand what behaviors are normative.

(2) Additional learning opportunities for military parents and legal guardians that are provided by FAP, New Parent Support Program, DoDEA, and CDP/YP to gain confidence and build skills in initiating developmentally appropriate conversations with their children, from an early age, about:

- (a) Respect for personal physical boundaries.
- (b) Healthy peer relationships.
- (c) Social-emotional competence.
- (d) Understanding consent.

(3) Parent(s) and legal guardian(s) engagement to build literacy on the safe consumption of media with their children, raising awareness of the psychosocial impact of children and

adolescents' exposure to developmentally inappropriate, sexually explicit, or violent content through digital media and technology.

#### **b. Secondary Prevention.**

Secondary prevention for PSB-CY will mitigate risk for children or youth who have exhibited non-normative sexual behaviors from engaging in PSBs, and promote protective factors against children or youth being impacted by PSB-CY, by:

(1) Requiring training and continuing education for FAP clinical and non-clinical staff, DoDEA personnel, CDP/YP personnel, and military pediatric and behavioral HCPs to recognize and differentiate sexual behaviors that are normative, non-normative, and problematic, in consideration with children's and adolescents' age and developmental stage.

(2) Screening children seen by FAP clinical providers or military HCPs for abuse, neglect, or exposure to trauma (e.g., witnessing domestic abuse) for related traumatic stress, and providing clinical interventions, with the consent of their parent(s) or legal guardian(s)

(3) Setting norms among frontline military professionals governing the identification and referral of suspected PSBs, so as to do no harm, by:

(a) Establishing a trauma-informed response to suspected behaviors, recognizing that PSB-CY exhibited by children and youth may be a symptom of post-traumatic stress associated with exposure to violence, abuse, or neglect, including child sexual abuse.

(b) Using person first language such as child impacted instead of "victim" or exhibiting or engaging child instead of "offender" or "perpetrator" to underscore the following principles:

1. Referral or identification of non-normative sexual behavior to FAP or DoDEA is not a "report" and does not constitute in itself the determination that such a behavior is indicative of PSB-CY.

2. Children and youth who are suspected to have engaged in PSB-CY are not adults and are to be afforded the same intervention and care as all other children.

#### **c. Tertiary Prevention.**

Tertiary prevention for PSB-CY will reduce the risk of continuation of current or future problematic behaviors in children and youth who have exhibited PSB; mitigate potential harm among children and youth impacted by PSB; and ensure parents and families of children or youth who have exhibited or been impacted by PSB are provided appropriate support by:

(1) Ensuring children or youth who have:

(a) Exhibited PSB are offered appropriate clinical services by informing their parent(s) or legal guardian(s) of all available military and community-based providers.

(b) Been impacted by PSB are offered supportive services and clinical intervention by:

1. Informing their parent(s) or legal guardian(s) of all available military and community-based support options.

2. Helping create a safety plan for the impacted child, to include consideration for the safety of children who have been impacted by a sibling's behavior.

(2) Facilitating access to behavioral health and emotional support for the parents of children and youth who have been impacted by or who have exhibited PSB, including through child-focused advocacy for parents, military and family life counselors, and military and community-based behavioral health providers.

## GLOSSARY

### G.1. ACRONYMS.

ACRONYM	MEANING
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
CCR	coordinated community response
CDP/YP	Child Development Program/Youth Program
CPS	Child Protective Services
DASD(MC&FP)	Deputy Assistant Secretary of Defense for Military Community and Family Policy
DAVA	domestic abuse victim advocate
DoDEA	DoD Education Activity
DoDI	DoD instruction
DoDM	DoD manual
FAP	Family Advocacy Program
FHE	forensic health care examiner
HCP	health care provider
LE	law enforcement
LEA	law enforcement agency
MCIO	military criminal investigative organization
MDT	multidisciplinary team
MTF	military medical treatment facility
PSB	problematic sexual behavior
PSB-CY	problematic sexual behavior in children and youth
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

**G.2. DEFINITIONS.**

Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

<b>TERM</b>	<b>DEFINITION</b>
<b>case management</b>	Process of providing or coordinating the provision of clinical and supportive services for all functions related to a PSB-CY referral.
<b>case manager</b>	Personnel as described in DoDM 6400.01, Volume 1 who provide or coordinate the provision of comprehensive services for children, youth, and families involved in PSB-CY cases from referral to case closure.
<b>CCR</b>	Defined in DoDI 6400.01.
<b>CDP</b>	Defined in DoDI 6060.02.
<b>child</b>	Defined in DoDI 6400.01.
<b>child-focused advocacy</b>	Assisting parents and legal guardians to engage in and provide support and advocacy on behalf of their child(ren) involved in an PSB-CY incident.
<b>clinical intervention</b>	Defined in DoDM 6400.01, Volume 1.
<b>clinical safety plan</b>	A plan created by FAP clinical providers, as part of the multidisciplinary response, with input from family and children or youth who have engaged in PSB that outlines the safety and supervision guidelines for the home and other settings in which the child or youth may interact with other children or youth. Each plan is customized to fit the individual, family, and community needs and is modified over time to reflect youth and family demonstrated progress in recommended clinical service plans. Clinical safety plans should support other co-existing safety plans developed by other members of the MDT such as DoDEA, CDP/YP, and can include New Parent Support Program and Child Focused Advocacy for Parents involvement in development and execution.
<b>CPS</b>	A branch of a State’s social services department that is responsible for the assessment, investigation, and intervention regarding cases of child abuse and neglect, including sexual abuse. In all of its procedures, CPS must follow State and Federal laws.
<b>cultural competency</b>	The capacity to appreciate, understand, and effectively intervene with members of diverse populations within a community.

<b>TERM</b>	<b>DEFINITION</b>
<b>developmentally appropriate</b>	Grounded in theory and research on typical child and adolescent development. Three core considerations for implementing developmentally appropriate approaches and practices are knowledge of typical child development and learning, knowledge of what is individually appropriate for a child based on their development, and knowledge of cultural appropriateness.
<b>domestic abuse</b>	Defined in DoDI 6400.06.
<b>evidence-informed services</b>	Objective, balanced, and responsible use of current research and the best available data to guide policy and practice decisions, such that outcomes for children and families are improved. Evidence-informed services can include assessments, strategies, or interventions demonstrated to be effective through empirical research rather than through anecdote or professional experience alone.
<b>exhibiting child or youth</b>	A child or youth engaging in problematic sexual behavior. Replaces the term “perpetrator or offender” to reinforce person first language when referring to the behavior of children and youth.
<b>FAP</b>	Defined in DoDI 6400.01.
<b>FAP clinical provider</b>	FAP personnel who conduct clinical assessments, coordinates clinical case management and provide counseling as part of the FAP. Requirements include graduation from an accredited college or university with a masters or doctoral degree in social work or other behavioral health field, a current, valid, and unrestricted license, certification, or registration authorizing independent clinical practice. and credentialing in accordance with Service implementing policies and guidance.
<b>HCP</b>	Defined in DoDI 6000.19.
<b>impacted child or youth</b>	A child or youth directly impacted by the problematic sexual behavior of another child or youth. Replaces the term “victim” to reinforce person first language when referring to the behavior and reaction of children and youth.
<b>installation family advocacy committee</b>	Defined in DoDI 6400.01 as “family advocacy committee.”

<b>TERM</b>	<b>DEFINITION</b>
<b>MDT</b>	A team composed of designated members with varied but complementary experience, qualifications, and skills that contribute to the achievement of the team’s specific objectives, which include, but are not limited to, cooperative information sharing, collaborative and coordinated response, restorative resolution, effective investigations and assessments, evidence-based clinical interventions and rehabilitation, and prevention of PSBs.
<b>non-normative</b>	Behaviors that do not conform to, or reflect an established norm for a child or youth’s chronological age or developmental functioning.
<b>person-first language</b>	A type of linguistic prescription that puts a person before a diagnosis, describing what a person “has” rather than asserting what a person “is.” Examples include child exhibiting PSB, child engaging in PSB, or child with PSB as opposed to “offender” or “perpetrator”; or, child impacted by PSB as opposed to “victim.”
<b>personally identifiable information</b>	Information that can be used to distinguish or trace an individual’s identity, either alone or when combined with other information that is linked or linkable to a specific individual.
<b>protected health information</b>	Defined in DoDM 6025.18.
<b>PSB-CY</b>	Defined in DoDI 6400.01.
<b>psychoeducational support</b>	Provides people with mental health conditions information about the causes, symptoms, prognosis, and interventions for their diagnosed condition.
<b>supervision plan</b>	Approaches and strategies for maintaining close and continuous visual supervision of a child or youth while in contact with other child(ren) or youth that increase the safety and success of intervention recommendations. For example, the plan may consider the use of technology, intentional placement of furniture, and changes in daily routines. Supervision plans are often part of clinical safety plans and safety plans created by other members of the MDT such as DoDEA and CDP/YP.

<b>TERM</b>	<b>DEFINITION</b>
<b>trauma-informed</b>	A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.
<b>youth</b>	Defined in DoDI 6060.04.

## REFERENCES

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- DoD Directive 5124.02, “Under Secretary of Defense for Personnel and Readiness (USD(P&R)),” June 23, 2008
- DoD Instruction 5400.11, “DoD Privacy and Civil Liberties Programs,” January 29, 2019, as amended
- DoD Instruction 5525.15, “Law Enforcement (LE) Standards and Training in the DoD,” December 22, 2016, as amended
- DoD Instruction 6000.19, “Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers,” February 7, 2020
- DoD Instruction 6025.18, “Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs,” March 13, 2019
- DoD Instruction 6060.02, “Child Development Programs (CDPs),” August 5, 2014, as amended
- DoD Instruction 6060.04, “Youth Services (YS) Policy,” December 4, 2019
- DoD Instruction 6310.09, “Health Care Management for Patients Associated with a Sexual Assault,” May 7, 2019
- DoD Instruction 6400.01, “Family Advocacy Program (FAP),” May 1, 2019
- DoD Instruction 6400.03, “Family Advocacy Command Assistance Team (FACAT),” April 25, 2014, as amended
- DoD Instruction 6400.06, “DoD Coordinated Community Response to Domestic Abuse Involving DoD Military and Certain Affiliated Personnel,” December 15, 2021
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- Public Law 114-328, Section 575, “National Defense Authorization Act for Fiscal Year 2017,” December 23, 2016

Public Law 115-232, Section 1089, “John S. McCain National Defense Authorization Act for Fiscal Year 2019,” August 13, 2018

United States Code, Title 5, Appendix, Inspector General Act of 1978

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