Standards for Sexual Abuse Intervention Programs funded by the Ministry of Children & Family Development

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PART ONE: INTRODUCTION

1. Background

1.1 The SAIP Program in BC

The Sexual Abuse Intervention Program (SAIP) was formally introduced in 1990 through an inter-ministry initiative to enhance services for child victims of sexual abuse, their families, and for youth under the age of 12 with sexual behaviour problems. The Ministries of Health, Social Services, Education and Attorney General agreed that Child and Youth Mental Health (CYMH), at that time part of the Ministry of Health (MoH), would be given the lead responsibility to develop and implement the program.

In 1996, CYMH was transferred to the Ministry of Children and Family Development (MCFD) and oversight of the SAIP contracts became the responsibility of the MCFD regions. Subsequent to implementation of the Child and Youth Mental Health Plan for BC, it was recognized that SAIP services warranted increased focus and support as an important element of the service spectrum. Hence in 2005, a provincial review of the SAIP program was undertaken and a report and recommendations released in 2006. The review concluded the SAIP program would benefit from greater collaboration and direction from the ministry and there was a need for clarification of program mandate and clear program standards.

http://www.mcf.gov.bc.ca/mental_health/pdf/SAIP%20Report%20Final%20_July06.pdf

1.2 Purpose of the Standards

The purpose of this document is to provide contract managers, contracted agencies and treatment providers with provincial standards to support the delivery of services provided by Sexual Abuse Intervention Programs, funded by MCFD. These standards replace the Guidelines for Sexual Abuse Intervention Program issued by the Ministry of Health in 1990. The standards are intended to ensure a consistent level of access to, and quality of, SAIP services across the province and to facilitate accountability. It is recognized that some SAIP provider agencies have been accredited through the Council on Accreditation for Children and Family Services (COA) or the Commission on Accreditation of Rehabilitation Facilities (CARF). These standards are consistent with those set by these accrediting bodies as well as with standards issued by MCFD for the provision of Child and Youth Mental Health Services.

1.3 Content of this Document

This document provides provincial direction with respect to the goals and objectives of community-based sexual abuse intervention services for children and youth, provides standards for the delivery of services and coordination with other community agencies, and addresses legal issues related to the provision of treatment of child sexual abuse.

The information presented here has been examined for consistency with *The BC Handbook for Action on Child Abuse and Neglect* (2007 edition) which outlines policies for all service providers to follow. All SAIP providers should consult this handbook regularly and be well versed in its content.

2. Program Goals and Objectives

2.1 Goals

The overall goal of community-based SAIP is to provide a range of appropriate, timely and accessible assessment, treatment and/or support services to children and youth who have been sexually abused, and to children under the age of 12 with sexual behaviour problems.

2.2 Objectives

The specific objectives of sexual abuse intervention services are to:

- alleviate psycho-social impairment and/or trauma-related symptoms in children and youth who have experienced sexual abuse,
- reduce the likelihood of adverse long-term consequences of child sexual abuse trauma (e.g., depression, substance misuse, etc),
- manage or reduce problematic behaviours including inappropriate sexual behaviours
- provide specialized treatment services to children with special needs (e.g., children with disabilities) who have been sexually abused.
- assist non-offending family members and significant others in supporting children/youth who have experienced sexual abuse,
- instil knowledge and skills that reduce the likelihood of future incidents of sexual abuse,
- assist the child and/or caregivers to develop an understanding of healthy sexuality, and
- as resources permit, build capacity to educate the public and the community on the prevention and early detection of child sexual abuse.

2.3 Special Considerations

SAIP agencies must strive to work with Aboriginal and other cultural and diverse populations in a respectful and sensitive manner.

3. Principles

The following principles, adopted from the publication *A Transformation Lens for Policy Analysis*, establish the fundamentals upon which MCFD funded services are designed and delivered. The principles are designed to promote a strengths-based developmental approach to service delivery, thereby improving outcomes for children, youth and families in British Columbia.

- ***STRENGTH-BASED***

The intrinsic strengths, resilience and abilities of children, youth, families and communities are recognized and supported by promoting self-determination in service development, decision-making and utilizing existing networks.

- ***CHILD RIGHTS***

The rights of children set out in the United Nations Convention on the Rights of the Child, and ratified by Canada and the Province of British Columbia, must be protected.

- ***CULTURALLY RELEVANT***

The traditions, cultures, values and beliefs of Aboriginal peoples and other ethnic groups are respected and integrated into child, youth and family services. Traditional cultural practices that support child protection and healthy child, youth, family and community development and healing are recognized as being of equal value to evidence-based practice and mainstream programs.

- ***RESPECTFUL***

The intrinsic worth and dignity of each individual is valued and respected. Any form of discrimination against children, youth, families and communities is unacceptable.

- ***COLLABORATIVE***

The care for children and youth is a shared societal responsibility, involving engagement and collaboration with clients and service providers. The voices of children, youth and families are heard.

- ***RESPONSIVE***

The service system is driven by the needs which are identified at the child, family and community level, with regional and provincial governance responding with appropriate resources and services.

- ***PERMANENCY***

Children and youth should be provided with the opportunity to grow up in their family. When this is neither possible nor in their best interests, an alternative, timely plan of care should be established to provide for enduring and nurturing relationships.

- ***HOLISTIC***

A continuum of integrated services from least intrusive to more intrusive is available and accessible to vulnerable children, youth and families. These services embrace the social, emotional, physical, spiritual, cognitive, and cultural needs of children, youth and families.

- ***FAIRNESS***

All children, youth and families in British Columbia receive fair and equitable resources and services from the Ministry of Children and Family Development.

- ***ACCOUNTABLE***

In providing high quality, evidence-based services to British Columbians, the Ministry of Children and Family Development operates with transparency and openness.

PART TWO: STANDARDS

Standard 1: Eligibility

1.1 Determining Eligibility

Service eligibility is determined on the following basis:

1.1.1 Children and youth may self-refer for sexual abuse intervention services or be referred by a third party or agency.

1.1.2 Children and youth are eligible for sexual abuse intervention services if they are under the age of 19, and

- Have experienced sexual abuse or sexual exploitation and/or are
- Under the age of 12 and have sexual behaviour problems believed related to sexual abuse or sexual exploitation experiences.

1.1.3 Children and youth with disabilities are eligible for sexual abuse intervention services.

1.1.4 Contact with the alleged offender does not preclude eligibility for service if the child's safety is assured.

1.1.5 Children and youth who are involved in a case before the courts are eligible for sexual abuse intervention services.

1.1.6 Children and youth may be eligible for sexual abuse intervention services without parental consent under provisions of section 17 of the Infants Act.

1.2 Guidelines for Meeting Standards

1.2.1 *Open Referral*
Children/youth and/or their families/guardians may request services on their own initiative or be referred by other community programs, health care providers, MCFD, or the police.

1.2.2 *Sexual Abuse and/or Sexual Behaviour Problems*
Disclosure, or other signs or indicators of sexual abuse or exploitation must be present for a SAIP therapist to proceed with treatment. Definitions of sexual abuse and sexual exploitation adhere to those developed by MCFD and documented in *The BC Handbook for Action on Child Abuse and Neglect* (2007 Edition). See The Handbook for possible warning signs and/or indicators of child sexual abuse.

Children with sexual behaviour problems are eligible for treatment if they are under 12 years of age and have experienced sexual abuse or sexual exploitation. Sexual behaviour problems do not necessarily constitute evidence of child sexual abuse. In the majority of cases, inappropriate sexual behaviour is a manifestation of a larger cluster of behaviour problems characteristic of children/youth with externalizing disorders. Evidence-based treatment of externalizing disorders involves an intervention protocol that is very different from the treatment of sexual abuse. If the expertise to treat externalizing disorders does not exist within the SAIP agency, then the child should be referred to local CYMH services. At a minimum, expert advice and consultation on the management of the case should be sought.

Children aged 12 or over charged with sexual offences under the Youth Criminal Justice Act (2002) fall within the mandate of the Youth Sexual Offence Program within Youth Forensic Psychiatric Services (YFPS). YFPS can only accept referrals from Youth Justice Courts, Youth Probation Officers and Youth Custody Centres.

1.2.3 *Children with Disabilities*

There is a higher incidence of sexual abuse among children with disabilities. Children who are physically or mentally challenged should have full access to SAIP services. However, as the therapeutic approach with such children can be different from those without disabilities, serving these children requires special skills.

1.2.4 *Continued Contact with the Offender or Alleged Offender*

Services should not be denied in situations where the courts have allowed access by an offending or (alleged offending) parent or sibling. The SAIP therapist must be satisfied that the child's safety is assured by a Child Welfare Worker , the legal system, or other safety mechanisms and that counselling is in the child's best interest. Such cases should be closely monitored by the appropriate authority.

A collaborative assessment of the child and family's needs is critical for children in contact with an offender, or alleged offender, and integrated service planning, integrated case management, and/or wraparound services may be required to ensure appropriate support. If treatment is not the most appropriate intervention then other services and supports are considered.

1.2.5 *Legal Proceedings*

Legally, there are no grounds for precluding children from receiving services when their cases are being adjudicated. The provisions of the Criminal Code Amendment (Bill C46) are designed to ensure victims are not deterred from seeking counselling because of legal proceedings. Valuable resource information on working with victims of crime has been developed by Victim Services, Ministry of Public Safety and Solicitor General and is available through their Help Starts Here webpage:

http://www.pssg.gov.bc.ca/victim_services/publications/index.htm#help

1.2.6 *Parental Consent to Treatment of a Child/Youth*
Under the provisions of Section 17 the Infant's Act, if a child or youth is capable of consenting to treatment on their own then the parent's consent is not necessary. In this circumstance, the practitioner must be convinced that treatment is in the child/youth's best interests and must be satisfied that he/she understands the nature and consequences (foreseeable risks and benefits) of treatment. Where possible, however, the involvement of parents or caregivers in treatment should be strongly encouraged.

Standard 2: Reporting Requirements

2.1 Reporting Sexual Abuse

2.1.1 A SAIP therapist who has reason to believe a child has been, or is likely to be, sexually abused/exploited, or is at risk for sexual abuse/exploitation[1] or any other form of abuse or neglect, where the parent(s) is unable or unwilling to protect the child, has a legal duty under the Child, Family and Community Services Act (CFCSA) to promptly report concerns to a Child Welfare Worker in the local MCFD office or delegated Aboriginal agency.

2.1.2 SAIP agency personnel are familiar with the contents of relevant provincial government publications on reporting sexual abuse, specifically: *The BC Handbook for Action Child Abuse and Neglect for Service Providers*.

2.1.3 When children are in imminent danger, SAIP therapists will call 911 or the local police immediately.

2.2 Guidelines for Meeting Standards

2.2.1 *Reporting to Authorities*
Proof of abuse and/or neglect is not necessary to warrant reporting. "Reason to believe" means that on the basis of information received or observed, including disclosure or other indicators, you have knowledge or suspect a child has been sexually abused or exploited, has suffered any other form of abuse or neglect, or is likely to be at risk for abuse or neglect. Failure to report in these circumstances is an offence under the *Child, Family and Community Service Act* and may result in prosecution. It is important to note that the duty to report remains even when the therapist believes that someone is reporting the situation or when a Child Welfare Worker is already involved.
Information on how to contact a Child Welfare Worker during, and after, office hours can be found on page 57 of the *BC Handbook for Action Child Abuse and Neglect for Service*

[1] The *BC Handbook on Action of Child Abuse and Neglect* provides the following definitions of sexual abuse and sexual exploitation.
Sexual abuse is when a child is used (or likely to be used) for the sexual gratification of another person. It includes touching or invitation to touch for sexual purposes, intercourse (vaginal, oral or anal), menacing or threatening sexual acts, obscene gestures, obscene communications or stalking, sexual references to the child's body/behaviour by words/gestures, requests that the child expose their body for sexual purposes, deliberate exposure of the child to sexual activity or material, and sexual aspects of organized or ritual abuse.
Sexual exploitation is a form of sexual abuse that occurs when a child engages in a sexual activity, usually through manipulation or coercion, in exchange for money, drugs, food, shelter or other considerations. Sexual activity includes: performing sexual acts, sexually explicit activity for entertainment, involvement with escort or massage parlour services, and appearing in pornographic images.

Providers. If you are unsure who to call in your community, phone the Helpline for Children at 310-1234.

A Child Welfare Worker will notify police if the information they have received indicates that a child has been physically harmed, a child has been sexually abused or sexually exploited, or a criminal act may have occurred that affects the safety of the child.

A SAIP agency may be asked to provide services to a client who has experienced sexual abuse in the past. In such cases, several factors are important in assessing the therapist's reporting obligations. The first is whether there is current risk of sexual or physical abuse, the second is whether the abuse was due to action or inaction of a parent, the third is when the client is in a position to suspect their abuser could be abusing other children, and finally when it appears that a criminal offence may have been committed. Cases of historical abuse which occurred in a school, youth custody centre, or child care centre, should be reported to the head of that organization. If there is concern that a crime was committed, a report should be made to the police. When in doubt about reporting historical abuse, call a Child Welfare Worker to discuss the situation.

Clients must be advised of the therapist's obligation to report sexual abuse/exploitation.

2.2.2 *Reporting Guidelines*

The BC Handbook for Action Child Abuse and Neglect for Service Providers is available online at:

www.mcf.gov.bc.ca/child_protection/publications.htm

In cases of uncertainty, it is the Child Welfare Worker's job to determine whether abuse has occurred and the risk status of the child. A report to a Child Welfare Worker need only contain the basic facts. As the child may have to tell their story to the Child Welfare Worker and possibly the police as well, the SAIP therapist need not go beyond a general account of what happened. The above publication outlines the nature of the information the Child Welfare Worker will ask the therapist to provide.

2.2.3 *Children in Imminent Danger*

In certain cases, there may be compelling reasons such as the immediate safety needs of the child or others where it is essential to report an incident or concern directly to the police. In these circumstances, the police should be contacted immediately so that a plan to keep the child safe can be put in place.

Standard 3: Release of Information

Ownership of client records resides with the SAIP contracted agency and is subject to the *Personal Information Protection Act* (PIPA) which governs how organizations collect, use and disclose personal information. Release of information is also subject to the *Child, Family and Community Service Act* (CFCSA) to ensure protection of children. SAIP agencies are legally responsible for all client personal information that is either in their custody or under their control.

3.1 Releasing Confidential Client Information

3.1.1 Personal information about a child or youth can be disclosed or released when there is consent from that individual, or his/her legal guardian.

3.1.2 Releasing personal information without consent only occurs when the disclosure is necessary to comply with a subpoena, warrant or order by a court or other agency with jurisdiction to compel the production of personal information or under urgent circumstances to ensure the child's health and safety and/or to prevent harm to another individual.

3.1.3 Agencies comply with provisions of the *Child, Family and Community Service Act* (CFCSA), outlined in Schedule F of SAIP contracts, authorizing access by the Province to client data when required for legal investigations and proceedings that involve MCFD.

3.1.4 Release of personal information to other parties in regard to matters related to criminal proceedings requires guidance from legal counsel.

3.1.5 Confidential client information is never released to researchers without informed signed consent from clients and/or their legal guardians.

3.2 Guidelines for Meeting Standards

Collection, use, and disclosure of personal information is governed by the *Personal Information Protection Act* (PIPA) www.qp.gov.bc.ca/statreg/stat/P/03063_01.htm . SAIP agencies and personnel working with clients and their records are required to be familiar with this legislation. A very helpful guide to understanding and applying PIPA can be found at www.oipcbc.org/sector_private/resources/index.htm

Part 5 of the *Child, Family and Community Service Act* (CFCSA) also speaks to disclosure of personal information relating to children/youth and their families. SAIP providers are to be knowledgeable regarding sections of this Act that pertain to release of information but also familiar with the Act in its entirety insofar as CFCSA is the legislative authority for the MCFD's child protection services.

3.2.1 *Consent for Release of Information*
Subject to certain specified circumstances, individuals have a right under PIPA to consent, or withhold consent, to the release of their personal information.

Younger children and children with mental incapacity may not be able to fully understand the nature of informed consent. Section 76 of the CFCSA states that the person who has legal

care of the child has the right to consent to release of the child's information. PIPA permits a legal guardian to exercise the rights of a minor which includes the right to give or refuse consent to the collection, use and disclosure of personal information of the minor, if the minor is incapable of exercising that right.

The child/youth and/or their parent/guardian must be informed at intake of the circumstances under which personal or treatment information may be disclosed within the agency, to MCFD, and/or to other parties and when consent is, and is not, required.

Express consent must be obtained for the release of information not otherwise authorized by legislation or urgent circumstances. Consent must be in writing and specify the information to be disclosed, to whom the information may be disclosed, and indicate a time limit for such disclosure. Note that it is inappropriate to obtain blanket consent for release of information.

Sharing of information is always done in the interests of the child/youth's well-being and may involve release of information to the following parties:

- Other Service Providers

With consent from the client or their legal guardian, SAIP therapists may release, to other service providers, a summary of personal information about the child who has been abused and may release confidential communication that has taken place in the treatment context. Disclosure should be restricted to the areas that are reasonably necessary to enable other service providers to carry out their responsibilities effectively, and should not reveal confidential information about a third party.

SAIP therapists requesting confidential client information from another service provider should make the request in writing and indicate:

- who will receive the information
- the nature of the requested information
- the authority to collect the information (copy of individual's written consent or legal authority)

A copy of the request for information along with a record of any response to the request must be kept in the client's file.

- Related clients

Where the SAIP therapist is assisting two or more clients within a family relationship, he/she may summarize and share confidential communication only if informed written consent has been obtained from the client and the sharing of information is critical to achieving treatment objectives.

- Clients and guardians

Children/youth or their legal guardians have the right of access to information about themselves, to know how the information is being used, and to whom and for what purposes their personal information has been disclosed. If a child is capable of consenting to treatment under the *Infants Act*, he/she is capable of exercising the right of access to his/her records. If a child is not capable, the custodial parent or legal guardian can exercise access rights on the child's behalf. A request for access to personal information must be made in writing.

Release of information does not include access to information regarding third parties (including other family members) if the third party has not consented to the release of information.

Information may be withheld from the custodial parent or legal guardian in circumstances where disclosure of the information could reasonably pose a threat to the child/youth's health or safety. Situations where the client has been neglected or abused by a parent who is requesting information could fall into this category. For children capable of consenting to treatment, the therapist must seek his/her informed consent prior to the release of personal information to the parents or guardians.

3.2.2 *Circumstances Permitting Release of Personal Information without Consent*

In the absence of consent, and if the treatment provider considers that the information is not necessary to ensure the safety, health and/or well-being of the child, he/she can refuse to disclose client information unless compelled by legislation or court ordered.[2] SAIP agencies may be obliged or required to disclose personal information without that person's knowledge or consent in the following limited circumstances:

- To comply with a subpoena, warrant or order by a court

Agencies must disclose client clinical information or clinical records when a court order or subpoena is served on the organization.

A **valid subpoena** is served personally, names a specific individual, compels that individual to attend court to give evidence on a given date and requires them to bring their records with them to assist in answering questions while on the witness stand.

A **court order** typically requires the production of records without the necessity of a court appearance. A court order should be checked to ensure that:

- it has been signed by the judge or district registrar and has the stamp or seal evidencing filing at the particular registry
- it has been signed by the plaintiff's lawyer
- it has been signed by the defendant's lawyer.

- To assist in an investigation of an offence under the laws of Canada or a province of Canada.

PIPA allows disclosure to a law enforcement agency to assist in an investigation undertaken with a view to a law enforcement proceeding. Agencies will provide the police with information when it appears a criminal offence may have occurred or is likely to occur.

[2] When in doubt about release of information, SAIP contractors may consult with their identified MCFD contract manager prior to releasing any requested information.

- To respond to a potential threat to the health or safety of an individual or the public

When there are reasonable grounds to believe that the health or safety of any individual is at risk, it may be necessary to disclose personal information to the appropriate authorities.

3.2.3 *Release of Information to the Ministry of Children and Family Development*

The Ministry may require client personal information for purposes of review of critical incidents as specified under its contractual agreement with the agency. Where the Director under CFCSA, or a delegated Child Welfare Worker, requests information pursuant to Section 96 CFCSA, the service provider is legally obligated to comply with the request and provide the information.

In addition, reporting of aggregated client and or administrative information to MCFD may be required as a deliverable specified in the contractual agreement.

3.2.4 *Release of Information related to Criminal Proceedings*

- To Defence Counsel in Criminal Proceedings

A major issue in the current legal context for treatment surrounds the disclosure of a child's treatment records to counsel for persons charged with sexual offences. Lawyers for the accused are permitted access to a complainant's personal records only in certain circumstances and under restricted conditions. In criminal cases involving sexual offences, SAIP agencies first receive a subpoena requiring them to bring a client's file to court, similar to the process in a civil case. However, in criminal cases, a court hearing will occur in which certain legal issues are decided by the judge before any disclosure of the file is made. Further, the agency, as the record holder, and the client/guardian are entitled to notice of this hearing and are able to make submissions to the judge as to why the records should not be disclosed. Legal counsel is recommended for these hearings.

3.2.5 *Research Requests for Information or Data*

Researchers are not granted access to personal information about clients unless informed signed consent has been obtained from those clients or their legal guardians. Informed consent requires that clients are made aware of the purpose of the research, how client information will be used, how confidentiality will be maintained, and how and where the results will be disseminated. SAIP agencies will have a formal mechanism to review requests for releasing information to researchers. Research requests that involve access to program information, client records, administrative data, or involve staff/client interviews and surveys should be subject to a rigorous research application approval process that meets legal and ethical requirements.

Section 18 of PIPA makes provisions for disclosing client information to an archival institution, where reasonable for research or archival purposes. Specifically, if the agency feels the information they have collected would someday assist others or contribute to research, they can transfer records to an archival institution. The institution will determine if it will accept these records.

3.2.6 *Special Considerations - Electronic Sharing of Information*

The sharing of information by email or fax can result in a breach of client confidentiality. Inadvertently, highly sensitive information may be seen by people who should not have access to it. PIPA requires that reasonable measures are taken to protect personal information from security breaches. Suggestions to ensure the protection of sensitive information when sending faxes and emails are provided by the Office of Information and Privacy Commissioner for BC entitled *Faxing and Emailing Personal Information*, available at: http://www.oipcbc.org/pdfs/public/fax-emailguidelines(Feb2005).pdf

Standard 4: Screening, and Assessment

4.1 Screening and Assessment to Inform the Provision of Services

4.1.1 All referrals to SAIP services are screened for the purposes of determining eligibility, the nature and severity of presenting problems, and the urgency of service need.

4.1.2 Efforts to establish urgency are made at the point a referral is received.

4.1.3 On screening, cases are triaged to establish prioritization and the type of intervention required.

4.1.4 Children and youth who are deemed to be in crisis situations are served immediately or supported to access appropriate services.

4.1.5 Children/youth deemed eligible for service will receive a comprehensive, biopsychosocial assessment that considers the client's spiritual and cultural context, and examines strengths and difficulties before treatment and support services commence. Assessments consider both abuse-related and general mental health needs and may require collaboration with CYMH clinicians.

4.1.6 Screening and assessment are conducted using methods and instruments recognized as acceptable in the sexual abuse field.

4.1.7 SAIP therapists administer only those psychometric instruments/tools/practices that they are qualified to utilize.

4.1.8 Children/youth deemed ineligible or in need of other specialized interventions are referred to, or co-managed with, other community services as appropriate.

4.1.9 All referrals to SAIP must be triaged in a timely manner.

4.2 Guidelines to Meet Standards

4.2.1 *Purpose of Screening*
The purpose of screening is to establish first whether referred children/youth are appropriate for SAIP services on the basis of the eligibility criteria outlined in Standard 1. Screening must also include a determination of the nature of presenting problems, a preliminary assessment of the severity of problems and, related to this, the urgency of service need so that cases can be prioritized. As such, screening should be conducted by qualified clinical staff.

4.2.2 *Urgency*
A determination of the urgency of a case should be made at the time of initial contact from a client, his/her family/guardian, or referral source. Generally this may be accomplished through brief questioning via telephone.

4.2.3 *Triage*

Triage procedures performed by clinical staff ensure that there is a systematic process to respond quickly to those children and youth with the most urgent needs and to assign them to different types of interventions (e.g., crisis response, psychoeducation, treatment, support) or to refer children/youth on to other services in the community.

4.2.4 *Clients in Crisis*

When screening or other information indicates a child or youth is in crisis, immediate services and/or supports are required. This may mean providing immediate clinical intervention through a SAIP therapist or referring the client to the appropriate clinical resource in the community (e.g., Adolescent Crisis Response Teams), or if necessary to emergency services or hospital. Children/youth with urgent care are not assigned to waitlists.

4.2.5 *Assessment*

When screening indicates that the child or youth is appropriate for SAIP services and not in crisis, a comprehensive, biopsychosocial assessment with attention to spiritual and cultural needs will be conducted before treatment begins. A determination of strengths in the child/youth and his/her family environment and social support network is integral to the assessment. The child's lifetime trauma history as well as abuse-related and general mental health symptoms, behavioural difficulties, and functional impairment form part of a comprehensive assessment. Assistance with aspects of the assessment from a CYMH clinician may be warranted.

4.2.6 *Screening and Assessment Methods*

The use of screening and assessment tools that have established psychometric properties is required. Systematic clinical assessment should include instruments and methods validated for use with children and youth and appropriate to the field of child sexual abuse. The selection of assessment tools should also address the specific needs of diverse clients.

4.2.7 *Qualified Use of Psychometric Instruments*

Some test publishers specify the required qualifications to administer and interpret different psychometric instruments that may be used for screening or assessment. Instrument technical manuals and related documentation should be consulted for information on restricted use. Many assessment instruments are available in the public domain.

4.2.8 *Referrals to Other Services and Supports*

Information derived from the screening and assessment process may indicate that a child or youth has clinical needs which are beyond those which can be provided by SAIP agencies. For some children/youth, evidence of mental disorder will warrant referral to, or collaboration with, a local CYMH team so that the child or youth will have access to needed treatment. In other cases, the SAIP provider must seek to access the appropriate services in the community on the child/youth's behalf. This may involve working with the referral source, the guardian, and the family physician to determine the preferred course of action.

4.2.9 *Timely Screening and Triage*

Screening of children/youth referred to SAIP services should occur as quickly as possible after the initial request for service, or at the time of request/referral in cases of suspected urgency. Subsequent to the screening and triage process, comprehensive assessment should be completed within a few weeks for higher priority cases.

Standard 5: Treatment Planning and Interventions

5.1 Treatment Planning and Interventions

5.1.1 Children/youth, or legal guardians on their behalf, provide informed consent prior to participating in treatment or other interventions.

5.1.2 A treatment/support plan with specific, measurable and realistic treatment goals is developed with the child/youth or guardian and included in the clinical record.

5.1.3 Interventions are delivered in a manner sensitive to considerations of diversity and culture.

5.1.4 Clinical intervention(s)

- are matched to the specific problems and strengths identified in the comprehensive assessment,
- are supported by research evidence of effectiveness and/or accepted clinical practice guidelines for children/youth who have experienced sexual abuse and children with intrusive or age-inappropriate sexual behaviour,
- focus on building strengths and resilience to prevent long-term problems which may develop from a history of sexual abuse as well as the current presenting problems experienced by the child/youth,
- are time-limited and delivered in the least intrusive manner.

5.1.5 A component of service for all children/youth includes safety planning to prevent future incidents of sexual abuse/exploitation.

5.1.6 Non-offending parents/caregivers are included in the treatment of children who have experienced sexual abuse/exploitation, whenever possible.

5.1.7 Sexual behaviour problems, arising from the presence of an externalizing disorder, are referred or treated in collaboration with a CYMH clinician.

5.1.8 SAIP therapists assess whether children/youth are at high risk for self-harm, including suicide, or at risk to harm others and immediately access appropriate community resources to establish a safety plan.

5.1.9 Termination planning begins at the outset of treatment, is linked to the achievement of agreed upon treatment goals, and involves the client, family and therapist.

5.1.10 For highly complex cases, or when therapeutic progress is not being made, clinical supervision or case-consultation with more qualified and experienced clinicians is obtained.

5.2 Guidelines to Meet Standards

5.2.1 *Consent to Treatment*

Prior to initiating service, the therapist must provide children/youth and/or their guardians with sufficient information to enable an informed decision regarding consent to treatment. Key information includes the nature of the treatment and/or other interventions, any risks associated with the treatment and/or other interventions, benefits that can be expected given current knowledge on the effectiveness of the treatment and/or other interventions, and the limits of confidentiality (see Standard 3). Child and youth and their guardians must also be informed of legal reporting requirements regarding disclosures of sexual abuse, other forms of abuse or neglect, and risks of harm to self or others.

The consent of a legal guardian is not required if the child/youth is deemed capable of providing consent through provisions outlined in the *Infants Act.*

Evidence of consent to treatment must be documented through a signed consent form on the child/youth's record.

5.2.2 *Treatment Planning*

Child/youth and family involvement in the development of a plan of treatment and support is critical. The goals of treatment should be agreed to by the therapist and child/youth and should be clearly documented as measurable outcomes in the treatment plan. Treatment goals should reflect the problem areas identified through the assessment process.

The treatment plan should include:

- The interventions to be used;
- The expected outcomes of treatment/support;
- The anticipated duration of treatment and frequency of treatment contacts;
- The key people to be involved in treatment and their roles;
- Recommended referrals to other agencies/services
- A record of client/guardian agreement to the above.

5.2.3 *Diversity and Cultural Sensitivity*

SAIP agencies must be prepared to respond to diverse client populations. Sensitivity to diversity and culture promotes services that are both accessible and acceptable to Aboriginal children and families as well as to other diverse and ethnic groups.

Strategies that improve access for diverse and cultural client groups include flexible service delivery models through convenient geographical locations, extended hours of service, ethno-cultural representation on staff, and organized outreach to ethnic communities.

5.2.4 *Clinical Intervention(s)*

Interventions selected on the basis of known effectiveness in relation to identified problems have the greatest likelihood of achieving treatment goals. Effective treatments are those which are supported by the research evidence and/or by expert consensus. Clinical practice guidelines that are current and issued by a credible organization represent expert consensus on recognized best practice.

While abuse-related emotional and behavioural problems in the child/youth represent the key focus of treatment, an important additional focus is his/her long-term welfare. Interventions which may reduce the likelihood of future problems associated with childhood trauma are an important preventive measure.

Specific intervention strategies are required for children under the age of 12 with sexual behaviour problems, which may or may not be associated with a history of sexual abuse.

5.2.5 *Safety Planning to Prevent Revictimization*

Children/youth who have been referred to SAIP services must be considered high risk for subsequent sexual abuse or exploitation. An essential component of treatment is psycho-educational interventions that equip the child/youth with knowledge and self-protection skills to reduce the risk of revictimization.

5.2.6 *Parent/Guardian Involvement*

Whenever possible, non-offending parents/guardians should be involved in the treatment of children and youth. While family therapy is not within the mandate of the SAIP program, assisting family members/guardians to support the sexually abused child/youth is important. When indicated, parents may also require help to effectively provide a safe environment for the child. In the case of younger children, treatment is mediated through the parent/guardian and proceeding in the absence of parent involvement is very difficult.

5.2.7 *Treatment of Sexual Behaviour Problems*

Approximately half of prepubescent children with sexual behaviour problems have no history of sexual abuse. Sexually inappropriate behaviour is often one of a cluster of behavioural symptoms/problems common to externalizing disorders. Such disorders respond to specific treatments including behaviour management training for parents and typically require the involvement of a mental health professional.

5.2.8 *Risk of Harm/Suicide*

SAIP agencies may serve clients who are at risk for harm to self or others. Prompt and appropriate intervention is crucial to save lives and/or prevent further deterioration. Agencies will have specific protocols and strategies around risk assessment and emergency intervention for high risk children and youth including staff training, networking, and co-ordination that are in keeping with MCFD established *Practice Principles: A Guide for Clinicians working with Suicidal Children and Youth*, available at:

http://www.mcf.gov.bc.ca/mental_health/pdf/suicid_prev_manual.pdf

On completion of a risk assessment, if more specialized services are required SAIP therapists will seek needed community, regional, and/or provincial resources as appropriate.

5.2.9 *Termination and/or Referral*

Children/youth and their families should understand early in their involvement with a SAIP agency that termination of treatment will occur when significant progress toward treatment goals has been achieved. Regular monitoring of progress provides the client and therapist with important feedback. In cases where expected progress is not being made, the intervention may need to be changed and supervisory review may be required.

After-care planning establishes the steps children/youth and their guardians should take in the event that difficulties arise after completion of treatment

5.2.10 *Complex Cases*
Children/youth who have been sexually abused and display severe trauma syndromes and/or serious psychological and behavioural symptoms may require more intensive and specialized interventions. In such cases referral to, or co-management by MCFD CYMH clinicians, physicians, psychiatrists or other specialists may be required. Consultation with the local CYMH team should be made at the earliest possible time for children with severe/complex presenting problems to determine an appropriate course of action. Consultation for complex cases occurs in addition to routine consultation/supervisions activities.

5.3 Special Considerations

5.3.1 *Treatment for Children with Disabilities*
Children with disabilities may include those with mild developmental delays or those with severe or multiple physical, cognitive and communication disabilities. Although the principles of treatment will be the same for sexually abuse in children with disabilities the focus and techniques used may be different. Specialized training is required for therapists to work effectively with children with disabilities.

Standard 6: Collaborative Service Planning

6.1 Collaborative Service Planning

6.1.1 A collaborative approach is applied in all cases when multiple services and providers are involved.

6.1.2 SAIP providers collaborate with other providers, with client/guardian participation, to support an integrated approach to planning and service delivery across the continuum of services through integrated case management or other mechanisms.

6.1.3 With Aboriginal children who have been sexually abused, SAIP providers work in partnership with a delegated Aboriginal Child and Family Services agency as well as other significant members of the Aboriginal community, as identified by the client and guardian.

6.1.4 Agency protocols to facilitate service transfers to CYMH teams are consistent with established regional or provincial templates.

6.1.5 Release of information to other providers, or discussion of cases with other providers, adheres to standards outlined in Section 3 of these standards and to stipulations in the Personal Information Protection Act (PIPA).

6.2 Guidelines to Meet Standards

6.2.1 *Multiple Providers*
SAIP therapists will determine which other services and supports in the local community the child/youth/family is either receiving or requires. In many cases Child Welfare Workers will be key partners and would typically lead the collaborative plan or case management process.

6.2.2 *Collaborative Models*

Integrated case management (ICM), integrated service delivery and multi-disciplinary collaboration means service providers from varied disciplines work together and share their knowledge, skills, perspectives and experiences to improve opportunities for positive outcomes for children and families. The goal is to increase communication resulting in a coordinated plan for services and supports that mobilizes the strengths of the client and family. The ICM approach to delivering services is client-centered, rather than aligned around professional disciplines or programs, thus meeting the holistic needs of the client. When MCFD is involved in the case, government staff will coordinate and lead the case management process.

More detailed information about Integrated Case Management is available at:
http://icw.mcf.gov.bc.ca/manuals/man_icm

6.2.3 *Service Collaboration for Aboriginal Clients*

For an Aboriginal child/youth, it is often appropriate for involved members of his/her Aboriginal community to take on particular roles and responsibilities with respect to the development and implementation of a child's treatment and support plan. SAIP agencies will ensure that they initiate and nurture collaborative work not only with Aboriginal families (including extended families as appropriate) but also, as directed by the family, work with Aboriginal agencies, personnel, and communities, to facilitate a culturally relevant response. Involvement of other members of the Aboriginal community must be dictated by the desires and consent of client and guardian.

6.2.4 *Protocols for Service Transfer*

Protocols outline the circumstances where transfer of service between SAIP agencies and the local CYMH office is appropriate and the processes to be followed. MCFD regional offices will have information about templates that have been established to guide service transfer procedures.

6.2.5 *Collaboration and Protection of Privacy*

SAIP agency personnel face unique challenges in protecting privacy when collaborating with multiple providers and providers need to strike a fine balance between respecting the privacy of clients and sharing the information necessary to develop an effective and coordinated service plan. Please see section 3 regarding the Release of Information to Other Service Providers for guidance.

Additional information can also be obtained from A Guide to the Privacy Charter at:
http://www.mcf.gov.bc.ca/publications/privacy_charter/final_guide.htm

Standard 7: Therapist Competencies and Qualifications

7.1 Therapist Competencies and Qualifications

7.1.1 SAIP therapists have a minimum of Master's level educational training in a behavioural health discipline from an accredited post-secondary institution and specialized training and experience in evidence-based child sexual abuse treatment.

7.1.2 SAIP therapists demonstrate the following core competencies:

- Understands and applies relevant legislation, policy and procedures
- Applies professional ethics to clinical practice
- Maintains competencies, exercises professionalism, and acts within scope of practice constraints
- Participates in regular clinical supervision and/or clinical consultation
- Recognizes the signs and indicators of child sexual abuse and/or maltreatment
- Understands age-appropriate sexual behaviour and typical and atypical child development
- Differentiates between the factors that constitute abuse and/or neglect, and normative parenting styles
- Knowledge of sexual exploitation and perpetrator behaviour patterns
- Demonstrates awareness and sensitivity to diversity and culture
- Understands unique vulnerabilities and treatment considerations in children with disabilities
- Understands and applies a strength-based perspective
- Proficient in comprehensive assessment practices using established standardized measures and approaches
- Is knowledgeable regarding mental health symptoms and syndromes
- Trained in the delivery of evidence-informed treatment and interventions for child sexual abuse and inappropriate sexual behaviour
- Employs age-appropriate treatment modalities
- Understand and applies a family and community systems perspective
- Balances potential benefits from clinical interventions with potential risks as part of the treatment planning process.

7.2 Guidelines to Meet Standards

7.2.1 *Educational Qualifications and Experience*

Individuals qualified to deliver sexual abuse clinical intervention services may come from different professional backgrounds including psychology, counselling, clinical social work, and nursing. SAIP therapists possess Masters level training, at a minimum. Some specialization in sexual abuse treatment through basic training, continuing education or clinical experience is also critical.

Selection of staff may be more problematic in certain geographic areas such as remote or rural communities. In such circumstances, it may be necessary to hire individuals without Master's level training. Bachelor's level trained staff, or any staff lacking in the core competencies for working with sexual abuse clients, will be assigned less complex cases, be required to work under the close supervision of a skilled Master's level (or higher) therapist, and to pursue training in areas where core competencies are lacking.

7.2.2 *Core Competencies*

The following table outlines required knowledge and skills to meet core competency requirements for SAIP therapists.

COMPETENCY	SPECIFIC KNOWLEDGE AND SKILLS
Professional Practice	
Understands and applies relevant legislation, policy and procedures	▪ Understands and operates in accordance with the *Child, Family and Community Services Act, Freedom of Information and Protection of Privacy Act*, *Youth Criminal Justice Act*, *Infants Act*, etc. ▪ Is familiar with the *Criminal Code of Canada,* in particular Part V: Sexual Offences, Public Morals and Disorderly Conduct ▪ Understands legal duty to report abuse and/or neglect. ▪ Regularly consults the *BC Handbook for Action on Child Abuse and Neglect for Service Providers* (2007 edition*)* and the companion document, *Responding to Child Welfare Concerns: Your Role in Knowing When and What to Report.*
Applies professional ethics to clinical practice	▪ Acts in accordance with ethical standards established by respective professional or licensing body (e.g., College of Registered Nurses of British Columbia; College of Psychologists of BC; Board of Registration for Social Workers; BC Association of Clinical Counsellors) ▪ Recognizes conflict of interest situations and acts in the best interest of the client ▪ Declares potential or actual conflict of interest situations to employer and clients ▪ Does not refer or accept agency clients in his/her private practice (if applicable)
Maintains competencies, exercises professionalism, acts within scope of practice	▪ Maintains a standard of competence in accordance with respective professional body or, in the case of unregulated practitioners, related to their skills and to representation of their skills ▪ Avoids misrepresentations of: ○ professional qualifications & affiliations ○ purpose or outcomes of interventions ○ associated institutions and organizations. ▪ Acts within scope of practice and professional limitations and, secures additional or alternative services for clients, where necessary ▪ Pursues continuing education to maintain to and improve competencies and to meet professional regulating body CE requirements
Child Sexual Abuse and Maltreatment Knowledge	
Recognizes the signs and indicators of children who may have been sexually abused and/or maltreated	▪ Accurately identifies physical, emotional and behavioural signs and indicators of child sexual abuse and/or maltreatment in children/youth and their families
Understands age-appropriate sexual behaviour	▪ Describes developmentally-appropriate sexual knowledge, awareness and behaviours of children of different age groups and can determine when sexual behaviours require further assessment and intervention

COMPETENCY	SPECIFIC KNOWLEDGE AND SKILLS
Differentiates between the factors that constitute abuse and/or neglect, and normative parenting styles	▪ Ability to assess the interaction of individual, family and environmental factors that contribute to sexual abuse, and identify strengths that will preserve the family and protect the child ▪ Describes the factors that may impact risk of current and future sexual abuse
Knowledge of sexual exploitation and perpetrator behaviour patterns	▪ Awareness of how perpetrators may manipulate victims to minimize resistance and reduce likelihood of disclosure
Child Development	
Is knowledgeable with respect to typical and atypical child development	▪ Plans and communicates treatment in a fashion that corresponds to levels of cognitive and emotional development that are appropriate to the age and circumstances of the child
Diversity and Cultural Sensitivity	
Demonstrates awareness and sensitivity to diversity and culture	▪ Is aware of, and utilizes, diversity and culturally appropriate practices and delivery styles when working with diverse client populations including Aboriginal, ethnically and other diverse client populations, families and communities
Children with Disabilities	
Understands unique vulnerabilities and treatment considerations in children with disabilities	▪ Ensures the treatment plan accommodates differently-abled children in terms of physical, emotional or intellectual capacities and works to maximize the effectiveness of treatment in the face of challenges.
Assessment and Treatment	
Proficient in bio-psycho-social assessment using established measures and approaches	▪ Is able to administer, score and interpret psychometric instruments validated for children and youth who have suffered sexual abuse
Understands and applies a strength-based perspective	▪ Awareness and encouragement of child/youth, family and community strengths in all aspects of interaction.
Is knowledgeable regarding mental health symptoms and syndromes	▪ Familiarity with the DSM-IV-TR classification system and ability to recognize possible mental disorders based on symptom presentations and collateral reports
Trained in the delivery of best practice interventions for child sexual abuse and sexual behaviour problems	▪ Employs evidence-informed and best practice interventions and treatments based on the research evidence and/or expert consensus through established clinical practice guidelines
Employs age-appropriate treatment modalities	▪ Provision of sexual abuse treatment for younger children may require that the use of expressive therapies.
Understands and applies a family and community systems perspective	▪ Understands clients within their context - considering the reciprocal relationship between individual, family and community, and how this interaction influences emotional and behavioural functioning.
Balances the potential benefits against potential risks of treatment and other interventions	▪ Considers child's physical and emotional safety in planning and providing treatment and other interventions and collaborates with the family, service partners (e.g., Child Welfare, Child and Youth Mental Health) and others as needed

Standard 8: Documentation and Records Management

8.1 Documentation and Records Management

Documentation is any written or electronic information about a client and the services provided to that client. Such information becomes a formal record and may be used in a court of law.
PIPA requires that personal information is accurate and complete, protected and appropriately disposed of.

8.1.1 SAIP providers collect only client information that is relevant and necessary for the provision of service(s) to the child/youth and family and ensure that information recorded is accurate.

8.1.3 SAIP agencies have a common identified client file format that guides the types of information and records collected.

8.1.4 SAIP agencies ensure that paper and electronic information about child/youth is protected from "unauthorized access, collection, use, disclosure, copying, modification, disposal or similar risks" [section 34, PIPA].

8.1.5 SAIP agencies have written policy regarding storage of records, how long they are to be kept, and when and how they are to be disposed of or destroyed.

8.1.6 Video or audio recording conducted for the purposes of treatment or supervision requires signed, informed consent prior to recording, must be securely transferred and must be erased/destroyed as soon as is reasonably possible.

8.2 Guidelines to Meet Standards

8.2.1 *Relevance and Accuracy of Personal Information*
A client file should not contain information that is not germane to the reasons for, and delivery, of service. SAIP therapists must make a reasonable effort to ensure all information recorded in a client record is accurate and complete.

8.2.3 *Client File Format*
Standardization of client records is part of sound records management. The contents of a client record should contain:

- referral and intake information
- relevant historical data
- consent forms
- legal material, agreements or contracts
- assessment reports
- treatment plan
  - goals of treatment
  - nature of the treatment to delivered
  - outcomes

- collaborative care plans
- progress notes
- consultation/supervision notes
- letters/case-related emails
- termination/discharge summary

8.2.4 *Protection of Records*

The Guide to PIPA defines three types of safeguards for ensuring the security of client records:

- Physical Safeguards including locked file cabinets, restricted employee access, removing client files from desk tops at end of working day, shredding paper containing personal information, completely erasing the hard drive of any computers that contain personal information.

- Administrative Safeguards including confidentiality agreements with employees, training and reminding employees about policies for protecting personal information, PIPA requirements, and disciplinary consequences for failing to implement safeguards.

- Technical Safeguards including positioning computers so that others cannot see personal information of clients which may be displayed on the monitor, installing screen savers to limit displays of personal information, ensuring computers and networks are secure through firewalls and encryption, responsible use of passwords and regular changing of passwords, and erasing or destroying hard drives before they are discarded, sold, or donated.

8.2.5 *Retention and Disposal of Records*

- Clinical records must be maintained and confidentially disposed of in a manner consistent with *Personal Information Protection Act* (PIPA) legislation. The Ministry of Children and Family Development recommend that client records created and owned by the Contractor providing SAIP services should be retained for at least 7 years after services are no longer provided. This will allow for compliance under Section 32 of the PIPA legislation for reasonable access by any individual for which the record was created for. The Ministry further recommends that a Contractor who feels the length of record retention is not sufficient or too lengthy, should seek independent legal advice and guidance to establish their own retention policy.

Standard 9: Clinical Supervision and Consultation

9.1 Clinical Supervision and Consultation Plan

9.1.1 Regular clinical supervision or consultation by designated individuals with a minimum of a Master's level training and expertise in evidence-based sexual abuse treatment will be provided to all counselling staff.

9.1.2 SAIP agencies will develop an annual written plan that documents how therapists will receive clinical supervision and case consultation to support skill development in the

application of best practice assessment and treatment practices and building of other core competencies.

9.1.3 Planning for clinical supervision or consultation will involve the local CYMH team leader or designate.

9.1.4 SAIP agencies will be responsible for implementing the clinical supervision or consultation plan and for monitoring progress on a semi-annual basis.

9.1.5 Clinical supervision and case consultation practices will be based on accepted models and utilize only those professionals as supervisors/consultants who have expertise in empirically supported approaches to child sexual abuse.

9.2 Guidelines to Meet Standards

Clinical supervision and case consultation potentially benefits both clients and therapists by improving the capacity to provide more effective services. These activities are part of an overall professional development strategy that may include continuing education, peer support, self-study, etc.

In clinical supervision arrangements, the supervisor is employed in-house and has a legal and clinical responsibility for the case. In consultation arrangements, an external consultant provides clinical advice to a therapist but has no legal or clinical obligation. Clinical supervisors and consultants adhere to professional codes of ethics and to established clinical practice guidelines.

The annual plan for supervision or consultation should seek to improve knowledge and skills in line with the required competencies outlined under Standard 7. The nature and level of supervision/consultation required is dependent on individual needs.

Supervision may be provided through senior clinicians within the SAIP agency. Clinical consultation may be arranged with other qualified clinicians in the local community or via telephone with experts outside of the community. The individuals who provide supervision or consultation have appropriate qualifications as described in the competencies outlined in section 7. Clinical consultation arrangements that involve private practicing clinicians should be discussed with the local MCFD CYMH team leader.

Standard 10: Professional Conduct

10.1 Standards of Conduct

The Government of British Columbia is committed to the highest standards of conduct among public service employees and its agents. This standard is essential to maintain and enhance the public's trust and confidence in the public service.

10.1.1 In general, staff employed by MCFD funded SAIP agencies should adhere to standards that are consistent with those established for BC Government employees. These standards are documented in the Standards of Conduct for Public Service Employees, found at:

10.1.2 SAIP agency employees and contractors must follow the code of conduct/ethics of their respective regulatory body and /or professional organization.

10.1.3 Employees and contractors working in Council on Accreditation (COA) or Commission on Accreditation of Rehabilitation Facilities (CARF) accredited SAIP agencies must adhere to the professional conduct standards requirement of that accrediting body.

GLOSSARY

Behavioural health discipline: typically includes psychology, counselling, social work, nursing, and child and youth care.

Best practice: clinical practices that represent the consensus of reputable groups and organizations regarding current knowledge on approaches to assessment and treatment in the field of child sexual abuse and child and youth mental health.

Biopsychosocial: involves the interplay of biological, psychological, and social factors on the health and wellness of an individual.

Child: anyone under the age of 19.

Comprehensive assessment: is conducted by qualified professionals to obtain necessary information relevant to the presenting problem and to the services provided by the agency. The aim of comprehensive assessment is the development of an individualized treatment plan. Assessment information is obtained primarily from the client and his/her guardian but may include appropriate collateral sources. A biopsychosocial perspective is employed that involves both assessment of problems and strengths and considers the client's spiritual and cultural context.

Core competencies: are the essential knowledge, skills and attitudes necessary for the provision of effective sexual abuse intervention services.

Clinical consultation: the voluntary process in which a specialist is engaged to provide expert knowledge and skills in a specific work-related area. A consultant has no authority over the staff concerned and does not assume clinical responsibility for services delivered by the agency. The consultation process is bound by agency policies and procedures and the relevant professional ethical codes.

Clinical supervision: a professional activity that provides expert knowledge and skills, education and training to develop competence in the supervisee and ensure the integrity of clinical services through a collaborative interpersonal process. Clinical supervision may include educational, administrative and supportive functions and is distinct from clinical consultation in that a clinical supervisor is ultimately responsible for the actions of the person being supervised i.e. vicarious liability.

Crisis situation: a period of unusual instability caused by excessive stress and either endangering or felt to endanger the mental and/or physical safety of an individual.

Evidence-informed or evidence-based: clinical practice that utilizes interventions demonstrated to be efficacious or effective in well-designed, peer-reviewed research studies.

Expressive therapies: using one or more creative expressions such as art, music, movement, drama, writing, play, etc. in psychotherapy or counseling.

Externalizing disorders: mental disorders in children and adolescents that involve acting out or other behaviours that may have a negative impact on others. The externalizing disorders include conduct disorder, attention-deficit hyperactivity disorder, and oppositional defiant disorder.

Informed consent: Explicit, written agreement by a client/legal guardian to participate in assessment/treatment/support services. For the consent to be informed the clinician needs to determine that the client/guardian understands the specific procedures to be used, as well as the expected risks/benefits of participating or not participating, and other alternatives the client/guardian might want to consider. When the client giving consent is a minor, the clinician seeking this consent must assess whether the client is capable of understanding risks or consequences of participation, and must determine whether participation in the service is in the best interest of the client. Consent can be revoked by the consenting person at any time.

Integrated case management: A formalized process of collaboration that includes the client/family and that takes place when more than two service providers are working with the same client/family. The goal of ICM is to increase communication between client/family and all service providers and to develop individualized, well coordinated plans, which focus on mobilizing the strengths of the client/family.

Intervention: Clinical activities that are matched to the needs of the individual client to prevent harm and/or improve functioning by working with the individual and his/her family to modify behaviours, cognitions, or emotional states.

Personal information is information about an individual and his/her circumstances that, if released to a third party, would enable the third party to establish the identity of the individual

Psychoeducation: the provision of educational information to children/youth and their guardians that assists in the understanding of a condition and in the acquisition of skills and other strategies to deal with that condition.

Screening: a preliminary test or procedure applied uniformly to clients to determine whether they meet the eligibility criteria for the services provided through the agency and whether the need for service is urgent.

Triage: a formalized process for prioritizing referrals based on their need for assessment and treatment.

Urgency: refers to the need for immediate services to stabilize and prevent further deterioration in the child/youth's condition.

Wraparound services: The coordination of delivery of services to children and their families that is individually tailored to each case with the goal of keeping the family together in the community and minimizing the disruption to normal functioning.