British Columbia Network of Child & Youth Advocacy Centres

PRACTICE PRINCIPLES

These Practice Principles were adopted by the BC Network of Child and Youth Advocacy Centres in June 2022.

Next review for revision will be June 2023.

Acknowledgements

The BC Network of Child and Youth Advocacy Centres (CYACs) acknowledges that the work of each agency and CYAC takes place on the unceded ancestral territories of Indigenous people. As a network, we strive to work in a way that honours and learns from the traditional teachings of Indigenous peoples and endeavours to serve all children, youth, families and communities with cultural humility and safety.

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[1] The BC Criminal Justice Branch provided input on the sections in the manual regarding CYAC's relationship with Crown Counsel and interviewing of children and youth.

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II. Definitions

TERM	DEFINITION
Abuse	Any form of physical, emotional and/or sexual violence, exploitation or neglect that causes actual or potential harm to a child or youth. *Child maltreatment* is a term most often used in the medical field and encompasses the above definition of abuse.
Advocate, or Child and Youth (Family) Advocate	A position unique to Child and Youth Advocacy Centres. The Advocate typically supports the family, child, youth, caregivers from time of referral and coordinates the information sharing between the multi-disciplinary team and assists the family with service navigation. May be referred to as a "coordinator" or "navigator" or another term at the local level.
CAC/CYAC	Stands for "Child Advocacy Centre" and "Child and Youth Advocacy Centre". CYAC is the coordinated and formalized service model of partnership agencies that respond to child victims of crime. A designated facility is not required to be considered a CYAC response. *"CYAC" will be used in this document and includes response models that call themselves a "CAC".*
Child/children	Any individual under 19 years of age and includes "youth".
Client	Children, youth, and their non-offending caregivers and family members who are served by a CYAC multi-disciplinary team response.
Cultural Safety	A sacred space where culture can be freely expressed, shared, learned, and supported. Cultural safety is a theory and practice that considers power imbalances, institutional discrimination, colonization and colonial relationships as they apply to social policy and practice.
CYAC/Centre File	CYAC files are those where clients receive a MDT response and where the case is coordinated by the CYAC. Clients have consented to a case management process.
DAA	A Delegated Aboriginal Agency has an agreement with the Ministry of Children and Family Development to provide child welfare services for a specific Indigenous community.
Developing CYAC	A community that has completed a feasibility study and is working towards operationalizing.
Emerging CYAC	A community that is working towards developing a CYAC. Typically, the community is in the process of gathering stakeholders, applying for needs assessment and feasibility study funding, or in the process of completing a feasibility study.
Forensic Medical Exam	A specialized medical evaluation that screens for injuries and medical conditions requiring treatment; collects forensic evidence; provides photo and written documentation of findings; and reassures children and families about their well-being. May be used as evidence in criminal and child protection investigations.
Health Services	Services provided by medical professionals in the care of clients of a CYAC. Health services are part of the collaborative MDT response to abuse and violence against children and youth.

TERM	DEFINITION
Indigenous	In Canada, the term Indigenous peoples refers to First Nations, Métis and Inuit peoples. These are the original inhabitants of the land that is now known as Canada.
Interview Phase	A period of time from when a case is identified through the preparation, planning and conducting of a statement from a child or youth to when debriefing of that statement occurs with the MDT.
Mature Minor	A mature minor is a youth deemed capable of consenting to health services or response services related to violence. Assessment for mature minor status takes into account that the youth understands the nature and consequences of a particular plan of care, along with its benefits and risks. There is no fixed age to determine whether someone is a mature minor although some public agencies use age 12 and up as a guide.
MCFD	Ministry of Children and Family Development is the provincial government ministry in charge of child welfare.
MDT or multi-disciplinary team	A team of cross-sector professionals that work on CYAC case files, usually comprised of professionals from: child protection, law enforcement, victim services, Indigenous organizations, child and youth advocacy centre organizations and medical/health services.
Medical Evaluation	Services provided by a medical professional that include forensic medical exams, general or wellness exams and behavioural assessments.
Mental Health Services	Trauma-informed, evidence-supported services provided by a trained, specialized mental health professional; this includes Indigenous culturally-safe services.
Network	The BC Network of Child and Youth Advocacy Centres
Partnership	The formalized group of multi-disciplinary agencies and organizations that form the CYAC response. Usually recognized through the signing of a partnership agreement or Memorandum of Understanding.
Stakeholder	An agency or organization that is not a formalized partner to the CYAC but that contributes to the MDT response on specific CYAC files. A stakeholder signs an affirmation of confidentiality agreement (see **Appendix 3**) and participates with consent of the CYAC client.
TRC	Truth & Reconciliation Commission of Canada. The TRC provided those directly or indirectly affected by the legacy of the Indian Residential Schools system with an opportunity to share their stories and experiences. The TRC's Final Report was published December 2015 and includes 94 Calls to Action for child welfare, education, health and justice sectors of government.
Trauma	Exposure to harmful and/or overwhelming events or circumstances. The experience of these events will vary from individual to individual, and the effects may be adverse and long-lasting in nature.

TERM	DEFINITION
Trauma-Informed Practice (TIP)	Trauma-Informed Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma. It emphasizes physical, psychological, and emotional safety for everyone, and creates opportunities for survivors to rebuild a sense of control and empowerment.
Traumatic event	A frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity. Witnessing an event that threatens life or physical security of a loved one can also be traumatic. Traumatic experiences can initiate strong emotions and physical reactions that can persist long after the event (National Child Traumatic Stress Network).
Trauma symptoms	Cognitive, affective, or behavioural signs of trauma exposure that cause distress to the individual or impairment in the person's functioning or relationships.
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples. This was adopted in 2007 and endorsed by the Government of Canada in 2016. The Declaration is the most comprehensive international instrument on the rights of Indigenous peoples. It establishes a universal framework of minimum standards for the survival, dignity and well-being of Indigenous peoples of the world and it elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situation of Indigenous peoples.
Victim Services	A program funded by Ministry of Public Safety & Solicitor General that supports victims of crime. Communities may have community-based, police-based or court victim service programs or any combination of the above. In the context of a CYAC, Victim Service Workers typically provide: navigation of the criminal justice system to victims of crime, including updates on proceedings, court preparation, orientation and accompaniment.
Wellness Exam (non-acute)	A medical examination conducted to screen for injuries and medical conditions but primarily to provide reassurance to a child of their physical wellbeing and to help them progress through their overall healing journey. This may include a mental health assessment to address emerging or future mental health concerns.

III. Background

In 2016, the Ministry of Public Safety & Solicitor General's Community Safety and Crime Prevention Branch (the Branch) received funding from the Department of Justice Canada to develop a provincial network to support emerging child and youth advocacy centres (CYACs). With this funding, the Branch brought together leaders from each of the CYACs to create a Steering Committee to share knowledge and resources and to work towards creating a common voice for this unique response model.

In 2018, the Branch and Steering Committee hosted a Provincial Roundtable that brought together leadership, policy makers, and representatives of each developing and operational CYAC in BC. At this two-day event, participants learned more about the model, worked to understand the barriers centres faced in the current systems of practice and outlined a roadmap for further developing this model in the province. This was the start of what is provided in this manual. The data that was collected from the Provincial Roundtable was summarized and analyzed by the Steering Committee and prioritized for next steps. Out of this came the four work teams described below and an Advisory Team of sector leaders. The Advisory Team was tasked with providing input and sector-specific guidance in the development of the provincial practices guidelines found in this manual.

The work teams were comprised of cross-sector practitioners who regularly work within or close to CYAC service models. The work teams concentrated on four prioritized areas: health services, mental health services, interviewing children and youth, and case management of CYAC cases.

These practice principles were developed to guide the practice of individuals and teams working within CYACs. The principles are not standards created by an accreditation body and are meant to act as guiding parameters for the work of CYACs in the province of British Columbia.

The goal of providing these practice principles is to ensure that the services provided within a CYAC model will be consistently conducted across our province. It is recognized that in practice these principles may be adapted differently depending on the size and geographic region of the CYAC community and the resources and partnerships within that CYAC. **However, it is expected that each CYAC will strive to implement these practice principles in the spirit in which they are intended – which is to support evidence-based practice that meets the unique needs of children and youth.**

We acknowledge the work that was previously done in the area of guidelines and standards for CYACs, and we have relied heavily on documents such as the National Children's Alliance's *National Standards of Accreditation for Children's Advocacy Centers* and the *National Guidelines for Canadian Child Advocacy Centres/Child & Youth Advocacy Centres* to inform our work on practice principles for CYACs in British Columbia. We will refer to these documents throughout this manual as the "NCA Standards" and the "National Guidelines" respectively.

This manual can used as communities develop their CYAC model and for current operating CYACs examine or look to expand their service.

IV. The Child and Youth Advocacy Centre Model

Child and Youth Advocacy Centres arose from the need to reduce the stress that child and youth victims of abuse and violence are subject to during abuse investigations (Department of Justice Canada, January 2018). Practices such as interviewing children and youth in interrogation rooms at police detachments, and having a child retell their abuse story multiple times to multiple service professionals, are traumatizing and not beneficial to conducting successful abuse investigations - nor are they trauma-informed. Professionals tasked with responding have often operated separately from each other, not engaging in timely communication or coordination.

The CYAC service model provides a child-focused process in a friendly setting, usually at a central location where all service providers coordinate their investigative and support efforts. This approach is more conducive to the safety, comfort, and the building of trust with the child or youth and results in improved quality of statements and investigations along with less gaps in support services.

A CYAC collaborative multi-disciplinary team response can:

- reduce system-induced trauma;
- maximize efficient information sharing for investigative, prosecution, therapeutic and support service needs;
- eliminate duplication of services; and,
- enhance seamless service delivery to children, youth and families throughout the life of the case.

CYACs enhance the likelihood of young victims and their non-offending family members participating in the criminal justice system due to the ongoing support received in this service model. Established in the United States since 1985[2], and a growing field in Canada since the 1990s[3], CYACs are recognized as the preferred response model for providing the best outcomes for child and youth who are victims of abuse and violence.

Child and youth advocacy centres have certain features that make them a “CYAC”. This section outlines some of those foundational aspects.

[1] See National Children’s Advocacy Center www.nationalcac.org for more information

[2] See https://cac-cae.ca

1. Formalized Partnership Agreements

Child and Youth Advocacy Centres undertake a process to develop a formalized agreement between the multi-disciplinary partners. Formats common to the CYACs in British Columbia are Memorandums of Understanding, Letters of Understanding, and Partnership Agreements. It is a foundational principle that CYACs endeavour to solidify their partnership through signing a Memorandum of Understanding (MOU)/ Partnership Agreement.

At a minimum, these agreements should include:

- identification, role and responsibilities of the lead agency[4];
- roles, responsibilities and limits of each partner agency;
- information sharing parameters and the relevant privacy legislations;
- outline of the service model;
- any existing local protocols that affect the service model;
- process for decision-making and dispute resolution; and,
- term of the agreement, process for dissolution and renewal.

Ideally, the development of the agreement is a focus during the development phase of the service model. By making time at the outset for MDT partners to engage in a process to clarify their respective roles and responsibilities within the CYAC service model, and terms within the MOU, this will better situate the partnership prior to service implementation. Such interagency agreements ease growing pains and provide comfort to all MDT members on items such as information sharing. Efforts to establish shared values, a vision, and a commitment to work through challenges creates a foundation for the work to come.

The network has developed a template MOU that can be shared with all communities developing or operating a CYAC. The MOU template is in the process of being reviewed and approved by the various organizations that are partners to CYACs and will be available for use in 2022. If you require an example MOU please reach out through www.bccyac.ca

There is another project underway by the network to assess whether a privacy impact assessment and application to have a Common or Integrated Program Agreement under the BC *Freedom of Information and Protection of Privacy Act (FIPPA)* would serve CYACs well.

[4] See National Guidelines for information on operational capacity required of the lead agency.

2. Multidisciplinary Team (MDT)

A core concept in CYACs is the development and collaboration of a multi-disciplinary team (MDT).

A MDT is a group of service professionals from different disciplines - each providing specific services - who coordinate their contributions to provide an improved and comprehensive service to shared clients.

In terms of a CYAC, at a minimum, the MDT partnership consists of policing, child protection and victim service programs. It is recommended that Indigenous agencies are engaged as early as possible and form part of the core MDT. It is recommended the MDT includes health, school districts, mental health services, counselling agencies and others as determined by the local context and available resources.

It is expected that emerging CYACs will engage with the relevant organizations in their area when developing a CYAC response model. Becoming a "MDT" requires dedication and time to come to a common understanding of this unique service model and how it will be implemented in a particular geographical area. As stated by the accrediting body for Child Advocacy Centres in the United States:

"A CYAC is **not just a facility** but serves as an interagency coordinated response center" (National Children's Alliance, 2017, p. 12).

All MDT representatives contribute their knowledge, experience and expertise for a coordinated, comprehensive, compassionate, and professional response to child abuse. MDTs coordinate their involvement in a case from first report throughout the life of a file, with the goal of mitigating and preventing trauma to children, youth and families. In addition, the MDT aims to improve the effectiveness and efficiency of investigations and services, while preserving and respecting the rights, mandates and obligations of each agency.

ROLES AND RESPONSIBILITIES:

All MDT members and stakeholders continue to hold a duty to their home agency or organization and the respective legislation and policies under which they are legally bound to fulfill their specific investigative, therapeutic or support service mandates. Each partner in the MDT will ensure that there is representation from their sector or an alternate member for regular participation in MDT case management and case review processes. All terms should be outlined in the MOU or Partnership Agreement.

A. Child and Youth Advocacy Organization

The role of the child and youth advocacy organization is to bring together the various partners and stakeholders responsible for responding to child and youth victims of abuse and violence in order to provide an enhanced and highly coordinated response.

The Child and Youth Advocate or "Advocate[5]" is a central position in, and unique to, CYACs and is employed directly by the centre.

The role of the Advocate is to coordinate all points of service for the child, youth and family and to act as a primary contact of the MDT from the time of intake until service is no longer required. The Advocate also acts at the 'voice of the client' within the MDT and during case management to ensure that the child, youth and family's needs are upheld at the center of the work.

Duties of the Advocate may include:

- acting as the voice of the child in all MDT and case conference discussions related to the file;
- ensuring continuity of service for the family by acting as single point of contact where possible;
- coordinating the interview time and place with the MDT;
- liaising with other service providers to determine any unique needs of the child;
- greeting the child and family and ensuring their physical and emotional readiness for the interview;
- completing a service intake with mature minor youth or caregivers;
- explaining the service model to clients;
- assessing for immediate needs and providing resources;
- answering questions about the process and roles of the MDT personnel;
- liaising between the youth, family and the MDT to provide information and resources;
- overseeing case management by facilitating communication between the MDT members through case reviews and tracking actions items for the MDT; and,
- educating community service providers on the CYAC model.

[5] Individual centres may name this role differently.

B. Victim Service Programs

Victim Service programs provide emotional support, information, referrals and practical assistance to victims[6] of crime, including children and youth. The Ministry of Public Safety and Solicitor General funds and supports over 160 Victim Service programs across BC, including:

- **Community-Based Victim Service (CBVS) programs** serve victims of family and sexual violence, ethno-specific and diverse communities, children, and Indigenous peoples. These programs operate out of non-profit organizations. There are 70 community-based victim service programs. Some communities have community-based victim service programs that specialize in assisting Indigenous victims of violence.
- **Police-Based Victim Service (PBVS) programs** serve victims of all types of crime and trauma, and assisting police and communities in situations involving multiple injuries or deaths. There are 91 police-based victim service programs operating out of police departments/detachments in BC.

As required by their service contract, a local protocol must be in place in service areas where both CBVS and PBVS programs exist, to outline roles and responsibilities of each program and how they will work together. All victims of family and sexual violence are to be referred by the police-based victim service program to the community-based victim service program in a timely manner and in accordance with the Referral Policy for Victims of Power-based Crimes[7]. As such, CBVS is typically the main service provider for CYAC files and PBVS acts as a referral source.

Victim Service Programs are integral partners of the CYAC service model and participate as a member of the MDT (see **Appendix 6** - for detailed responsibilities of the Victim Service Worker).

What is the difference between an Advocate and a Victim Service Worker?

A Child and Youth Advocate is typically a unique position in a community and created to facilitate the service model of a CYAC. Advocates are usually employed by the CYAC itself. The focus of the Advocate is coordination of service and acting as the hub of information within the MDT. A Victim Service Worker is employed in a community-based or police-based victim service program to support victims, including children and their families.

Depending on the size of the community served, resources available, a client's needs, and the service model created, there may be varying modalities of collaboration between the Advocate and Victim Service Worker roles in CYACs. Duties may shift between roles depending on the agreement at the local centre. There is great value in the two roles working closely together to enhance service to the children, youth and caregivers.

Regardless of the role or agency employing the Advocate or Victim Service Worker, all are governed by privacy legislation that outlines how sharing of information occurs. See more in Section V, Information Sharing.

[6] "Victim" – is contract language used to identify the client; for the purposes of this document "child or youth" will be used moving forward.

[7] See Referral Policy for Victims of Power-based Crimes: https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/victims-of-crime/vs-info-for-professionals/info-resources/power-based-crimes-referral-policy.pdf. In exceptional circumstances, where a client specifically indicates that they do not wish to be referred to a community-based victim service program, this must be documented in the file, to remain with the police-based program. In situations where involvement of both police-based and community-based victim service programs is identified, the programs should coordinate an approach to service delivery and jointly develop victim-centred support plans.

C. Police

Police are the criminal investigative body for offences involving child victims of crime or child witnesses of crime. Police also provide an assisting role to MCFD and other agencies in support of their crime prevention programs. Police are an integral partner of the CYAC service model. RCMP operate under the Federal Privacy Act while municipal police forces, as public bodies, are governed by the BC *Freedom of Information and Protection of Privacy Act (FIPPA)*.

D. Child Protection Social Workers

The Ministry of Children and Family Development (MCFD) is the provincial government ministry in charge of child welfare. A Delegated Aboriginal Agency (DAA) operates through an agreement with MCFD, to provide child welfare services for a specific Indigenous community. Social workers of either agency are responsible for the safety and well-being of children. They assess and respond to concerns of child abuse and neglect by interviewing caregivers, children and youth; developing safety plans; and determining if children or youth are in need of protection. MCFD and DAAs are integral partners of the CYAC service model and are governed by BC *Child, Family and Community Service Act (CFCSA)*.

E. Indigenous Communities & Organizations

Each CYAC should endeavour to have Indigenous organizations and/or communities as a core partner in the service response model. It is best practice to involve Elders, knowledge keepers or a traditional trusted ally to inform CYAC partners of specific cultural traditions, needs of clients and their families and community in order to support appropriate facilitation of culturally safe and relationally connected service provision for Indigenous children, youth and family members.

In envisioning and delivering services to Indigenous clients, "Wise Practices" can be offered that are effective and culturally safe. CYACs will consider the use of Wise Practices, in which traditional teachings and wisdom specific to a culture or community are integrated within a contemporary or mainstream system approach[8].

[8] The integration of traditional wisdom and western medical models have been used in First Nations communities, and with Indigenous peoples in urban settings (see Nabigon & Wenger-Nabigon, 2012).

F. Medical and Mental Health Services

Medical and mental health service providers are important members of a CYAC partnership. They have areas of expertise that contribute to the well-being of children that is not duplicated by any other partner, and their work can inform the investigation and case management of a file. This is expanded upon in Section VII.

G. School Districts

Local school districts may form part of the CYAC partnership. The benefit of school district personnel participating in the MDT is the often-close connection they have to children and youth through the school system where children spend a substantial amount of time. This increases referral pathways from the schools to the CYAC and the opportunity for extending support to the child in the school environment, as indicated by case review.

H. Other Partners

Additional community partners may be relevant and necessary to the CYAC partnership as determined by the local context of a CYAC.

I. Stakeholders

Some agencies may not formally sign on to a CYAC partnership but be considered close allies to the response service. Stakeholders are invited to participate in case management on a case-by-case basis, in accordance with client consent, and can play a role in supporting the development and implementation of action plans. Stakeholders must sign a confidentiality statement before participating in information sharing and case management.

3. CYAC Service Models in BC

Currently there are three main CYAC service models in British Columbia. These are either part of an established umbrella agency that hosts CYAC programming or are specifically established societies.

Co-located Service Model

In this model, the CYAC has a dedicated space that is the main work site of the MDT. With co-location we see all partners embedded at the site where services are provided in a collaborative manner. Administrative support staff, communal spaces such as lunchrooms and meeting areas are generally included in a co-located model.

Coordinated Location Service Model

In this model, the CYAC has a dedicated space, however it is not the MDT members' main work site. The CYAC staff work from the location that houses specialized interview, monitoring, meeting and waiting rooms. The MDT maintain offices within their home agency, attending the centre location as needed to provide collaborative and coordinated service.

Rural or Remote Service Model

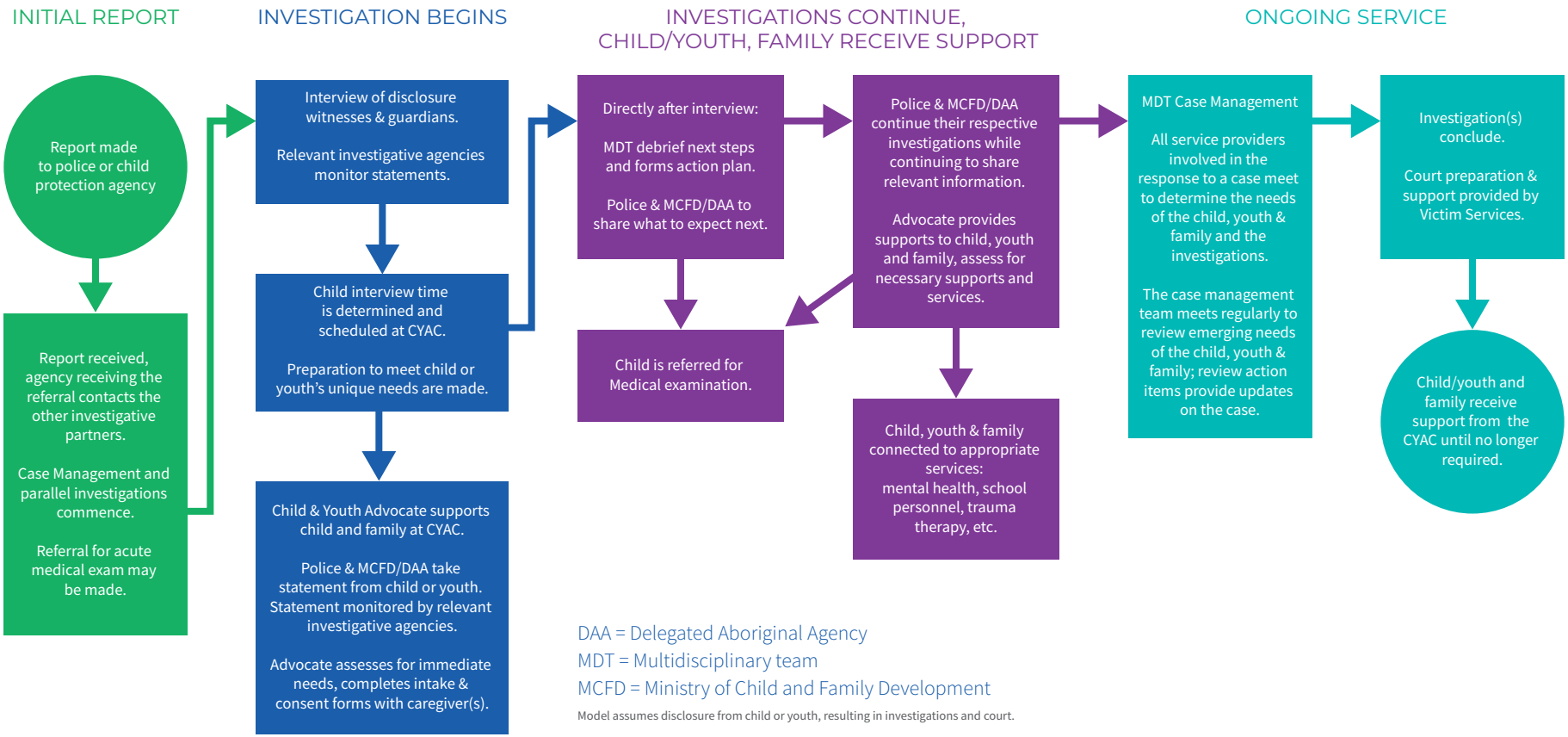
In a rural model, the CYAC does not have a dedicated "centre" space. Usually there is a soft interview room with monitoring capability created in a local service agency's existing space. The MDT coordinates service from their own home agencies and come together for child interviews and case conferences. This model is a creative solution to the geographic and resource realities of rural and remote areas of the province.

The CYAC model has strength in that it can be adapted to suit the community it is serving. Service models may change over time as emerging needs are identified, or more resources come available. Any of the above models may include a mobile response to better serve outlying areas or provide safe venues from where to testify. This responsiveness and adaptability are hallmarks of the CYAC model.

4. Case Flow

The CYAC flow of services and support follows a general sequence of events. Flexibility in the sequencing of these activities will be needed considering the various ways in which CYACs and MDTs operate in different communities and geographic settings. It is most important that the flow of service is conducted according to the best interests of the child or youth.

Below is an illustration of typical case flow. Please see **Appendix 1** for detailed steps in the CYAC case flow continuum.



DAA = Delegated Aboriginal Agency
MDT = Multidisciplinary team
MCFD = Ministry of Child and Family Development

Model assumes disclosure from child or youth, resulting in investigations and court.

V. Information Sharing

MOUs or Partnership Agreements created by the CYAC partnership should detail the privacy legislation that each partner falls under in order to develop a common understanding of how and when information about a CYAC case can be collected, used and disclosed.

Privacy legislation that applies to the MDT agencies

Each MDT member is responsible for ensuring that information management in the CYAC collaboration adheres to the requirements of the privacy laws that govern their respective ministry, agency, and/or profession.

The laws which may apply are:

- The Federal Privacy Act applies to RCMP, a federal government body;
- BC *Freedom of Information and Protection of Privacy Act (FIPPA*) applies to public entities such as municipal police forces, provincial ministries, health authorities, public education bodies, and contractors providing services on behalf of a public body;
- BC *Personal Information Protection Act (PIPA)* applies to non-profit organizations and charities, such as community service agencies that house Community-Based Victim Service programs, Sexual Abuse Intervention Programs (SAIP), transition house societies and other agencies who serve vulnerable victims. This Act applies to the personnel employed by the non-profit entity that houses the CYAC.
- BC *Child, Family and Community Service Act (CFCSA)* guides social workers in carrying out their child welfare duties. This includes the privacy sections under which the Ministry of Children and Family Development may or may not collect and/or disclose information with/without consent. This Act also provides that anyone who has reason to believe a child needs protection must promptly report to a child protection social worker.
- BC *Victims of Crime Act (VOCA)* outlines rights afforded to victims involved in the criminal justice system. Specifically, the Act provides that justice system personnel provide the victim with specific information related to the case.

Parameters: Information That May Be Shared

Information sharing within MDTs is at the center of effective service provision through interagency collaboration. Personal client information is collected and shared on a "need to know" basis and only to the degree necessary to provide effective case management.

Types of information to be shared may include:

- Safety concerns or high risk indicators;
- needs for support or service for the child, youth and non-offending family members;
- names and contact information of victims and non-offending family members;
- overview of previous contact/services with partner agencies as relevant to the current situation;
- summary of the alleged offence(s), including the alleged offender's name and relationship to child or youth and family, type of abuse, and other circumstances that may be relevant;
- criminal investigation and court process information including court dates, custody status, orders; and,
- referrals to services.

Confidentiality

Each partner of the MDT must determine what information is necessary to share in order to meet their duties and obligations and to permit the other partners to fulfil their duties. The information shared by and among partners is conducted with the understanding that there is a mutual or common expectation of confidentiality for the purposes of: section 19(1) (c) of the *Privacy Act*, section 75 of the CFCSA, sections 16 (1) (b) and 22 (2)(f) of the *Freedom of Information and Protection of Privacy Act*, and section 18 of the Personal Information and Protection Act.

Personal information must not be used for another purpose than the original intended purpose (ie. assisting the MDT in providing collaborative service to the client).

All MDT partners will sign a Confidentiality Agreement (see **Appendix 3** – Affirmation of Confidentiality Agreement Template).

Consent-Based Services

Clients of CYACs must provide their consent for service and consent for the collection, use, and disclosure of personal information, in order for MDTs to proceed with the collaborative response model. Information sharing between the MDTs cannot occur[9] unless the relevant consent forms are signed by the client through an informed consent process.

An informed consent process ensures that the client understands what they are agreeing to. During this process the following items are fully explained:

- the CYAC model and participating agencies;
- the reason for collection of personal information;
- what information will be collected;
- applicable privacy laws and policies;
- their rights and responsibilities when receiving service;
- how personal information will be used and how it will be stored; and,
- how to revoke consent.

The person who collects consent from the client will vary between CYAC models. Where there is a Child and Youth Advocate, this is generally their responsibility and conducted during the intake process. After the Advocate has outlined the above items, explained the MDT's information sharing approach, and the benefits and risks of information sharing between partners for effective service delivery, the client is asked to sign consent forms. It is only with client consent that CYAC collaborative services can be activated.

[9] One exception to this is the sharing of information between police and child protection which can occur without consent where there is an issue of safety.

Who can give consent

Consent must be obtained from the youth or one of the child's legal guardian(s).

- For children in Ministry care, their social worker must sign consent on their behalf.
- For situations where there is a Family Law Act (FLA) dispute, please refer to the Mature Minor Guide at **Appendix 4**.

Mature Minors: A youth client can consent to service on their own behalf if the service provider believes that the youth can understand the nature and consequences of their consent. An assessment is conducted to determine that this requirement is met. Please refer to the Mature Minor Guide for more detailed information.

If a client is on the cusp of mature minor status, it is wise practice to explain the information sharing process and have them sign the consent forms alongside their legal guardian. This will assist with information sharing processes over the life of a case file and ensure autonomy and direct service as the child ages and matures.

Revoking Consent

Consent forms should include a timeframe for expiry, in addition to outlining the right of the client to revoke their consent for service at any time. The consent form must meet privacy law requirements. Should a client revoke consent for MDT services, this must be respected and no further coordinated services be offered. Individual services may continue if the client has provided consent for those services or if they are a mandated service. The utmost effort will be made by the CYAC Advocate or designated MDT member, to ensure client understanding of the benefits of service and implications of having no service.

"No Consent, No Service"

In some cases, where consent for coordinated MDT services is declined or unable to be obtained, a referral to a CYAC may result in only the child or youth interview and no further services. In instances where no guardian is available to provide consent, the Advocate or designated MDT member will make reasonable efforts to obtain consent. Without consent, information sharing for the purposes of case management cannot be conducted. Exceptions may apply as outlined below.

Sharing Information Without Consent

In the event that a client does not provide consent to share information, each MDT partner will respect that decision and will not share information except as required. In such cases, if a partner decides to collect and disclose information without consent of a client, it must be made with regards to client and public safety and aligned with current privacy legislation.

- Police and child welfare are authorized to act and are not required to get consent for the purposes of law enforcement or emergencies and where a child is in need of protection.
- FIPPA section 33(3) permits provincial public bodies such as municipal police and mental health services to disclose personal information without consent where compelling circumstances exist that affect anyone's health or safety.
- RCMP and federal Parole under the federal Privacy Act section 8(2)(f) are permitted to disclose personal information without consent for law enforcement purposes.
- Child protection social workers are authorized to obtain information in the custody or control of a provincial public body without consent under section 96 of the CFCSA, if this information is needed to ensure the safety and well-being of a child. Also, child protection social workers may disclose information without consent under section

79 (a) and (a.1) if the disclosure is necessary to ensure the safety or well-being of a child or the safety of a person other than a child.[10] This section takes precedence over FIPPA privacy provisions.

- Child protection social workers may disclose information without consent if the disclosure facilitates or supports an Indigenous child's learning and practicing of their Indigenous traditions, or the child belonging to their Indigenous community, CFCSA ss.79(a.2)(i) and (ii). Child protection social workers may, without consent, disclose information obtained under the CFCSA if the disclosure is made to a First Nation, the Nisga'a Nation, a Treaty First Nation or another Indigenous community in accordance with an agreement made under section 92.1 CFCSA s.79(a.3).
- PIPA permits a non-profit organization to disclose information to a public body or law enforcement agency in Canada to assist in an investigation or in making a decision to undertake an investigation. Section 18(1)(j).
- PIPA permits a non-profit organization to disclose without consent where there are reasonable grounds to believe that compelling circumstances exist that affect the health or safety of anyone. Section 18(1)(k).
- PIPA permits a non-profit organization to disclose information to another organization without consent if the disclosure is in the interests of the individual and consent cannot be obtained in a timely way. Section 18 (1) (a).
- PIPA permits disclosure without consent where disclosure with consent would compromise an investigation or proceedings and disclosure is reasonable for purposes related to the investigation or proceeding. Section 18 (1) (c).
- Those working under professional ethics codes are not breaching their privilege or confidentiality in circumstances that involve disclosing information about immediate danger to clients or others.

When an agency decides to disclose information without consent, this must be:

- considered on a case-by-case basis;
- based on the necessity to disclose;
- ensure that only relevant and no extraneous information is disclosed; and,
- immediately and fully documented.

In cases where an agency decides to disclose personal information without consent of the client, case documentation should reflect the following:

- why the disclosure is being made and what risk was identified;
- what information is being disclosed and to whom; and,
- what restrictions for use of this information is placed on the recipients.

BC's provincial privacy laws also contemplate the need and potential benefit of more seamless information sharing between agencies in situations where there is an integrated service delivery model. In the event that local CYAC partners sign a Common or Integrated Program Agreement or CIPA, that agreement is considered sufficient authority for the parties to collect and disclose personal information without consent, FIPPA sections 27(1)(e) and 33(2)(k) and PIPA section 18(1)(o). The Office of the Information and Privacy Commissioner of BC must be notified of the intent to develop a CIPA and to review the CIPA.[11]

[10] Note: Any person who believes that a child (under 19yrs of age) needs protection has a legal Duty To Report under Section 13 of the CFCSA. For more information on how to report, please refer to: Ministry of Children and Family Development (2017) BC. Handbook for Action on Childhood Abuse & Neglect for Service Providers: http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/public-safety/protecting-children/childabusepreventionhandbook_serviceprovider.pdf

[11] For more information see: https://www.oipc.bc.ca/guidance-documents/3516

VI. Record and File Management of CYAC Files

Parameters for CYAC records and file management should be outlined in the MOU between partner agencies. Considerations include:

Ownership of Records

Each agency or organization is responsible for generating a record for the purposes of carrying out their own mandate and retains their own client file according to the requirements of their workplace and the legislation that guides their work. Each agency is responsible for storing its own records and adheres to their own security policies and procedures for the security of files and records.

Police retain the audio-video recordings of criminal investigation interviews.

CYAC Records

CYACs will create and hold a file that is separate and distinct from files held by other agencies. The CYAC agency will take all reasonable measures to safeguard physical and electronic client files, statistical data, and other records, and it will maintain confidentiality and authorized use as outlined in the agency's records management policies.

CYAC records can only be viewed by the CYAC agency. Records are not shared beyond the scope of what was agreed upon with the client. Access to the records is for the purposes of providing service to the client, quality monitoring processes and supervision.

Client requests to view their CYAC file will be met according to the CYAC agency's policies and procedures.

Shared Records

Shared records may exist in the form of action plans created during the course of the MDT case management process. In these situations, the CYAC agency will record the action plan during case reviews. Action plans assign the roles and responsibilities for each MDT partner and timelines for follow up on the case plan. The action plan may be distributed to all MDT members and kept on the CYAC file.

VII. Guiding Frameworks in CYAC Models

There are a variety of concepts and frameworks that apply to the overall work of CYACs and these should be embedded in each aspect of service that is provided. For example, cultural safety must be considered when developing and providing interviewing, case management, mental health and health services for clients of a CYAC.

In this section, we provide background on these different concepts and practices as context to the principles presented in this manual.

1. Provision of service to Indigenous children, youth, families & communities

As a network, we recognize the uniqueness of Indigenous cultures and the Indigenous children, youth, families and communities that we serve. The Network acknowledges that the work of our centres takes place on traditional, ancestral and unceded Indigenous territories. We acknowledge the importance of and meaningfully fulfill our role in truth and reconciliation.

When working with clients who are Indigenous, First Nations, Inuit, or Metis it is imperative that the CYAC does so with commitment to:

- the use of Indigenous-specific trauma-informed knowledge;
- acknowledging the role of the individual, family and community in the child or youth's healing and how colonization introduced devastating impacts to Indigenous peoples' health and well-being through forced displacement from their land, disconnection from culture, purposeful breakdown of family and community structures, language, ceremony and tradition; and,
- striving towards improved health and wellness outcomes for Indigenous people.

It is recommended that the CYAC partnership and stakeholders receive training and engage in knowledge gathering in the following areas: colonial history and the specific history of the Indigenous Nations, communities and groups where the CYAC is located, anti-racism, unconscious/conscious biases, trauma-informed practice, and cultural safety and humility. These expectations are in alignment with recommendations from the *In Plain Sight* report, the UN Declaration on the Rights of Indigenous Peoples (UNDRIP), and the Truth and Reconciliation Commission of Canada (TRC) Calls to Action, the Final Report on Missing and Murdered Indigenous Women and Girls, and other publications.

The need for strengthening awareness and knowledge of Indigenous histories, worldviews and their practical applications when interacting with victims, families and communities has been further emphasized in *Reclaiming Power and Place: The Final Report of the Nation Inquiry into Missing and Murdered Indigenous Women and Girls*, released in June 2019. In November 2019, British Columbia formally adopted the UN Declaration on the Rights of Indigenous People by passing the *Declaration on the Rights of Indigenous Peoples* Act (Declaration Act or *DRIPA*) as the province's framework for reconciliation.

With respect to CYAC work with Indigenous clients in British Columbia, MCFD's *Aboriginal Policy and Practice Framework in British Columbia* (2015) document outlines a pathway towards restorative policy and practice that supports and honours Indigenous peoples' systems of caring, nurturing children and resiliency. Cultural values of respect, inclusion, truth telling, wisdom and belonging guide and inform policy and practices when working with all groups.

These values are defined in the following ways:

Respect: To hold esteem, recognition and regard for the knowledge, traditions, distinct cultures, languages and processes of Aboriginal children, youth, families, and communities, and to be informed of Aboriginal histories and current experiences.

Inclusion: To involve and engage Aboriginal peoples, including working with families and communities in partnership, with an emphasis on a spirit and practice of collaborative and inclusive decision-making.

Truth Telling: To listen and share in an honest and open way, beginning with Aboriginal children, youth, and families.

Wisdom: To know that culturally significant knowledge, the teaching of histories and experiences are relevant and must guide choices, actions, and decisions.

Belonging: To support caring and nurturing relationships where Aboriginal children, youth and families have a positive sense of family and community, feel valued and safe and have a positive sense of place and belonging (pp. 10-11).

The *Aboriginal Policy and Practice Framework* document also offers a conceptual foundation for fostering cultural safety for Aboriginal children, youth and families.

Roles of Ancestors, Community, Elders, Family and Extended Family in Upholding the Sacredness of:

Children: Aboriginal cultures honour the sacred link between past generations and their responsibilities for current and future generations. The family, including extended family, is recognized as the expert in caring for their children. Elders and traditional knowledge keepers also hold an important role in sharing the traditional values and sacred teachings of caring for and nurturing children.

Cultural Safety: A sacred space where culture can be freely expressed, shared, learned and supported. Cultural safety is a theory and practice that takes into account power imbalances, institutional discrimination, colonization and colonial relationships as they apply to social policy and practice.

Culture, Tradition, Values, Language and Identity: The roles of culture, tradition, values and language are essential to the well-being of Aboriginal children, youth and families, and are fundamental to healthy processes of identity formation. The way in which services are delivered – and the way in which Aboriginal children, youth and families are engaged with these services – must reflect and respect their cultures, language, traditions, and values.

Interconnectedness and Relationships: A pivotal element of Aboriginal cultures and worldviews is that all living things and the environment are interconnected and interdependent. Children, youth and families cannot be viewed in isolation from their extended family, their communities and the mental, physical, environmental, social and spiritual realms of their lives. Indeed, everything must be viewed through the lens of "relationships", both past and present.

Diversity, Self-Determination, and Autonomy: There is vast diversity amongst Aboriginal peoples and communities, and it is critical to support the aspirations of all Aboriginal peoples to lead the development of policy and practice, as well as decision making regarding their children (pp. 13-15).

In their work with children and communities who have been impacted by inter-generational traumas and abuse, CYACs have a responsibility to uphold the process of reconciliation and it is imperative that this is considered at every stage of development and operation of a CYAC, including for each and every child, youth and family that is served.

The Network commits to proactive and continuous learning and growth in the area of reconciliation and is embarking on work to further develop practice principles for CYACs.

2. Cultural Safety, Equity, Diversity & Inclusion

CYACs are intended to meet the needs of the children, youth and families of the communities they serve, and as such, all MDT members must be able to understand the client's worldview and their experiences, and adopt practices that will foster the best outcomes for clients (National Guidelines). An inclusive attitude and approach in all aspects, from the beginning of service through to the end of the client's case, must take into account:

> age/generation, national origin, culture, ethnicity, spirituality, socioeconomic status, ability, gender identity and/or expression, sexual orientation, learning/communication skills and style, or family structure. These factors including their intersectionality, contribute to an individual's worldview, unique perceptions and experiences through the investigation, and should influence interventions and case management processes (page 9).

If all these aspects are considered and the approach is inclusive, there is a greater chance that children, youth and families will feel welcomed, regardless of their background, and be more apt to engage in services and embark earlier on the path to healing.

In 2018, the BC Provincial Roundtable meeting held with cross-sector service providers revealed several dominant themes in this area, including:

- cultural responsiveness and inclusivity must be embedded as part of the CYAC model, not as an "add on";
- the Truth and Reconciliation Commission recommendations must be part of the core values that everyone adheres to and promotes;
- engagement with communities and development of relationships in order to guide practice; and,
- flexibility and taking the lead from the child to guide frontline service.

The Roundtable provided a summary document of the discussions in this area and a work team on the topic of equity, diversity and inclusion will be struck in order to review those discussion materials and to create and publish specific practice principles for use by CYACs. In the meantime, for further background reading, please refer to the *NCA Standards* and the *National Guidelines*.

3. Trauma-Informed Practice

Trauma-Informed Practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma. It emphasizes physical, psychological, and emotional safety for everyone, and creates opportunities for survivors to rebuild a sense of control and empowerment[12].

The Healing Families, Helping Systems: A Trauma-Informed Practice Guide for Working with Children, Youth and Families (TIP Guide) (2017) was created by a cross-sectoral, government-led work team to guide the professional work of practitioners assisting children, youth, and families in British Columbia.

The TIP Guide includes the following four principles within which a trauma-informed approach may be incorporated:

A. Trauma Awareness - A trauma-informed approach begins with building awareness among staff and clients of the commonness of trauma experiences; how the impact of trauma can be central to development; the wide range of adaptations people make to cope and survive after trauma; and the relationship of trauma with a range of physical and mental health concerns. This knowledge is the foundation of an organizational culture of trauma-informed care and one that supports worker wellness. Trauma-informed services involve service users, practitioners, managers, and all other personnel working in ways that demonstrate this awareness of the needs of people who have experienced trauma.

B. Emphasis on Safety and Trustworthiness - Physical, emotional, and cultural safety for clients is key to trauma-informed practice because trauma survivors often feel unsafe, are likely to have experienced abuse of power in important relationships and may currently be in unsafe relationships or living situations. Safety and trustworthiness are established through practices such as welcoming intake procedures; adapting the physical space to be less threatening; providing clear information about the programming; ensuring informed consent; creating safety or crisis plans; demonstrating predictable expectations; and scheduling appointments consistently. The physical environment is developmentally appropriate for children and youth, and culturally safe for both clients and staff.

[12] https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/trauma-informed-practice-resources

C. Opportunity for Choice, Collaboration, and Connection - Trauma-informed services create safe environments that foster a sense of efficacy, self-determination, dignity, and personal control for those receiving care. When working with families, service providers will strive to equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to the type of service preferences whenever possible, and work collaboratively with clients. Opportunities are provided for families to provide feedback, ask questions, and express their concerns; similarly, clinicians and other MDT members have a forum for doing so in the context of their work environment. Importantly, having the opportunity to establish safe connections with service providers throughout the service delivery, and with families, peers, and the wider community as a whole - is reparative for those with early or ongoing experiences of trauma.

D. Strengths Based and Skill Building - Clients in trauma-informed services are assisted to identify their strengths and to further develop resiliency and coping skills. Programs strive to shift away from a model based on deficits to one that places an emphasis on developing strengths. Service providers recognize and value the strengths of their clients, and in partnership with children and their families they aim to support and empower the use of these strengths. In addition, service providers teach and model skills that enable clients to enhance their capacity for coping. Service providers ask about, and incorporate into treatment, their clients' interests, goals, coping and survival strategies, community connections and spirituality. Service providers use "person-first language" (e.g., children who have experienced abuse; children with special needs). Attention must be paid to practitioners' competencies and learning these skills and values. (p. 13). It is recommended that MDTs are trained in the area of trauma-informed practice and that the foundation of procedures and protocols of a CYAC include TIP principles and practices.

VIII. Practice Principles

The practice principles outlined in the following sections are intended to guide the development and practice of CYACs. They are built on the work that came before their creation, primarily in the National Guidelines, and are intended to provide province-specific guidance in CYAC work.

The principles are meant to be embedded with the guiding frameworks above. It is recognized that in practice, these principles may be adapted differently depending on the size and geographic location of the CYAC community and the resources and partnerships within that CYAC. However, it is expected that each CYAC will strive to implement these practice principles in the spirit in which they are intended – which is to support evidence-based practice that meets the unique needs of children and youth.

1. Case Management Practice Principles

The practice principles of case management are organized according to the flow of services from first report and entry into to a CYAC, throughout the time services are provided, and until file closure. Each practice principle is followed by a more detailed description of the principle and its rationale. CYACs will endeavour to implement these guidelines in the spirit of providing child- and youth-focused, collaborative case management for improving outcomes for children and youth and their families.

a. Principle: CYACs will collaboratively support children and youth who have experienced abuse or violence.

CYACs will serve children and youth who have experienced or witnessed abuse or violence including:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Domestic or Intimate Partner violence
- Sexual exploitation
- Trafficking
- Neglect
- Risk or threat of potential harm

This principle is consistent with the mandates of CYACs elsewhere in Canada and throughout the United States. Cases where a child or youth has experienced any of the above benefit from a multidisciplinary and coordinated investigative response to the allegations, with services and support provided by multiple systems over an extended period of time.

b. Principle: CYACs will support children and youth of all ages who have experienced abuse or violence.

In British Columbia, a child is defined as 0 to 18 years old, and CYACs may continue to serve clients beyond the age of majority when their case has ongoing involvement with the criminal justice system (eg. trial, sentencing), or if the client has other related needs. This principle is in keeping with a developmental understanding of adolescence, continuing through the entirety of the teenage years and possibly beyond, particularly for vulnerable youth who contend with adverse childhood experiences.

Centres may also agree to provide space to conduct interviews with developmentally delayed or otherwise vulnerable adults who would benefit from the supportive and welcoming CYAC setting.

It is recognized that some communities may need to phase in the service for different age groups over time. For example, in some jurisdictions, the mandate of specific police units connected to the CYAC is limited to children only while adolescents are served by other units. It is ideal that over time the CYAC services are expanded to serve all children 0 to 18 years of age.

c. Principle: CYACs will foster multiple points of entry to service for children and youth who have experienced abuse.

In most cases, clients enter the CYAC service through a report made to police or a child protection service.

DID YOU KNOW:

Relying on only one point of entry, such as direct reporting to a police non-emergency phone number, likely maintains low rates of child abuse reporting.

Retrospective Studies show that: Reports by adult survivors across Canada (Afifi et al, 2014) and adolescents in British Columbia (McCreary Centre Society, 2018) reveal staggeringly high rates of child abuse compared to the relatively low number of cases formally reported to law enforcement and/or child protection (Cotter & Beaupre, 2014).

Having several different pathways for children and youth to access a CYAC helps increase reporting and ensures that children and their families receive early access to relevant resources and age-appropriate services and supports to help their journey towards healing and wellbeing.

DID YOU KNOW:

Many children never disclose & some don't report until years later, due to:

- Family distrust of law enforcement; child protection and/or the courts
- Fear the abuse will become known in the community, bringing shame to the child & family
- Parents not believing their child's disclosure
- Fear of reprisal from the abuser
- Family preferring to support the child and move forward without involving external systems

CYACs can help to bridge the gap in reporting

Possible points of entry include police, child protection agencies, schools, community agencies and medical services. Mechanisms to assist in pathway development can include:

- local agreements for collaboratively assessing abuse allegations that reach each agency (eg. police, child protection, health sector); and
- inviting direct referrals to the CYAC from families or other community services while ensuring law enforcement and/or child protection agencies are properly notified.

These referral routes enhance the likelihood that the child, youth and non-offending caregivers will not face barriers and will feel supported at the initial stages of a case and proceed with making a report.

Educating and raising awareness is an important responsibility in promoting new service pathways to the CYAC. CYACs will work to engage all relevant partners and stakeholders who investigate or provide services on cases involving children and youth who have been the potential victims of abuse or violence.

d. Principle: CYACs will form a coordinated, multidisciplinary case management team for managing shared files.

A CYAC file is initiated when the child or youth could benefit from a multidisciplinary response. The CYAC partners bring together all relevant agencies to form a unique multidisciplinary team for each client case.

As described in Section 2, MDT ***partnerships*** usually consist of police, child protection agencies, victim service programs, Indigenous organizations, medical and mental health services, school districts and others. The MDT specific to a ***case*** may comprise *all or some* of the partner agencies and may also include stakeholder groups from outside the partnership. The case-specific team is made up of those with relevant roles depending on the services needed by the client at a particular stage of the file.

The MDT collaborates from the point of report and throughout a child, youth and family's involvement with the CYAC. The MDT for that case dissolves upon revocation of consent from the client, or when a child or youth no longer requires service.

e. Principle: Ongoing information sharing and communication form the basis of the CYAC response model.

Upon receipt of the client's consent for service and information sharing, the MDT partners will operate together in a spirit of collaboration committing to work through any challenges they face. The MDT will engage in regular communication about the needs and best interests of the child and their non-offending caregivers and family members from intake until the end of service.

COMMUNICATION between members of the MDT can take the form of:

- sharing details of the initial report between police and child protection
- preparations for the child to attend the CYAC
- debriefings following child interviews
- sharing case-related updates and developments related to investigations and support
- interventions, referrals, connection to service
- court preparation and participation
- participating in formal case conferences and case reviews.

Although each discipline or agency has distinct responsibilities that are specific to their mandate, their focus within the CYAC setting is to ensure that their collective response is:

- **child-focused**, recognizing and prioritizing the needs and experiences of the child or youth
- **coordinated**, thereby reducing the onus on the family to navigate systems and services and minimizing the need for the child or youth and family to repeat their story and provide their personal information in multiple settings and to multiple professionals.

A coordinated MDT approach serves the following functions:

- facilitates the efficient gathering and sharing of information;
- broadens the knowledge base with which decisions are made by including information from many sources; and,
- improves communication among agencies.

More thorough and shared information and improved along with timely evidence-gathering throughout a case contributes to a more successful outcome. A MDT response also fosters education, support and treatment for children and families, which may enhance their willingness and ability to participate in any court processes.

On a case-by-case basis, CYACs may choose to provide service to a caregiver causing harm[13] in cases where family preservation or reunification is an established goal or other circumstances exist where this service is in the best interest of the child or youth.

[13] For example: cases where the child has only one guardian but is not removed by child protection and only the alleged offender can consent to service. This may also be considered where the child is removed and the intent is to return them home.

f. Principle: Youth will be assessed for mature minor status.

Youth who access CYACs often have many vulnerabilities and may not be ready to share traumatic events with their parents or guardians. In order to ease access to MDT services, CYACs must support the option for youth to engage in services on their own. Early building of rapport and trust with the advocate or another MDT member can make it possible for youth to begin to feel safe, to share, and give voice to their perspective on their needs, thus enabling a connection to services. Such an approach may help prevent the development of future mental health concerns or other issues by addressing therapeutic and support needs in a timely, child-centered way.

The CYAC should have a clear policy and process for providing service to mature minors. Considerations should include:

How to assess for capacity to consent to service

Minors under the age of 19, if found to be mature enough, can consent to services. The service provider needs to be satisfied that:

- The youth understand the nature and consequences as well as the benefits and risk of the proposed plan of care; and,
- They have made reasonable efforts to determine and decide that the services are in the youth's best interests. (Please refer to BC. *Infants Act*).

The assessment process should include asking a series of questions of the youth to ascertain if they have the maturity (the cognitive, physical and emotional capacity) to consent to CYAC services. Moreover, their consent must be given voluntarily, and be consistent with the information that a reasonable person would be expected to understand when making a similar decision for services.

Informed consent process

An assessment must be conducted in an objective manner and at a distance from parents to determine whether the CYAC service is in the youth's best interests. Therefore, the Advocate must create an opportunity to meet with the minor on their own to determine the minor's own sense of their needs and desire for services. Achieving consent may require several conversations and meetings at the CYAC.

If assessed as a mature minor, the service provider must respect the youth's right to receive or decline services. In some cases, where appropriate, it may be desirable to extend an invite for both the youth and legal guardian(s) to engage in services, and to obtain signed consent from all parties.

Documentation

The service provider should record their rationale for their determination that the youth has the necessary capacity to consent to CYAC services and include the process they followed to ascertain whether the youth understood the services being proposed and the risks associated, and their conclusion about the youth's cognitive capacity to understand.

Informing caregivers of mature minor status and information that can/not be shared with them

If the service provider has determined that the youth is capable of consenting to services, consultation with the parents on what is in the best interests of the child should only be done with the permission of the mature minor. If caregivers are questioning why their child is receiving services, they should be informed that their child has demonstrated their capacity to provide consent themselves as a mature minor. Caregivers should also be made aware that the service provider is required to abide by BC's privacy laws, PIPA and FIPPA, in the determination of what can be shared about a youth's personal information with the caregiver.

For more information, see: *Practice Guide: Children and Mature Minors' Capacity to Consent to Child and Youth Advocacy Program Services* at **Appendix 4**.

g. Principle: CYACs utilizing service dogs must ensure they are Accredited Facility Dogs.

Accredited Facility Dogs are meant to assist community care professionals in situations where there would be physical, social or emotional improvement with the addition of a dog and its specially trained handler (Pacific Assistance Dogs Society (PADS)).

CYACs are encouraged to consider having a facility dog to support child and youth clients and to only obtain them through an accredited organization[14]. The handlers must be trained through the accredited association.

Accredited Facility Dogs (AFD) can be deployed at CYACs in a variety of ways, depending on the work of the trained handler(s). AFDs may sit with children and youth before or after their interview to provide emotional support. They may accompany an interviewer to take a statement from a child. Some dogs will be deployed during the criminal justice system process and accompany children to court.

[14] See: Assistance Dogs International https://assistancedogsinternational.org

h. Principle: CYACs will provide services and supports to address the needs of the child or youth who has experienced abuse or violence as long as needed.

A child or youth who becomes the client of a CYAC may be on the MDT's caseload for an extended period of time depending on the complexity of the case and any ongoing court processes or client needs. During the life of a file, the MDT is assessing emerging or ongoing needs, developing and implementing action plans to address those needs and sharing relevant information in a timely way. As long as there is a role for the MDT and consent for service is maintained, a file will remain open.

A child, youth and family's involvement with the CYAC is concluded:

- When the family indicates that no further support is required; or
- When the MDT has connected the family to other sources of support and services to assist the family with needs that are outside the scope of the CYAC services; or
- When the MDT, through case review and discussion, has jointly agreed to closure of the child, youth and family's CYAC file; or
- When a client has revoked consent for service.

Any individual MDT agency may retain an open file after the conclusion of the CYAC file, however, the conclusion of the CYAC file signals that information sharing for the purposes of case management has ended.

2. Child & Youth Interviewing Practice Principles

The following practice principles were developed by a work team of cross-sector practitioners who regularly work in or close to the field of child and youth interviewing. Interviews are central to child abuse investigations and effective child protection processes and may be the start of the healing journey for children and youth victims of abuse and violence. The *National Guidelines* note that:

The manner in which a child, caregiver or witness is treated during any interview may significantly impact their understanding of, and ability to respond to the investigation process and/or criminal justice system, as well as potentially affect the reliability of statements from the child, page 11.

CYACs promote child and youth interviews that are developmentally appropriate, trauma-informed and culturally safe. Information provided during interviews of children and youth are used by investigative partners and the case management team to make decisions about next steps. It is expected that each CYAC will make every effort to implement these practice principles to support an evidence-based[15] interviewing practice that meets the unique needs of each child and youth.

[15] The best practices research cited throughout this section comes directly from a variety of sources synthesized and consolidated into a bulletin published by the U.S. Department of Justice. For ease of reading, individual citations have not been included in this section, but it should be referred to for more detailed information, and for a comprehensive list of references. The citation is: Newlin C, Steele LC, Chamberlin A, Anderson J, Kenniston J, Russell A, et al. Child forensic interviewing: Best practices. OJJDP Juvenile Justice Bulletin. 2015. Retrieved from https://www.ojjdp.gov/pubs/248749.pdf.

a. Principle: Child and youth interviews are conducted within a CYAC[16] model of service, where it exists, and are video and audio recorded.

Using a CYAC interview room helps to ensure a child-focused setting that is comfortable, private, has minimal distractions, and is both physically and psychologically safe for diverse populations of children. The room should be equipped for audio and video recording and necessary multi-disciplinary staff must be able to remotely observe the child interview.

Audio and video recordings are the complete and accurate way to document child interviews. They allow the trier of fact in legal proceedings to witness all forms of the child's communication in a transparent way, and document inappropriate interactions with the child by the interviewer(s), should they occur.

[16] Emerging research suggests that remote interviewing may be a strong option where in-person interviews by a skilled interviewer cannot take place. The principles will reflect that research once it is available.

b. Principle: Child and youth interviews are monitored by all relevant investigative agencies involved in a case.

Monitoring by other investigative agencies is a trauma-informed approach to reduce the number of statements a child or youth needs to provide to systems professionals. Monitoring also provides a level of quality assurance for interviews.

The interviewer should communicate with the team members monitoring the interview to determine whether to ask additional questions or whether there are any ambiguities or apparent contradictions to resolve. The interviewer often has to balance the team's request for further information with the need for the interview to be conducted in a legally sound manner and with the child or youth's ability to provide the information requested.

c. Principle: Child and youth statements are taken by skilled interviewers.

Skilled =
recognized training +
recent experience +
demonstrated competency

To be considered *skilled* an interviewer should have:

- Undertaken recognized training in interviewing of children and youth that includes a practice component;
- Recent experience in conducting interviews of children and youth whether through the recognized training program's practice component, a mentorship program of monitoring interviews and being monitored, or ongoing interviewing of children and youth; and,
- Demonstrated competency in interviewing children and youth (*see* **Appendix 5**).

It must be considered whether the interviewer possesses the abilities to interview a specific child or youth with respect to:

- the developmental level of the child;
- cultural competency as it relates to that child; and,
- the language abilities of the child.

An interview of a child is a developmentally sensitive and legally sound method of gathering factual information regarding allegations of abuse or violence. The interview is conducted by a competently trained professional utilizing research and practice-informed techniques as part of a larger investigative process.

It is widely accepted that professionals should have formal initial and ongoing child interview training; there is no single standardized training model. Child interviewers often receive training in multiple models and use a blended approach to best meet the needs of the child they are interviewing.

Consideration of the age and development of the child is essential; Lamb (2015) states that “age is the most important determinant of children’s memory capacity” (as cited in Newlin et. al, 2015: p. 3). Adolescents vary greatly in their verbal and cognitive abilities and may be reluctant to ask for assistance. Interviewers must guard against unreasonably high expectations for teenage witnesses and should not adopt a less supportive approach.

A child’s family, social network, socioeconomic environment, and culture influence their development, linguistic style, perception of experiences, and ability to focus attention. Cultural differences may present communication challenges and can lead to misunderstandings within the interview. Interviewers should have clear-cut guidelines and strategies for taking culture into account. Interviewers should demonstrate their ability to be culturally safe through taking additional steps to prepare for interviews. For example, offering the participation of a local First Nation or organization to assist when conducting interviews for Indigenous children or youth.

Interviewers and investigators must consider the influence of culture on perception of experiences, memory formation, language, linguistic style, comfort with talking to strangers in a formal setting, and values about family loyalty and privacy when questioning children and evaluating their statements. For example, to make sure that interviews are conducted in a developmentally and culturally appropriate manner, advance planning should be made for special accommodations. Examples:

- If the interviewer and the child or youth speak different languages, the services of an interpreter should be arranged by the police or child protection social worker.
- For a child with autism, engaging a speech and language pathologist may be required.

d. Principle: The MDT connects as soon as a child or youth is identified, and there is regular communication and sharing of information during the interview phase.

The interview phase is defined as the period from when a case is identified through to when the debriefing of an interview with the MDT occurs. During this time, open and timely communication occurs between the relevant agencies while collaborating to ensure that each agency's responsibilities can be fulfilled and that the unique needs of the child and any safety issues are being considered.

- Sharing of information between police and child protection agencies can occur as soon as the case is brought forward by one of those agencies.
- Sharing of information between the remainder of the MDT may begin as soon as consent to share information for case management has been obtained. (Please refer to Case Management Practice Principles for more information on the consent-based service model). This may occur before or after the interview.
- Preparation for the interview of a child or youth is conducted jointly between the relevant investigative agencies. Coordinated planning prepares the interviewer by sharing information pertinent to the child, family or circumstances that may strengthen the interview.
- Joint processes and strong communication pathways ensure that child protection investigations do not move ahead of criminal investigations and impede any criminal justice response while respecting the timelines and responsibilities of child protection agencies to ensure the immediate safety of children.
- A debriefing process between agencies is in place once an interview is completed.

Interviews are best conducted within a multidisciplinary team context, as coordinating an investigation has been shown to increase the efficiency of the investigation while minimizing system-induced trauma in the child.

Before the interview, multidisciplinary team members[17] should discuss possible barriers, case-specific concerns, and interviewing strategies, such as how best to introduce externally derived information, should that be necessary.

[17] At this time, there are efforts being made on how to have CYAC staff included at the pre-interview stage ,as consent is not typically obtained by the client/legal guardian for MDT information-sharing. As such, currently it is the police and child protection (MCFD/DDA) MDT members who are able to preplan without consent.

e. Principle: Joint training of MDT members on interviewing techniques is regular and ongoing.

- Joint training of the MDT ensures that roles and responsibilities of each agency, with respect to interviewing, are clear and understood.
- Joint training allows a sharing of perspectives and needs of each relevant party.
- Crown counsel will be invited to participate in training on interviewing skills to facilitate a shared learning process and common understanding.
- Statements from children may have different uses, for example: criminal investigation, criminal court, child protection and safety. It is important to understand the needs of each potential user of a child's statement and how that statement may be used.

Knowledge of child interviewing significantly increases through training. Therefore, it is now widely accepted that professionals should have formal initial and ongoing forensic interview training. In the U.S., the field has yet to determine one standardized practice to follow throughout the country. Although training programs are generally based on the same body of research, some differences exist. Focusing on the variations among them often obscures consistencies within the various forensic interview models. However, forensic interviewers often receive training in multiple models and use a blended approach to best meet the needs of the child they are interviewing.

In 2010, representatives of several major forensic interview training programs - the American Professional Society on the Abuse of Children, the CornerHouse Interagency Child Abuse Evaluation and Training Center, the Gundersen National Child Protection Training Center, the National Children's Advocacy Center, and the National Institute of Child Health and Human Development[18] - gathered to review their programs' differences and similarities. The resulting discussions led to the bulletin (Newlin et al., 2015) which consolidates current knowledge on the generally accepted best practices of those conducting forensic interviews of children in cases of alleged abuse or exposure to violence.

[18] For further information, please see: www.apsac.org; www.cornerhousemn.org; www.issuu.com/gundersenncptc; www.nationalcac.org; and www.nichd.nih.gov

f. Principle: CYACs have an established peer review process for child interviews.

Peer review is a structured process for child forensic interviewers to receive feedback on their interview. The facilitator of the peer review must be trained and experienced in child interviews. The structure of the review can range from formal to semi-formal and include various partner agencies. (For more information, please refer to **Appendix 5**: Peer Review Rubric for Child Interviews).

Participation in peer review is vital in assuring that interviewers develop and strengthen their skills based on new research and developments in the field that impact the quality of their interviews. Peer review is a complement, not a substitute, for supervision, case review and case planning.

Key Principles:

- Peer reviews are scheduled, conducted regularly and at a minimum number of times per year
- Peer reviews are facilitated by trained and experienced child interviewers/peer review experts
- A structured feedback model is used
- In order for enhanced learning, a culture of safety is developed and maintained
- Peer review processes are not connected to job performance
- The recommended process for recording peer review notes is followed

Training does not always translate into significant changes in interviewer practices. Peer reviews should help interviewers integrate the skills they learned during initial training and also improve their practice over time.

Peer review is a facilitated discussion with other interviewers or team members and is intended to both maintain and increase positive practices in child interviewing. It is an opportunity for interviewers to receive emotional and professional support and for other professionals to critique their work. The peer review should be a formalized process in a neutral environment with established group norms and a shared understanding of goals, processes, and purpose. Training in the use of tools for providing more effective feedback (e.g., guidelines for giving and receiving feedback), checklists to assist peer reviewers in defining practice aspects for review, and strong leadership can assist practitioners in establishing a meaningful and productive process.[19]

At **Appendix 5** you will find a *Peer Review Guide* created as a companion to the above practice principle.

[19] In addition to the U.S. Department of Justice Bulletin cited in Footnote 2, resources for this section also include: NCA Standards for Accredited Members (2017, page 22); California Peer Review Guide (2016); and, Price, H., & Roberts, K. The Effects of an Intensive Training and Feedback Program on Police and Social Workers' Investigative Interviews of Children (2011).

3. Health Services Practice Principles

Health services is an essential part of the CYAC coordinated response to abuse and violence against children and youth. Services can be offered through the formalized CYAC partnership or through linkage agreements with health providers. The available services should include access to:

i. Forensic medical exams,
ii. General health or wellness exams,
iii. Mental health[20] and behaviour assessments.

For the purposes of this section, “medical evaluation” is used and means any of the above services.

[20] Mental health screening and assessment is outlined in Section 4 of this manual.

The purpose of offering these services is to ensure the health of the child as well as their safety and well-being. Areas of focus include:

- Screening for injuries and medical conditions, differentiating medical findings that are indicative of abuse apart from those which may be explained by other conditions (*NCA Standards*, 2017, p. 34);
- Collecting forensic evidence and providing a medical diagnosis and/or opinion for the purpose of an investigation;
- Identifying and documenting medical findings resulting from abuse (p.34);
- Initiating necessary treatment;
- Assessing for risk of vulnerability to abuse or violence (ie. developmental, emotional or behavioural issues needing further assessment and treatment, and mental health screening); and,
- Reassuring and educating children and families about their well-being.

Forensic medical examinations need to be conducted where a suspicion of child sexual and/or physical abuse has been identified. These exams may form part of the investigative process and evidence-gathering. Additionally, children and youth may present with emerging health concerns long after an assault has taken place or an investigation is completed and services need to be offered that are tailored towards their specific needs. Children and youth who are identified as vulnerable or having emerging health issues should be offered a general health and wellness examination or “wellness check” to provide an affirmation of their health. If needed, this would include a comprehensive medical assessment with on-going specialized care. Behavioural assessments may be required in cases where a child or youth has an ongoing or emerging issue in this area.

As the intention of CYACs is to go beyond investigative work and promote healthier, more resilient children, youth and families, the focus is on providing a complete set of services based on their needs.

a. Principle: Health services are a formal partner within the CYAC MDT model.

The role of health services as part of the MDT response is to mitigate system-induced trauma, re-traumatization, re-victimization, multiple examinations, loss of potential evidence, and delay in medical care.

This partnership is formalized in the local Memorandum of Understanding and/or Partnership Agreement and specifies the services provided, how information is shared in a legal and ethical way and participation in case management activities.

The *National Guidelines* recommend that all medical service providers who conduct medical evaluations at CYACS should have "adequate training, on-going continuing education and access to up-to-date equipment" (page 11). Further, they should be familiar with the latest research on child abuse and non-child abuse findings, sexually transmitted infections and recommended guidelines from their professional associations (p. 11).

Health care providers will educate the clients, caregivers, as well as the other MDT members regarding the purpose, nature, and benefit of a tailored health services.

b. Principle: CYACs will build partnerships with their local Indigenous communities and Indigenous-serving organizations to ensure the delivery of health services in a culturally safe manner.

By creating partnership and engaging in ongoing evaluation, health services can be delivered from a culturally safe perspective by:

- Using cultural safety and humility in seeking the potential paths of healing
- Health services striving to create a culture of equity and inclusion
- Providing training for health services professionals, in cultural safety and humility, systemic racism and unconscious/conscious bias[21]
- Demonstrating a commitment to best practice in MDT health services work.

[21] This is regular, ongoing training for MDTs that provides opportunities on the issues to support the evolution of all MDT service professionals' skills.

c. Principle: The CYAC partnership will strive to make health services available to all children and youth.

Health services will be routinely made available to all CYAC clients and coordinated as part of the MDT response. CYACs should have interagency protocols established which outline the linkages to health care service partners in order to provide services locally, where possible.

The CYAC's operating procedures should include the circumstances under which a forensic evaluation and/or wellness examination is recommended in acute, non-acute, or historic cases. The timing of medical evaluation is central to many child abuse investigations and an immediate consultation with the MDT will allow for critical decision-making about an examination and its timing (*NCA Standards, p.11*).

"The referral of children for medical examinations should NOT be limited to those for which forensically significant information is anticipated" (National Standards, p.30).

In most cases, children and youth should be provided with a "wellness exam" as part of the services coordinated by the CYAC. A routine physical examination whose purpose is to provide reassurance to the child, youth and family as well as to prevent future issues related to the abuse and trauma experienced should be offered.

d. Principle: The findings of the medical evaluation are shared with the MDT in a routine, timely, and meaningful manner.

The medical evaluation is an important aspect of the response to cases of child abuse and neglect, and for effective case planning decisions to occur, the medical examination findings need to be shared and explained to the MDT. This should be built in as a matter of regularly scheduled practice.

Sharing with the MDT in a responsive and timely way ensures that information gathering is coordinated, rather than duplicated. It is important that treatment recommendations from an acute or wellness exam are shared with the MDT so that the team can reinforce the recommendations and assist with access to services.

Detailed medical reports will usually not be shared with the entire MDT and may be requested by the investigative agencies to use for evidentiary purposes.

At some centres it is the non-medical CYAC staff who introduce the client to the medical evaluation component of service, so it is critical that MDT members receive training so they can answer basic questions about the purpose of the medical evaluations. Equipping staff with this knowledge can help demystify and reduce anxiety for children, youth and families about how evaluations are conducted and what the findings or lack of findings mean. CYAC staff need to be sensitive to clients' previous history and experience around medical providers, including mistrust of systems, racism, discrimination and cultural or religious beliefs around healing (*National Guidelines*, p. 16). As always, the MDT should follow the privacy and confidentiality policies and procedures outlined in the MOU/Partnership Agreement.

e. Principle: Medical providers must meet the training and eligibility standards for their respective scope of practice and engage in continuous quality improvement (CQI).

The *National Guidelines* advises, along with sufficient training, access to the latest equipment and continuing educational opportunities for all medical clinicians who conduct medical evaluations at CYACs.

Systems need to be in place that allow for consultation with "established experts" who can give a second opinion where findings are believed to be abnormal or unclear (p.16). In the United States, The *NCA Standards* outlines establishing a regular peer review process for medical professionals in which to participate, that will support best practice, competencies and systems meeting best standards.

At present, in British Columbia, medical partnerships are in a development stage with most CYACs. As such, CYACs and health services partners are encouraged to work towards the *National Guidelines* to set up processes to facilitate peer review and ongoing professional development.

For further reading, please see: **Appendix 6**: Standards for Medical Evaluation or see the *NCA Standards*.

4. Mental Health Service Practice Principles

The link between experiences of child abuse and later mental health challenges is well established and can extend throughout the lifespan. When a child or youth is abused, timely access to mental health interventions helps reduce the impacts of abuse, both in the short and long-term.

Providing support for caregivers[22] can enhance their ability to support and protect their child, moving the family in a direction of healing and safety (*NCA Standards*).

This section outlines practice principles for the delivery of mental health services to children and youth seen at CYACs.

[22] By addressing caregivers' own mental health (ie. histories of trauma, abuse, guilt, grief) the family as a whole will experience improved outcomes. This includes siblings who may benefit from having the opportunity to access therapy (NCA; 2017: p. 36).

a. Principle: Mental health services are a formal partner within the CYAC MDT model.

The purpose of delivering mental health services through CYAC partnership is to ensure quality and appropriately responsive services to all child or youth victims. Mental health services may be delivered either directly by the CYAC, or through partnerships or agreements with other organizations and/or community service providers. Partnership is formalized in the local Memorandum of Understanding and/or Partnership Agreement and specifies how the services are accessed, how information is shared in a legal and ethical way and participation in case management activities.

CYACs in British Columbia will provide, or connect clients to, mental health services that are culturally safe including to local Delegated Aboriginal Agencies who provide these services.

b. Principle: Mental health services are developed and delivered within a trauma-informed practice framework.

An understanding of trauma, and its impact on individuals, families and communities, is integrated into the service delivery model. Trauma-informed mental health services for children and their families and caregivers are provided in ways that:

- Recognize the universal need for children and youth's physical and emotional safety
- Build self-efficacy and positive self-regulation skills
- Create relational and cultural safety in all aspects of trauma-informed work
- Engage parents and caregivers in respectful and non-traumatizing ways, where further traumatization or re- traumatization (events that reflect earlier experiences of powerlessness and loss of control) is mitigated and where clients can learn and grow at a pace that feels safe.

c. Principle: Mental health services are conceptualized and delivered in a culturally safe and restorative manner that supports a process of reconciliation.

CYACs commit to ongoing efforts to increase cultural safety for their clients through fostering an anti-racist, anti- biased and anti-oppressive environment. CYACs work to acknowledge, value and create safe spaces for individuals across cultures, genders, sexual orientation, ability, incomes, and belief systems.

CYACs need to learn about the communities they serve through developing and nurturing relationships with community organizations. Establishing diverse advisory committees that represent the populations served can help guide the development and implementation of programming and treatment (*National Guidelines*, 2021: p.10.) Forming relationships with cultural knowledge keepers will inform the design and delivery of mental health services that reflect, and respect cultures, languages, traditions, values, and histories of colonization represented among the peoples and communities served by the CYAC.

d. Principle: Clinicians working with CYACs will practice within areas of competence and continue to develop and enhance professional competencies.

The *National Guidelines* recommends that mental health services and treatment are provided by professionals with trauma, child abuse and child development expertise. Also, "mental health professionals should meet the relevant provincial/territorial licensing requirements and/or standards" (p. 17).

The professional providing mental health services will possess the following qualifications:

- Minimum of a master's degree in a mental health or counselling-related field (e.g., Psychology, Social Work, Counselling).
- Registration with a professional licensing body (e.g., College of Psychologists of British Columbia; British Columbia College of Social Workers; British Columbia Association of Clinical Counsellors; Canadian Counselling and Psychotherapy Association); or be eligible for licensing with one of the bodies and supervised by a professional registered with one of these bodies.
- Training in the following areas: child development; child and youth mental health; child abuse and child trauma; developmental trauma.
- Ongoing professional development in providing trauma-informed and culturally safe therapeutic practices.
- Ongoing professional development in the field of child abuse, pertaining to developments that would impact their delivery of services to clients (e.g., new research on treatment approaches).

When providing mental health services, CYACs will consider the value of recruiting clinicians who are Indigenous and who reflect the rich diversity of cultural groups represented in the communities served by the CYAC. This will not only be an asset to the clients but will also strengthen the MDTs. CYACs will not make assumptions about culture and diversity but will instead approach its work with all groups from a standpoint of openness and curiosity to the needs and values of the individual.

e. Principle: Screening: The multi-disciplinary team will make a determination about the need for mental health services for the child and their family through a screening process.

The screening process is used to assess a child's emotional well-being in relation to experiences of abuse and/or their involvement in the investigative or criminal justice process. Screening may capture immediate, delayed, or long-term reactions to traumatic experiences.

Some children might have an existing connection to a mental health service that is considered by the child's caregiver and/or MDT as meeting the child's needs. Direct communication with that practitioner and the MDT should be pursued.

For children not currently connected to a mental health service, a screening, specific to trauma-related difficulties, will be offered. The screening is intended as a process that unfolds during the initial stages of the child's involvement with the CYAC. With consent, MDT members can share information relevant to the mental health needs of the child, increasing coordination and reducing duplication. When the screening suggests the need for mental health services, the CYAC will have a procedure for connecting identified children to further assessment and/or treatment. Such procedures remove the burden placed on families to navigate systems and referral procedures.

f. Principle: Assessment: Children screened as requiring mental health assessments will be referred to mental health professionals.

Mental health assessments help guide and specify treatment needs of children and youth. Assessments inform the development of treatment plans and monitor the progress of the treatment over time.

Assessments can vary in their size and scope – some can take place during the first appointment or as part of a service provider's intake process. Others, especially when the needs of the child or their family are complex, may require several sessions to complete.

Assessment includes the following components:

- Gathering a thorough trauma history: all forms of traumatic events experienced or witnessed by the child, including losses, family violence, community violence; and racialized violence.
- Assessing of the impact of the trauma on the child, such as reported symptoms, and the internal resources (ie: coping skills) and external resources (ie: attuned and supportive caregivers) that are available to the child.
- Using trauma-specific standardized clinical measures to identity the type and severity of symptoms the child is experiencing. Comprehensive trauma assessments use standardized measures that are shown to be reliable and valid, include items specific to trauma, such as assessing for PTSD symptoms and other common trauma reactions (e.g., dissociation and sexual behaviour concerns), as well as more general symptoms often observed in children who have experienced abuse, such as anxiety and depression.
- Gathering information about family functioning, particularly regarding the relationship between the child and their non-offending caregiver, and how the caregiver is coping with the child's traumatic experiences (i.e. assessment of parental stress) and how they understand and support their child's healing.
- Identifying the cultural needs of the child in relation to their healing: aspects of their culture, cultural identity and history, role of traditional healing practices, involvement of family, elders and community members in the child's well-being.

Some children will benefit from a more detailed and comprehensive psychological assessment. These assessments can be provided by one of the regional Suspected Child Abuse and Neglect (SCAN) clinics in the province of British Columbia. All CYACs should have relationship with the SCAN in their region in order to facilitate referrals.

g. Principle: Treatment: CYAC clients will be offered treatment services specific to their needs as identified through the assessment process.

Crisis Intervention: CYACs have a process for providing or connecting children and/or their non-offending caregivers in crisis to immediate mental health services.

Clients may experience crisis during any stage of the case file and this is frequently seen during the investigative stage. Crisis or urgent intervention refers to the response to significant emotional distress in the child, youth or caregiver.

These services are focused on establishing safety and stability. If possible, CYACs should consider having a clinician or staff on site to provide “bridge counselling” to provide immediate interim support to the child, youth and/or caregiver while referrals for further specialized mental health services are in progress.

Services to address concerns about suicidality may be referred to an emergency department or a specialized mental health crisis service, with the MDT supporting the family in accessing these services.

Therapy: When assessment of the child indicates the need for therapy, the child is offered a therapy that is supported by empirical evidence or is a "Wise Practice"[23].

There have been significant advances over the past decade in the development, evaluation, and dissemination of trauma-specific[24] treatments for children and adolescents who have experienced abuse. These treatments emphasize the importance of including non-offending parents or other caregivers in aspects of the treatment.

Mental health treatment needs to be offered and delivered in a manner that is trauma-informed (see TIP at Section VII.3). As outlined in the *Trauma Informed Practice Guide*, "trauma-specific services directly facilitate trauma recovery through specialized clinical interventions and Aboriginal traditional healing practices"[25]. Importantly, some children may benefit from treatments that target *other* behavioural, emotional or relationship difficulties (eg. parent-child conflict, problematic sexual behaviour, addictions, etc). These difficulties may need to be the focus of treatment, especially when the well-being of the child is closely connected to resolution of those difficulties and when there is an empirically supported or Indigenous healing practice that exists for that purpose.

Some treatments focus primarily on parenting to enhance the capacity of the parent/caregiver to support their child's healing and development.

[23] "Wise Practice'' is where traditional healing practices are integrated within evidence-based treatment models.

[24] The following electronic resources offer directories and information specific to empirically supported treatments for children who have experienced abuse/trauma: United States – California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/search/topic-areas/trauma-treatment-child-adolescent/; Canada – Vega Project, Family Violence Educational Resources: https://vegaproject.mcmaster.ca/

[25] Fitting for the treatment of (Indigenous) children who have experienced trauma, is a cultural adaptation of Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) called Honouring Children, Mending the Circle, which blends traditional Indigenous teachings with cognitive-behavioural methods, has been developed in the state of Oklahoma (see BigFoot & Schmidt, 2010).

h. Principle: CYACs will foster caregivers' capacity to support their child.

The mental health of the caregiver is an important factor in the caregiver's capacity to support their child.

Parents and caregivers may benefit from counselling and support that helps them address the emotional impact of the abuse allegations. As family members are often essential to the child's recovery, it is important to engage caregivers early in the treatment process. As soon as possible during their child's initial involvement with the CYAC, the caregiver will be supported by a mental health clinician or MDT member[26] in the following domains:

- Prioritizing the safety and well-being of their child;
- Mitigating the risk for future abuse;
- The emotional impact of abuse allegations on the child and the family; and,
- Concerns or distress that abuse allegations may trigger for the non-offending parent/caregiver.

CYACs will consider providing mental health treatment to caregivers, some of whom have victimization histories themselves or are current victims of intimate partner violence, or will ensure that caregivers are connected to other resources within their community that can effectively support them.

[26] Some victim service workers and ministry social workers have the requisite training to provide this initial support and education to parents and caregivers. Caregiver support groups led by a trainer facilitator are also a valuable offering.

i. Principle: Mental health professionals participate as part of the MDT case management team.

A mental health professional participating in the MDT case conference process ensures that the child's mental health and treatment needs are considered as the MDT makes decisions related to specific cases.

The CYAC partnership has written protocols or guidelines defining the role and responsibility of the mental health professional on the MDT, and may include:

- attendance and participation in MDT case conferences/reviews;
- sharing relevant information with the MDT;
- serving as a clinical consultant to the MDT on issues of trauma impact and treatment; and,
- supporting the MDT in monitoring progress and outcomes for children and families.

The CYACs procedural documentation should include provisions about how mental health information is shared, and about how client confidentiality and mental health records are protected.

The forensic process of gathering evidence and determining what the child may have experienced is separate from mental health treatment. Mental health treatment is a clinical process designed to assess and reduce the possible long-term adverse impacts of trauma or other diagnosable mental health conditions. Every effort should be made to maintain clear boundaries between these roles and processes.

Appendices/Templates

APPENDIX 1

Detailed Case Flow Process

Following are the general steps in a CYAC case. As every child and youth is unique, so is the case flow for that client. The steps may not always flow in the order set out below but most cases will go through most of the steps outlined.

1. An initial report is made to police or child protection. The agency receiving the report will contact the other party to determine whether this is a case to refer to the CYAC. Both parties will begin collaborative planning for conduct of the case.

   Note: A referral for an acute or forensic medical exam may be necessary at this time and take precedence.

   Note: "Self-referrals" can be made directly by a youth or caregiver or through a community stakeholder (eg. community agency, school) supporting a child or youth who is disclosing abuse or violence. The Advocate can assist in guiding the youth or support person with making the police and/or child protection report.

2. Disclosure statements and guardian statements are conducted prior to the child's interview and may occur over the phone, at the detachment or in other locations. Guardian statements are used to gather information about the child and are shared with the investigative agencies to prepare for the child's interview. MCFD/DDA should be involved in the monitoring of the guardian statements.

3. Once the investigative agencies have determined that a child interview is needed and they have shared any relevant information for the planning of that interview, the police and child protection agencies will prepare to jointly interview the child. They will communicate with the CYAC to coordinate the interview time and liaise with any relevant service providers to determine unique needs of the child or youth and any resources required (ie: translator). The designated MDT member will contact the youth or family to arrange the interview.

   Parents may ask the MDT member what they can discuss with their child. Caregivers can be told that they can talk with their child about how they are feeling, but not to discuss the (disclosure) event itself.

   Note: providing that the information sharing agreement of the CYAC service model permits this, the Advocate may seek consent from the client/legal guardian, to provide information and support to families prior to attending the CYAC. This may help to lower anxiety and provide the client with practical information (eg. location of CYAC, what to expect upon arrival).

   This is distinct from interview preparation, as police have direct contact with the family regarding interview-specific information.

4. Upon arrival at the CYAC, the child or youth and non-offending caregiver are greeted and oriented to the CYAC or child-friendly setting by an Advocate, CYAC Coordinator or Victim Service Worker who will ensure their physical and emotional readiness for the interview.

5. During the child or youth's interview, non-offending caregivers/family members will meet with the Advocate who will assess for immediate needs and provide resources. The Advocate will complete a service intake with the caregiver and answer questions about the process and roles of the MDT. The Advocate will outline the case management process, the MDT's information sharing approach, and the benefits of sharing between partners for effective service delivery and request consent from the caregiver.

   Note: Caregivers may meet with other MDT members at this stage.

   Note: If the client is a mature minor this step usually occurs after they have given their statement.

6. The MDT (or a subset of relevant MDT members, ie. police, child protection social workers, victim service worker, Advocate) debrief following the child or youth's interview to share relevant information arising from the interviews that will help determine immediate next steps. These may include basic needs (ie. food, money, shelter), safety planning to support the child and family, and to determine which agency will assume responsibility for specific tasks. The police and child protection social worker together speak with caregivers on next steps.

7. The Advocate, with input from the MDT, connects the child or youth and non-offending caregiver with services and necessary supports. Referral may be made for medical and/or mental health assessment or treatment. The Advocate will make plans with the child, youth and caregiver to meet again as indicated by the issues at hand.

8. Child protection and police continue to work on their respective investigations and to engage in information sharing.

9. Case reviews are conducted on a regular basis. This is an opportunity for the MDT, those with relevant roles from each agency depending on the involvement in the case at different stages, to share information and report on action items. These case management meetings are attended by a mix of frontline and supervisory personnel for each MDT agency.

   The CYAC agency coordinates case management meetings by facilitating communication between the MDT members during case reviews and tracks action items for the MDT.

   The Advocate/CYAC Coordinator maintains the client records for the CYAC and participates in the statistical reporting and evaluation process.

   A member of the MDT, as agreed upon by the MDT, serves as liaison to provide case-related updates to the family throughout the lifetime of the file.

10. The case management process ends when the MDT no longer has a role and the case is closed or the client has revoked consent. Individual agencies may continue to serve the client based on mandates or level of client need.

APPENDIX 2

Victim Service Worker Duties

Service models across the province differ in how Victim Services is embedded in the CYAC model. When working with children and youth, however, it is important to be knowledgeable since victim service work with "children, youth and families presents unique challenges to the worker that differ from work with individual adults" (Victoria Child Abuse and Counselling Centre; 2017: p.10).

The services provided by victim service programs contracted by the Ministry of Public Safety and Solicitor General are generally the same across communities.

Critical Incident Response

- Provide critical incident support and stabilization to victim
- Identify and address immediate emotional, safety, and logistical victim needs
- Liaise with justice system and/or medical personnel as required

Criminal Justice System - Information and Support

- Provide information to victims about their rights under the Victims of Crime Act (VOCA) and the Canadian Victims Bill of Rights
- Provide information about the criminal justice system process, and roles of key parties
- Assist victims to engage with justice system personnel (e.g., police, Crown counsel)
- Arrange, facilitate and/or accompany victims to meetings with criminal justice system personnel (e.g., police, Crown counsel, corrections staff)
- Support and prepare victims for the criminal court process

Safety Planning

- Develop safety plan with victim including coordination with community and criminal justice system partners where appropriate

Information and Referral

- Provide referral information about Ministry of Public Safety and Solicitor General supports (e.g., victim services, Victim Safety Unit, Crime Victim Assistance Program, violence against women counselling and outreach programs) and other supports (e.g., Ministry of Children and Family Development, social services, health services, counselling services, etc.)

Where victim service workers are involved with a CYAC and where resources allow, during the process of early investigation, the Victim Service Worker can:

- Provide updates to the child, youth and family on any court proceedings that are being scheduled and/or conducted
- Explain the process of a Report to Crown Counsel and update on progress
- Provide information to victim(s) about their rights under the Victims of Crime Act (VOCA)[27]
- Assist the family to complete Crime Victim Assistance Program (CVAP) funding forms and follow-up or advocate with CVAP as needed.

Where victim service workers are involved with a CYAC and where resources allow, if there is a criminal prosecution, Victim Service Workers can assist with:

- Arranging and accompanying to meetings with Crown Counsel, in the CYAC space where possible
- Supporting and preparing victims and non-offending family members for the criminal court process, including:
    - Discussing whether the child or youth may require testimonial accommodations
    - Preparing the child or youth for possible emotional responses to court proceedings and/or testifying
    - Providing court orientation by providing a courthouse tour, reviewing court room protocols, and providing public education materials
- Accompanying the child or youth to court; this may include the service of an Accredited Facility Dog
- Providing information about and assistance with completing Victim Impact Statements, and with registering for victim safety notifications
- Providing support to the child or youth and non-offending family member upon conclusion of the case, ensuring the child or youth and non-offending family members are aware of and understand the outcome, and have access to necessary follow-up resources including victim notification, where appropriate, and referral to any community supports where needed.

[27] Please see: Victims of Crime Act: https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96478_01

APPENDIX 3

Affirmation of Confidentiality Agreement Template

Child and Youth Advocacy Centre
Case Management Team
Affirmation of Confidentiality

I acknowledge that during the course of my work on the [CYAC] Case Management Team I may obtain access to and may disclose sensitive personal information to other members of the Team. I understand and affirm that I will hold such information in strict confidence.

I agree that any knowledge gained with regard to specific individuals as a result of my position on the Team is, and will remain, confidential, subject to very limited exceptions. I will collect, use and disclose personal information only for case management purposes. I will exercise due care that any personal information I provide to case management team members is information I am permitted to disclose pursuant to the privacy legislation which applies to my agency. If any question arises as to whether such information may be disclosed, I will refrain from providing the information until clarification is obtained.

I understand that once signed this Affirmation is irrevocable and continues to apply to me even when I withdraw from the [CYAC] case management team.

I have read the above *Affirmation of Confidentiality* and hereby affirm that I will abide by the terms herein.

_____	_____
Print Name	Signature
_____	_____
Date	Witness

APPENDIX 4

Practice Guide: Children and Mature Minors' Capacity to Consent to Child and Youth Advocacy Program Services

Background

The Child and Youth Advocacy Program is an interagency partnership that provides collaborative services to children and youth impacted by abuse and other crimes. Program partners may include: Police/RCMP, Child Welfare, Victim Services, Indigenous Organizations, and Transition Houses and Health-based agencies. Services may include forensic interviews, emotional support, advocacy, victim services, case management, and court preparation and support. Child and Youth Advocacy cases could involve anyone from an infant to an 18-year-old.

As investigative agencies, MCFD and police are not required to obtain consent before proceeding. However, for the case to be referred to the CYAC program, consent is required. This raises some key questions:

- Under what circumstances can a child or youth under age 19 consent to services provided by the program?
- Does the process for obtaining consent look different for a child or youth under 19 than it does for an adult?
- If the child or youth is not capable of consenting, which parent has the authority to consent on the child or youth's behalf?
- Under what circumstances can a child or youth under 19 make their own decisions about sharing their personal information?

Purpose of this Practice Guide

This document sets out guiding principles to help agencies and service providers navigate consent questions in the context of the CYAC Case Management Process. This Guide is not intended to be, and cannot be relied upon as legal advice. It is to be used in conjunction with participating agencies' internal privacy/confidentiality and records management policies. Individual service providers who are members of professional bodies may also have ethical frameworks which also need to be considered.

1. Under what circumstances can a child or youth under age 19 consent to the services provided by the program?

In BC, anyone age 19 or over is presumed to be capable of making decisions affecting their health and welfare whereas those under 19 (minors) are presumed to be incapable. But even a minor, if they are found to be mature enough, (a *mature minor*) can consent to health services or response services related to violence. According to BC's *Infant's Act* and case law, anyone under 19 is capable of consenting if the service provider:

- Is satisfied the infant understands the nature and consequences and benefits and risks of a particular plan of care and
- Has made reasonable efforts to determine and has concluded that the services are in the child's best interests.

There is no fixed age to determine whether someone is a mature minor, rather each case must be assessed individually depending on the maturity of the child or youth involved. In case law, the age range of situations where a child was deemed to be a mature minor runs from age 11 to 17. Some public agencies use age 12 as a benchmark to help determine whether a child has the legal capacity to consent.

2. Questions to Help Determine a Child/Youth's Capacity to Consent to the CYAC Case Management Process

To determine whether the child/youth is a legally capable of consenting to services, it is important to focus on their maturity, that is, their physical, emotional and intellectual capabilities rather than their chronological age. The following considerations can help guide the assessment process[28]:

- How did the child/youth behave?
- Are they able to adequately tell their story?
- Do they understand the nature of their situation?
- Are they able to make independent decisions?
- Do they understand their rights?
- Do they understand other points of view or possible outcomes in this situation?
- Do they understand the nature and consequences, benefits and risks involved in the process?
- Can they express consequences of their decision?
- Can they provide some details or points to justify their decision?

3. What are the Essential Elements of a Valid Child/Youth Consent?

It is often said that consent is a process not a form. Set out below are seven essential elements for a valid child/youth consent[29].

- The child/youth must be capable of making a decision about whether to give or refuse consent to the proposed advocacy services
- The child/youth's consent must relate to the proposed CYAC services
- The child/youth's consent must be given voluntarily
- The child/youth's consent cannot be obtained by fraud or misrepresentation
- The service provider must provide the child/youth with information that a reasonable person would require to understand the proposed services and to make a decision
- The child/youth should have an opportunity to ask questions and receive answers about the proposed services
- The proposed services must be in the child's best interests.

[28] This list of questions is adapted from: EVA BC. (March 2020). *Information bulletin: providing coordinated services to mature minors.*

[29] These essential elements are drawn from: Bryce, George K. (July 26, 2013). *BC Association of Clinical Counsellors legal commentary consent to counselling therapy services What counsellors need to know about the law of consent before they provide counselling therapy services to their clients.*

4. Best Practices for CYACs Seeking Consent

- Explain the nature and consequences, benefits and risks involved in the service
- Satisfy yourself that the child/youth understands
- Make reasonable efforts to determine that the services are in the child/youth's best interests
- Ensure the consent is voluntary, not the result of undue pressure
- Document your rationale
- Document the process you followed to ascertain whether or not the child/youth understood and appreciated the services being proposed and the risks. This would include any conclusions that you may have reached about the child/youth's intelligence and capacity to understand. If you are not skilled in performing such assessments, consult with a colleague who is more experienced.

5. Some Considerations in Determining What is in the Best Interests of the Child/Youth

The service provider's assessment as to whether or not the service is in the child's best interests must be done objectively and at arm's length from the parents. The service provider may consult with parents on the question of the child's best interests but should do so only if the child (if a mature minor) agrees.

It is important that the service provider not substitute their own opinion for that of the child/youth. The child/youth's view should not be dismissed simply because it does not accord with the view of the service provider. An effort should be made to understand the child/youth's reasoning. They may be mistrustful or fearful or unable to listen well due to trauma or mistrust of authority. It may be possible to address these issues by adopting trauma informed practices.

With respect to Indigenous children, Bill c-92 *An Act respecting First Nations, Inuit and Metis Children, Youth and Families*, lists 9 factors to be considered in determining best interests of the child including: importance to the child of an ongoing, positive relationship with their family, community and the indigenous group to which they belong; the importance of stability for the child; connection to the child's language and territory.

6. If the Child/Youth is Not a Mature Minor, Which Parent has the Authority to Grant Consent?

If the child is not a mature minor, the guardian who holds the appropriate parental responsibilities for the child has the legal authority to give consent. BC's *Family Law Act (FLA)* provides that when parents are living together and after separation, each parent is guardian of the child. Under the FLA, guardians are presumed to share all parental responsibilities, including decisions about health care and related services, in consultation with one another unless an agreement or court order provides otherwise. **This means that either parent may consent to have their child referred to the CYAC Program unless an agreement or court order allocates this responsibility to one parent or requires that they both consent.**

7. Does the Consenting Parent/Guardian Have to Consult with the Other Parent?

Under the *FLA*, the consenting parent/guardian is required to consult with the other parent/guardian unless this would be unreasonable or inappropriate. What is considered unreasonable or inappropriate would depend on the circumstances but would arguably include situations where consulting with the other parent/guardian would present a safety risk or if the location of the other parent is not known. The *FLA* requirement to consult does not mean that the other parent/guardian has to *consent*. Also, the service provider is not required to confirm that the consenting parent/guardian consulted with the other parent/guardian.

8. Best Practices When Obtaining Consent from Parents/Guardians

- Ask the consenting parent/guardian if there is a court order or agreement that requires consent of all parents/guardians or allocates decision-making to one parent/guardian
- If there is a court order or agreement assigning parental responsibilities, obtain a copy if possible
- If there is a court order or agreement assigning parental responsibilities, and the consenting parent cannot provide a copy, document that fact and any information the consenting parent provided regarding the contents of the agreement
- If there is no court order or agreement assigning parental responsibilities, then you may rely on the consent of either parent/guardian
- While you may rely on the consent of one parent/guardian, where appropriate, consider encouraging the consenting parent to help you obtain consent from the other parent/guardian
- If you are relying on the consent of one parent/guardian, document what that parent/guardian has said to you about consulting or not consulting the other parent/guardian.

9. What About Consent to Sharing the Child/Youth's Personal Information?

Applicable regulations under BC's privacy laws, including the *Personal Information Protection Act (PIPA)* and the *Freedom of Information and Protection of Privacy Act (FIPPA)*, provide guidance here. Many of the same considerations about capacity to consent to services come into play, namely:

- Is the child/youth able to understand their rights to confidentiality?
- Are they able to understand the nature and consequences of disclosure or non disclosure of their personal information?

As with the process for deciding whether a child/youth is able to consent to services, their age and level of development should be considered to determine whether they are capable of deciding for themselves.

Under *PIPA* and *FIPPA* regulations, the right to access personal information contained in a record may generally be exercised by a parent or guardian on behalf of a minor if the minor is not capable of making their own decisions about confidentiality. The regulations under *FIPPA* have been interpreted as also requiring that the parent or guardian be seeking access to the child/youth's information to protect or advance the child/youth's interests and not trying to obtain this information for their own use.

10. Best Practices When Deciding About the Child/Youth's Capacity to Decide about Release of Their Personal Information

- Document steps you have taken to determine the child/youth's capacity to consent to release of their personal information
- Consider the child's age and level of development. Is the child/youth able to understand their rights to confidentiality?
- Consider whether they are able to understand the consequences of disclosure or non disclosure of their personal information
- If you determine that the child/youth is not capable, then the parent or guardian can consent on the minor's behalf; in this situation, follow the best practices outlined above under: **8. Best Practices When Obtaining Consent from Parents/Guardians**

11. Outlining the Limits to Confidentiality: Best Practices

- Inform the mature minor (or their parent/guardian if the child/youth is not a mature minor), of the limits to confidentiality early in the relationship, at the first meeting if possible.
- Make it clear that subject to certain limited exceptions, their personal information will not be shared without their consent.
- Let them know what the exceptions are:
    - Someone is at risk of serious harm;
    - There is reason to believe a child is in need of protection under s. 13 of the *CFCSA*;
    - There is a court order requiring release of information.

Research and Writing

March 2021 Gisela Ruebsaat LL. B.

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APPENDIX 5

Child & Youth Interviewing Peer Review Guide and Rubric

Background

This guide was developed by a work team of cross-sector participants who regularly work in the field of child and youth interviewing. This document is meant to act as a guide for peer reviews of interviews within child and youth advocacy centre models in the province of British Columbia. It is recognized that in practice this guide may be adapted differently depending on the size and geographic region of the CYAC community and the resources and partnerships within that CYAC.

Once an interviewer has been trained on an evidence-based framework, peer review can provide additional skill-building opportunities.

What is Peer Review

Peer review is a facilitated discussion with one or more interviewers or team members and is intended to both maintain and increase desirable practices in forensic interviewing (Stewart, Katz, & La Rooy, 2011). It is an opportunity for forensic interviewers to receive emotional and professional support and for other professionals to critique their work (US Department of Justice, 2015).

Purpose of Peer Review

Building skills of interviewers is a practice principle of the child and youth advocacy centre models in BC. The purpose of peer review of child and youth statements is to promote the skills and comfort level of the interviewer by providing timely feedback on interviews. Peer review is considered a crucial addition to the formal training an interviewer receives, one that will assist interviewers to integrate the skills they have learned.

Psychologists Michael Lamb et al (2002) note: “In the absence of ongoing supervision and opportunities to re-examine their interviews closely, investigators tended to fall back on older, less desirable and less effective techniques. Continued discussion and problem solving within groups of investigators might have helped interviewers maintain superior interview practices.” (p. 40).

This peer review guide is not to be used for performance evaluation purposes. The process outlined in this guide is akin to mentorship and is based on an agreement of provision and acceptance of structured feedback in a confidential setting.

Timing

Feedback on interviews is most effective when provided in a timely way. Selecting a recent interview for peer review will best enhance the acquisition of new knowledge and skills and reinforce the methodologies of the structured interview process.

It is recommended that all interviewers taking statements from children and youth participate in the peer review process at a minimum of twice per year (*reference: taken from the National Children's Alliance Accreditation Standards*).

To avoid potentially frustrating a criminal prosecution, it is recommended that peer reviews not be conducted on interviews where the case is subject to a criminal investigation and charges are expected to be recommended, or the case is currently before the criminal court.

Reviewer

Reviewers should be selected based on a combination of knowledge, skills, and ability to communicate effectively with the interviewer. Reviewers must be trained in a structured methodology of child forensic interviewing. In some settings a group of peers may come together to perform reviews for each other while in other areas a reviewer may have to be selected from outside the interviewer's worksite.

Review Structure

The peer review should be a formalized process in a neutral environment with established group norms and a shared understanding of goals, processes, and purpose (US Department of Justice, 2015).

The peer review members agree to confidentiality of the information and feedback shared within the review process; this is essential for the emotional safety and comfort of all involved in order to foster sharing and feedback, to support professional growth and competency in the field of child and youth interviews.

The review of a child and youth statement should contain structured feedback. A Peer Review Rubric is included in this guide to provide the reviewer with categories for review.

Peer Review Documentation

As stated above, peer review documentation should not be used for the purposes of performance evaluation or where the case is subject to a criminal investigation and charges are expected to be recommended, or the case is currently before the criminal court.

As such, it is important that agencies have records management policy to address documentation created in peer reviews. This guide recommends that peer review notes are held outside of any personnel or case file records.

Peer Review Rubric for Child Interviews

STAGE ONE COMPONENTS: INTRODUCE RECORDING

CRITERIA	BEST PRACTICES	Y	N	N/A
Introduce Recording Prior to subject entering the room or at the beginning of the interview	Interviewer provides thorough information/best practices when introducing the recording: • Date/Time/Location • Interviewer and Monitor names • Subject Name/File #			
Comments:				

STAGE TWO COMPONENTS: INTERVIEW INTRODUCTION

CRITERIA	BEST PRACTICES	Y	N	N/A
Introduce Self	Interviewer introduces self and advises their role			
Audio/Video	Interviewer advises the subject of audio/video recording			
Door closed	Interviewer advises the subject the door is closed for privacy – free to leave anytime (parents/guardian etc. available)			
Rules	• Don't Know • Don't Understand Correct Me Repeat • Promise to tell truth o Talk about things you know, heard / saw yourself			
Rule Demonstration	Interviewer ensures the subject understands the rules by practice			
Personal Behaviour	Interviewer is aware of their personal body language / demeanor (clothing/voice/presence)			
Comments				

STAGE THREE COMPONENTS: PRACTICE NARRATIVE / RAPPORT

CRITERIA	BEST PRACTICES	Y	N	N/A
Rapport / Practice Narrative	Interviewer attempts to build rapport with the subject and practices open non-leading questioning • Beginning/middle/end • Tell me more about • Explain to me • Describe to me Start open and become more focused using open non-leading questions			
Purpose (Appropriately timed transition to topic of concern)	Interviewer transitions to topic of concern (open non-leading): • Tell me why you are here today? • Tell me your understanding of why you are here today? • What did X say about coming here today?			
Open non-leading transition to topic of concern	Interviewer invites the subject to provide a free narrative to topic of concern			
Comments				

STAGE FOUR COMPONENTS: NARRATIVE / TOPIC OF CONCERN

CRITERIA	BEST PRACTICES	Y	N	N/A
Topic of Concern Questions (TOC) Invite free narrative	Interviewer asks questions relating to topic of concern: **T.E.D** • Tell me more about • Explain to me • Describe to me Consistent "pairing" of questions			
(TOC) *(Seek Specific Details)*	Interviewer asks corroborative questions: **PLATO:** People, Location, Actions, Times, Objects Ask "how" ONLY when important to know			
(TOC) *(Open non-leading)*	Interviewer limits closed questions: - Only one Y/N question at a time - Pair multiple choice questions with "or something else?"			
(TOC) *(Pace / Listening)*	Interviewer: - Does not interrupt - Pauses between questions			
Comments				

STAGE FIVE: CLOSURE

CRITERIA	BEST PRACTICES	Y	N	N/A
Something else / Other concerns	Interviewer asks the subject • "Is there something else you think I should know?"			
Invite Questions	Interviewer asks the subject if they have some questions			
Safety	Interviewer discusses safety with the subject • "How safe do you feel right now?"			
Neutral Event	Interviewer introduces neutral topic to de-escalate			
Thank	Interviewer thanks the subject and asks if required will they speak to them again			
Comments				

SUMMARY

STAGE ONE: INTRODUCE RECORDING
STAGE TWO: INTERVIEW INTRODUCTION
STAGE THREE: PRACTICE NARRATIVE / RAPPORT
STAGE FOUR: NARRATIVE / TOPIC OF CONCERN
STAGE FIVE: CLOSURE

APPENDIX 6

Standards for Medical Evaluation

When CYACs are developing their health services process, it is important to aim for standards which are defined by resources such as the NCA Standards and Joyce Adams et al., (2018) which includes but are not limited to:

Medical evaluations are conducted by health care providers with specific training in child maltreatment that meets at least one of the following standards:

- Child maltreatment pediatrician sub-board eligibility or certification;
- Physicians without board certification or board eligibility in the field of child abuse pediatrics, advance practice nurses and physician assistants should have a minimum of 16 hours of formal didactic training in the medical evaluation of child sexual abuse;
- Medical professional providing services to CYAC clients must demonstrate continuing education in the field of child abuse consisting of a minimum of 8 contact hours every 2 years;
- Forensic Nurse Examiners/Sexual Assault Nurse Examiners without advanced practitioner training should have a minimum of 40 hours of coursework specific to the medical evaluation of child sexual abuse followed by a competency based clinical preceptorship. This means a preceptorship with an experienced provider in a clinical setting whether the examiner can demonstrate competency in performing exams.

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Resources

American Professional Society on the Abuse of Children: www.apsac.org

Assistance Dogs Society (PADS) https://pads.ca

Assistance Dogs International https://assistancedogsinternational.org

California Evidence-Based Clearinghouse for Child Welfare: https://www.cebc4cw.org/search/topic-areas/trauma-treatment-child-adolescent/

Canadian Advocacy Centres: https://cac-cae.ca

Corner House: Interagency Child Abuse Evaluation and Training Center: www.cornerhousemn.org

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Gundersen National Child Protection Training Center: www.issuu.com/gundersenncptc

National Child Traumatic Stress Network (NCTSN) https://www.nctsn.org

National Children's Advocacy Center www.nationalcac.org

National Institute of Child Health and Human Development: www.nichd.nih.gov

Office of the Information and Privacy Commissioner for British Columbia: https://www.oipc.bc.ca/guidance-documents/3516

Referral Policy for Victims of Power-based Crimes: https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/victims-of-crime/vs-info-for-professionals/info-resources/power-based-crimes-referral-policy.pdf

Vega Project, Family Violence Educational Resources: https://vegaproject.mcmaster.ca/

Victims of Crime Act: https://www2.gov.bc.ca/gov/content/justice/criminal-justice/bcs-criminal-justice-system/if-you-are-a-victim-of-a-crime/your-rights