Company's Mental Health Policy Sample

Policies & Procedures: Use as a Template

You can use this sample Policies & Procedures manual as much or as little as you wish. Delete, alter or add to it. It has to fit your organization; and not all of it will. Read each of the policies and procedures carefully; consider this as a best practice only.

A yellow highlighted area [organization's name] is meant to be an easy way for you to add your own organization's name/information easily and quickly.

Each organization will have different headings, topics and so on in your own policies and procedures, but below are some suggestions where you might easily add the policies and procedures listed in this Toolkit into your existing documents.

If you don't have a policies and procedures manual:

- Check out *HR Council for the Nonprofit Sector*: www.hrcouncil.ca; they have excellent resources to get you started on creating your own manual
- **Note**: If you do not have an existing manual, the manual in this Toolkit is not to be considered "complete"; rather, it lists the policies and procedures most related to working with clients with mental health issues.

If you have an *existing* policies and procedures manual:

- You might add the following policies from this manual in the "Organizational" section where you might have policies/topics such as: Corporate Objects, Vision, Mission/Values, Code of Conduct, etc.
    - Equity and Inclusion
    - Client Rights and Responsibilities
    - Staff Rights and Responsibilities
    - Volunteer Rights and Responsibilities
    - Student Rights and Responsibilities
    - Service User and Community Complaints

You might add the following policies from this manual in the "Client Services" section of your existing manual:

- Consent for Service
- Client Privacy, Confidentiality & Release of Information
- Consent and Information Sharing- *Children*
- Discriminatory Requests for Service
- Assessment & Service Planning
- Referrals to Community Services
- Urgent Service
- Collecting & Storing Client Data
- Dealing with Health Emergencies
- Aggressive or Threatening Behaviour
- Duty to Warn / Report
- Child Abuse Reporting / Documentation
- Adult Abuse
- Suicidal Behaviour & Client Suicide
- Client Autonomy
- Concerns with Client Capacity
- Limiting, Refusing or Withdrawing Service

And you might add the following policy from this manual in the "Human Resources" section:

- Harassment & Discrimination

ACKNOWLEDGEMENTS

This Policies & Procedures manual would not be a part of this Toolkit if it were not for the generosity of Family Services of Toronto (FST). This manual is used by FST staff and was last updated in 2009.

Mental Health
Policies & Procedures Manual

Name of Organization
[Department- *optional*]
[Issue Date]

TABLE OF CONTENTS

CONFIDENTIALITY

This manual details policies and procedures relevant to [Name of Organization]. Unauthorized copying and distribution is prohibited.

Policy Name and Number:	**1.1 Equity & Inclusion**
Date last reviewed:	
Approval or last revision:	
Approved by:	

Organization's name re-affirms its commitment to building a city which is equitable and inclusive. This means that in all aspects of its operations and at all levels of the organization, organization's name works to ensure that there is no discrimination on the basis of, but not limited to, ethnicity, language, race, age, ability, sex, sexual or gender identity, sexual orientation, family status, income, immigrant or refugee status(1), nationality, place of birth, generational status(2), political or religious affiliation.

- (1) organization's name recognizes that barriers to employment and services may exist due to immigration or refugee status based on legislation and/or contractual funding obligations
- (2) Generational status is intended to protect individuals with Canadian citizenship who are first, second or third generation immigrants from discrimination.

Organization's name further recognizes that the increasing diversity among residents in Peel Region has added cultural, social and economic benefits to our community. It is also sensitive to the fact that oppressed groups experience marginalization and encounter barriers to full access and participation in the community. Organization's name seeks to increase access and participation, especially for those who are marginalized, disadvantaged or oppressed.

Organization's name encourages individuals to participate fully and to have complete access to its services, employment, governance structures(board of directors, committees of the board and any board working groups that may be convened) and volunteer opportunities. It shall make every effort to see that its structure, policies and systems reflect all aspects of the total community and to promote equal access to all. To this end, organization's name strives to ensure that:

- Discriminatory or oppressive behaviours are not tolerated
- Individuals who engage with organization's name for service are valued participants who have opportunities to shape and evaluate our programs
- Community programs and services are developed and delivered to give priority to individuals in marginalized communities and are sensitive to the needs of diverse groups
- Programs are delivered in such a way that systemic barriers to full participation and access are eliminated and so that positive relations and attitudinal change towards marginalized groups are promoted
- Services are provided with sensitivity to the influence of power and privilege in all relationships, including service relationships, and are delivered in keeping with anti-oppression principles
- Communication materials present a positive and balanced portrayal of people's diverse experiences.

This policy is intended to act as a positive force for equity and the elimination of oppression.

SCOPE

This policy applies to all organization's name clients, employees, volunteers and students.

PROCEDURES

1. Organization's name has and will continue to work to embed the principles detailed in this policy within all relevant organization's name policies and procedures to ensure that equity and inclusion guides organization's name in all of its endeavours.

2. Individuals who believe that they have experienced harassment or discrimination in an organization's name context are encouraged to use the following policies and procedures to have their concerns or complaints addressed:

- Clients and community members may refer to the *Service User and Community Member Complaints* policy
- Employees, volunteers and students may refer to the *Harassment and Discrimination* policy
- Unionized employees may elect to use the *Harassment/Discrimination* provisions of the *Collective Agreement*

3. Organization's name staff, volunteers and students may also refer to the *Discriminatory Requests for Service* policy for guidance in addressing clients or community members who make such requests.

Policy Name and Number:	**1.2 Client Rights & Responsibilities**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
Individuals receiving service at organization's name have both rights and responsibilities. Clients and participants will be educated about their rights and responsibilities in a variety of ways (e.g., posters in service locations, in written form, by staff through the intake and assessment process).

SCOPE
This policy applies to staff of organization's name who serve clients and participants with the exception of program name that will have separate client rights statements particular to the requirements of their setting (e.g., in the case of the Seniors/Youth/Children/Etc. Program the wording of the statement is dictated by legislation).

LIMITATIONS
Clients have the right to ask for a change of worker however, the request will only be granted when it is reasonable and an alternative exists. Requests that are discriminatory in nature will not be granted.

PROCEDURES
1. Staff will explain to clients their rights and responsibilities as a regular part of the intake and assessment process.

2. Program Managers will ensure the client rights and responsibilities statement (below) is available in written form to clients and participants and in the client's preferred language.

3. Staff will ensure they are familiar with organization's name privacy policies and procedures so that they can answer client's questions and assist clients in exercising their rights in regards to their record.

➢ See next page for a sample client form

YOUR RIGHTS AND RESPONSIBILITIES AS A CLIENT OF ORGANIZATION'S NAME

Welcome to organization's name.
We hope that we can give you the kind of support and help that you are looking for.

When you receive services from organization's name you have the right to:

- Receive high-quality service
- Be treated with respect and courtesy
- Have your information kept private and confidential except as described in organization's name *privacy statement*
- Be listened to and have staff work with you to make a plan to address your concerns and needs
- Receive service in offices that are safe, clean and accessible
- Get information and support to help you make decisions to improve your situation
- Be served without discrimination
- Discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have
- Request a change of staff member if there is another staff person available who can address your issues and your request is reasonable -- you should know that discriminatory requests will not be considered

This is what we ask from you:

- Treat the staff and others at organization's name with courtesy and respect
- Let organization's name know 24 hours before if you can not come to an appointment.

Privacy Officer
The Privacy Officer for organization's name is [Title of Staff Person] who can be contacted [contact details].

➢ For more information about "Privacy Officer", see the PIPEDA Fact Sheet in the "Legislation" section of this Toolkit.

Policy Name and Number:	**1.3 Staff Rights & Responsibilities**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
Organization's name is committed to providing a safe, just, learning environment for all its employees. No person may cause or allow to cause conditions which are unfair, without dignity or violate human rights of any other employee of the organization.

SCOPE
This policy applies to all organization's name employees.

LIMITATIONS
Organization's name personnel may not:

1. Employ people without a position description and means of systematic evaluation.

2. Violate the terms of the organization's collective agreement or any other employment contract.

3. Promise or imply employment that cannot be terminated with reasonable notice.

4. Deploy employees who regularly fail to demonstrate the attitude, knowledge and skills required for their position.

5. Allow personnel to work in an unsafe work environment.

6. Prevent employees from grieving in situations where a violation of policy has occurred.

7. Fail to take appropriate, timely action in response to formal or informal allegations of racism, homophobia, sexual harassment or any other form of discrimination, or other contract violations.

RIGHTS
All employees, volunteers, students and contractors have the right to:
- Know about any risks or dangers in the workplace
- Participate in making the workplace safe
- Refuse unsafe work (Section 43, Occupational Health & Safety Act)

Policy Name and Number:	**1.4 Volunteer Rights & Responsibilities**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
Organization's name recognizes volunteers as integral to the organization's ability to achieve its goals and objectives. Volunteers will be treated with the same professionalism and respect as paid staff and in turn will be expected to act professionally and respectfully at organization's name.

SCOPE
This policy applies to volunteers and to staff and students who are working with them.

RIGHTS
Organization's name volunteers have the right to:
- Be screened using processes that are equitable, fair and free from discrimination
- Tasks appropriate to their skills and interests
- The necessary facilities, equipment and space to perform their duties
- Respect and recognition as a valued team member
- A clearly written position description
- An orientation to the organization, their position and the location where they will volunteer
- A copy of the organization's volunteer policies and any other organizational policies that are relevant to their work
- Sufficient initial training to accomplish their tasks and on-going training as appropriate to the role
- Supervision and support in their role
- Feedback about their volunteer work
- The opportunity to provide feedback and input
- Recognition for their contributions
- Work in a healthy and safe working environment
- Have their confidential personal information dealt with in accordance with organization's name privacy and confidentiality policies
- Adequate liability insurance coverage
- Reimbursement for out-of-pocket expenses incurred on behalf of the organization

RESPONSIBILITIES
Organization's name volunteers have the responsibility to:
- Adhere to relevant organization's name policies and procedures
- Maintain confidentiality and privacy with regards to organizational, client and other information of a confidential nature
- Work within the limits of their qualifications, education and skills
- Value, support and respect the rights of others
- Complete and return all organization's name registration documents as indicated on the orientation checklist
- Maintain an accurate record of their volunteer hours
- Be punctual and notify their supervisor of absences as much in advance as possible
- Carry out volunteer tasks specified in the position description responsibly
- Maintain a professional attitude toward their tasks
- Represent the organization accurately and positively to other organizations and individuals

- Request support when needed
- Participate in evaluations when asked
- Address areas of conflict or concern in accordance with organization's name policies
- Attend any designated training or orientation assigned by their supervisor
- Report any health and safety concerns to their supervisor
- Provide notice of intention to leave the organization or program

Policy Name and Number:	**1.5 Student Rights & Responsibilities**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
Organization's name is committed to providing meaningful learning opportunities to students in order to contribute to the fields represented by students, to build community capacity and to encourage learning within the organization. Students placed at organization's name have rights and responsibilities associated with their learning placement.

SCOPE
This policy applies to students and organization's name staff.

RIGHTS
Organization's name students have the right to:
- Be screened using processes that are equitable, fair and free from discrimination
- An orientation to the organization, their position and their work location
- A copy of the organization's student policies and any other organizational policies that are relevant to their work
- A clearly written learning agreement with goals appropriate to their skills and interests
- Sufficient initial training to accomplish their tasks and on-going training as appropriate to the role
- The necessary facilities, equipment and space to perform their duties
- Work in a healthy and safe working environment
- Supervision and support in their role
- Feedback about their work
- Evaluation of their performance in accordance with the academic institutions requirements
- The opportunity to provide feedback and input
- Have their confidential personal information dealt with in accordance with organization's name privacy and confidentiality policies
- Reimbursement for pre-approved out-of-pocket expenses incurred on behalf of the organization
- Adequate liability insurance coverage
- Respect and recognition as a valued team member
- Recognition for their contributions

RESPONSIBILITIES
Organization's name students have the responsibility to:
- Read, sign and honour the organization's confidentiality and conflict of interest agreements
- Complete a criminal reference check and a vulnerable sector search, if required
- Complete any other required paperwork
- Meet regularly with their field instructor for supervision
- Provide the field instructor with all necessary documentation from the respective educational institution
- Read and follow all organizational relevant policies and procedures
- Read and follow all policies and procedures from the relevant professional college
- Complete documentation of their work according to organization's name standards
- Notify the supervisor as soon as possible if unable to report to organization's name due to health or other reasons
- Participate in performance evaluation

- Complete their placement as agreed

Policy Name and Number:	**1.6 Service User & Community Complaint Process**
Date last reviewed:	
Approval or last revision:	
Approved by:	

Preamble
Organization's name values and encourages the feedback of service users and community members about the programs and practices of the organization. Complaints can provide important opportunities for improving service. A complaint may be defined as an expression of dissatisfaction or unmet expectation. A complaint can be made by the service user or community member with support if necessary. The complaint can relate to any aspect of the organization's programs and services. A service user or community member who believes they have experienced discrimination at organization's name contrary to the *Ontario Human Rights Code* can file a claim with the *Human Rights Tribunal of Ontario*. Information about the complaint process is available at *www.hrto.ca*.

POLICY
Organization's name is committed to listening to service user and community member complaints and responding in a fair, timely and respectful manner. All complaints will be given due consideration without reprisal or discrimination. Language support for non-English speaking service users or community members will be provided. Organization's name actively informs service users and community members of their right to register complaints (verbal or written) and seek resolution. This information is accessible and publicized in organization's name *Client Rights and Responsibilities Statement*. Service users or community members who speak languages other than those covered by the latter documents or who have reading difficulties are encouraged to have this policy explained to them by an organization's name staff person or the counsellor at the beginning of service. Organization's name will assist persons with disabilities to register their complaints and seek resolution.

All aspects of a complaint will be handled in confidence. However, if the complaint involves allegations of illegal or unethical behaviour, information may need to be shared with external authorities.

All complaints are documented. The maintenance of complaint files is the responsibility of department Managers.

Complaints deemed a risk to the organization are brought forward to the board of directors by the Executive Director. Complaints related to the violation of board governance policies are reviewed by the board. Directors (senior management) will provide information about complaints to the Executive Director's office so that a summary report can be created and submitted to the board annually. Clients with questions, comments or complaints about organization's name privacy policies and procedures or about the collection, use or disclosure of their personal information will be directed to the Privacy Officer.

SCOPE
The *Service User and Community Member Complaint* policy applies to all organization's name programs and services.

PROCEDURES
As the goal of organization's name is to give sufficient local authority to meet service user needs, complainants will be encouraged, but not required to work through the lines of authority within the organization.

To provide maximum support to the staff-service user and community member relationship, the complaint resolution process begins with the involvement of the staff person who provided service, unless this is not in the best interests of the service user or community member.

STEP 1: Receiving a Complaint
a. If the person providing service receives the complaint the service user or community member should be offered the earliest opportunity to discuss their concern(s).
b. If the complaint is received by any staff member or volunteer of the organization other than the person providing service the service user or community member should be directed to the person providing service with an explanation of organization's name policy. If the complainant is reluctant to speak directly to the person providing service they should be referred to that person's immediate manager. The person providing service should be alerted to the existence of the complaint.
c. In hearing a complaint the person providing service may decide to involve or consult their manager at any stage. This option should be taken if the service user brings a friend or advisor.
d. If the complaint is handled to the mutual satisfaction of the complainant and the person providing service, the complaint and resolution is documented on the *Complaint Form* and a copy is forwarded to the manager of the person providing service and the department director.

STEP 2: Discussion with a Manager
a. If the person providing service is unable to resolve a complaint, the complainant is offered the opportunity to speak with the manager.
b. The preferred method is to have the manager call the service user or community member. This affords the staff person the opportunity to discuss the matter with the manager prior to any further action or out reach to the complainant.
c. The manager calls the service user or community member as soon as possible after consulting with the person who provided the service.
d. If a service user or community member calls a manager to complain about the person providing the service or about the service provided, the manager should hear the complaint, but offer no action without discussing the matter with the staff person involved.
e. From the point a manager takes a call from a service user or community member or calls a complainant about a complaint, a meeting between the manager and complainant should be offered within five working days.
f. The staff person(s) and manager should jointly plan the response to the service user's or community member's complaint. Whenever possible the plan should support the integrity of the service user/community member/staff relationship and unless clearly contraindicated, the staff person will be present at any meeting between the manager and complainant.
g. The role of the manager is to resolve the matter to the satisfaction of the service user or community member and staff person(s) or, failing this, to inform the complainant of their right to seek resolution through a meeting with the Director.
h. A letter must be sent to the service user or community member within two weeks of the meeting. The Director of Programs and Services is informed of the complaint and the resolution or lack of resolution.

STEP 3: Meeting the Department Director
a. If the service user or community member is not satisfied with the response from the manager the initiative for carrying the complaint to the Director rests with the complainant.
b. The service user or community member should be informed of the name and phone number of the Director if she/he wishes to pursue the complaint. The Director is alerted immediately if a call is anticipated and a copy of the completed *Complaint Form* is provided.
c. If requested, the Director will meet with the service user or community member within two weeks of receiving the request.

d. Prior to this the Director will contact the manager and the staff person and seek any necessary consultation. Whenever possible the Director will attempt to involve the staff and manager in the planning process and may invite one or both to the meeting.
e. The Director will attempt to resolve the problem with the service user or community member. Whatever the outcome, the Director will inform the complainant by mail not more than two weeks after the meeting.
f. The Director will inform the Executive Director of the meeting with the service user or community member and the outcome.

STEP 4: Meeting the Executive Director
a. If the service user or community member is not satisfied with the response from the Director the complainant may take the complaint to the Executive Director and should be informed of the name and phone number of the Executive Director.
b. The Executive Director should be alerted immediately if a call is anticipated and a copy of the completed *Complaint Form* should be provided.
c. If requested, the Executive Director or her or his designate will meet with the service user or community member within two weeks and attempt to resolve the matter.
d. Prior to this, the Executive Director will inform the Director, manager and the staff person(s) of the approach and seek any necessary consultation.
e. Whenever possible the Executive Director will involve the staff person(s) and manager in the planning process and may invite one or all of them to the meeting.
f. Prior to the meeting the Director will ensure that a letter bearing his/her signature is sent to both the service user or community member and the Executive Director outlining the complaint and all the steps taken to resolve the complaint.
g. Within two weeks of meeting the service user or community member, the Executive Director or her/his designate will send a letter to the complainant setting out any agreement reached, or failing this, the Executive Director's decision regarding the complaint. The person(s) providing the service and those at the first level of authority will be kept informed throughout all attempts to resolve complaints. In instances where there is an allegation of criminal or serious ethical breach of conduct by organization's name personnel, the Executive Director may waive the requirement to inform personnel until legal and/or police advice is sought and may continue to refrain from informing the person during the course of an investigation providing there is no breach of a legal or contractual standard. While every attempt should be made to achieve a positive resolution with the complainant, the integrity of organization's name policies and the integrity and safety of organization's name personnel and other service users or community members must be maintained.

Documentation
All complaints received from a service user or community member are initially documented by the staff person who received the complaint using the *Complaint Form*. A flag noting that a complaint has been received is placed in the client or community member's record. A copy of the complaint is forwarded to the staff person's manager. The complaint file (includes all documentation, correspondence, resolution and follow up) is maintained separately from the service user's client record or the community member's file in the appropriate directors office.
A record of the complaint will be made available to the complainant on request except in the case where the confidentiality of another service user or community member may be breached. These records will be retained for the same period of time as the client or community member record (currently this period is 10 years).

Service User/Community Complaint Form

Service User or Community Member Information
Name:
File Number:
Contact:

Complaint Information
Date of Complaint:
Complaint Issues:
Solutions Sought by Service User or Community Member: (note the solutions the complainant is seeking to each of the issues listed above)
Complaint Background: (brief description of client's circumstances and situation leading to complaint)

-

Action(s) Taken
Step 1:
Date:
Staff Involved:
Notes:
Next Steps:
Step 2:
Date:
Staff Involved:
Notes:
Next Steps:
Step 3:
Date:
Staff Involved:
Notes:
Next Steps:
Step 4:
Date:
Staff Involved:
Notes:
Next Steps:

Outcome Resolution
(describe outcome of complaint and any improvements implemented as a result)

Name of Staff Member Signature

Name of Manager Signature

Name of Director Signature

Date

Policy Name and Number:	**1.7 Consent for Service**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

To be valid, consent must be:

- Voluntarily given, without any misrepresentation or fraud
- Given by a person who is capable of making service decisions
- Informed (meaning the person has been given sufficient information about the service and any implications of giving the consent)

Organization's name programs and services are voluntary, unless mandated by a court order. Participation in service is considered consent for service since clients are at liberty to withdraw from service at any time. Organization's name does not work with any client who does not consent to service.

Organization's name services and policies are first explained verbally at intake. At the first appointment all clients will receive written information describing the service, relevant organization's name policies and client's rights. The client will be asked to read the information and sign a form indicating that they understand the policies and consent to service. In some situations, signed consent may not be possible. In such cases, staff will explain the contents of the document and obtain verbal consent. Verbal consent will be documented in the assessment.

SCOPE

This policy applies to all organization's name programs and services.

DEFINITIONS

- **Expressed consent** is verbal or written consent for service.
- **Implied consent** is consent that is implied either by the words or the behaviour of the client or by the circumstances under which service is given. For example, where a client arranges an appointment, attends that appointment and participates in service, consent can generally be implied.

Consent can be given by the client or the client's legally authorized representative (such as a legal guardian or a person having a power of attorney).

PROCEDURES

1. Written Information

1.1 organization's name will ensure that written information describing the service, relevant organization's name policies and client's rights is available in the most common languages of service. The information will include a brief description of organization's name services, eligibility for service, policies on confidentiality and access to records, fees, clients' rights and responsibilities, and procedures for complaints.

1.2 The written information is provided to all new clients at their first appointment or as soon as is practical. Clients will be asked to review the information.

1.3 Staff will provide help if needed (e.g., help to address challenges due to literacy, fluency in English, disability or lack of familiarity with the concepts).

2. Written Consent

2.1 The organization's Settlement Worker will answer any questions about the written information.
2.2 The client will be asked to sign a form acknowledging that the client understands the information and consents to service.
2.3 Once assured of the client's consent and acknowledgement, staff will file the consent form and indicate that consent has been received in the client record.
2.4 In exceptional circumstances, the client may be asked to sign the consent form as soon as practical and/or verbal consent will be obtained and documented in the client record.

3. Acknowledgement and Consent for Minors

3.1 Consent issues related to children under the age of 12 are addressed in the *Consent and Information Sharing Regarding Children* policy. Individuals 12 years of age and older are deemed able to give consent.

4. Client Withdrawal of Consent

4.1 A client may choose not to participate in a particular organization's name program.
4.2 Staff will document the client's withdrawal of consent in the client file and close the file.

Policy Name and Number:	**1.8 Client Privacy, Confidentiality & Release of Information**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

In the course of delivering its services and programs, organization's name collects personal information from its clients. Personal information means any information that could be used on its own, or with other information, to establish the identity of a client, the client's service provider or the client's substitute decision maker. Personal information also includes any other information about a client including information that is contained in a client record.

Organization's name collects, uses and shares client's personal information for the following purposes:

- Providing quality programs and services to clients
- Providing information to other people or organizations with client consent (for example, making a referral for service)
- Contacting clients, donors and members to evaluate organization's name service and work
- Conducting research to understand the kinds of issues our clients are facing
- Contacting individuals about our fundraising and membership activities
- Reviewing client files to ensure high quality of service and documentation

Organization's name may also collect, use and share personal information with consent or as permitted or required by law.

Organization's name is committed to protecting the privacy of its clients and ensuring that:

- the personal information it receives from clients is kept safe, secure, confidential, accurate and up to date
- clients understand why their personal information is collected by organization's name
- organization's name obtains client consent before collecting, using, sharing or releasing client information, except as set out in this policy or permitted or required by law
- only the personal information necessary for the purposes listed above is collected from clients, unless otherwise consented to by the client or permitted or required by law
- access to client information is limited to the organization's name employees, volunteers and students involved in delivering services to clients
- any external agents to whom organization's name releases information have a need to know and only use and disclose client information for the purposes for which it was originally provided
- clients are able to withdraw their consent at any time to the collection, use and disclosure of their personal information
- clients have access to their record, except where organization's name is entitled to refuse an access request, and are able to copy or correct their record and ask questions about organization's name privacy policies and procedures
- complaints about organization's name privacy policies and procedures are handled efficiently and effectively
- all legal and regulatory requirements regarding client information are met and maintained

Only a person who provides a provincially funded health resource to an individual may require the individual to produce his or her health card. Organization's name personnel may ask clients to voluntarily provide their health card number in order to facilitate referrals to provincially funded health resources.

SCOPE
This policy applies to all organization's name employees, students and volunteers.

PROCEDURES
1. Obtaining Consent

1.1 As organization's name services often involve collaboration and consultation among employees, organization's name employees will discuss the following with new clients:

- the nature and extent of consultation and collaboration in the organization's name program or service which the new client is accessing
- the personal information that organization's name may collect
- the purposes for which organization's name collects, uses and shares personal information, as listed above

1.2 Client's rights and responsibilities including rights related to keeping client's personal information private will be reviewed with all new clients at their first appointment following intake
1.3 Clients will be asked to use a form indicating that the organization's privacy policies have been discussed and that the client consents to the collection use and sharing of personal information for the purposes listed in this policy.
1.4 The signed forms will be maintained by the program (e.g., in the client's paper record, filed centrally within the program). A note will be made in the client's electronic record that the form has been signed.
1.5 In cases where it is not possible or practicable to obtain the client's written acknowledgment (e.g., telephone only service), verbal acknowledgment that the organization's privacy practices have been explained to, and accepted by, the client will be recorded in an activity note in the client's record.
1.6 Consent will be that of the individual and must be knowledgeable, relate to the personal information and not be obtained through deception or coercion. A consent to the collection, use or sharing of personal health information about an individual is knowledgeable if it is reasonable in the circumstances to believe that the individual knows, (a) the purposes of the collection, use and/or disclosure, as the case may be; and (b) that the individual may give or withhold consent.
1.7 In the event that employees are concerned that a client does not have the capacity to consent to the collection, use and disclosure of his or her personal information, employees should:

- Consider whether the client understands the decision they are being asked to make
- Question whether the person understands the reasonably foreseeable consequences of the decision or lack of decision
- Consult with their supervisor

2. Client Withholding, Limiting or Withdrawing Consent

2.1 Clients have the right to stipulate who will have access to their personal information. This means that they can withhold, limit or withdraw their consent to the collection, use or disclosure of personal information. The request may cover all or a specific part of a client's record. When this happens, staff will implement the following "lock-box" procedure.
2.2 Electronic records: The organization's name employee receiving the client's request to withhold, limit or withdraw their consent will:

- Record the verbal instructions by the client in an activity note in the client's electronic record
- Scan any written instructions by the client into the client's electronic record
- Notify the Information Technology (IT) Department of the client's instructions and the IT Department will limit access to the electronic record in compliance with the client's request (e.g., closing access to the record; limiting access to the individuals specified by the client to be allowed access).

2.3 Paper records: If the client also has a paper file:

The client's file (either in whole or in part depending on the client's instructions) to which access is to be limited will be placed inside an envelope that will be sealed with the instructions from the client stapled to the outside of the file. If the client's request is to withdraw consent, the file will be safeguarded by organization's name Privacy Officer. If the client's request is to withhold or limit consent, the supervisor responsible for the program will determine how best to comply with the client's request.

2.4 In cases where the withholding, limiting or withdrawal of consent will limit or prevent organization's name from continuing to deliver services, employees will discuss with the client the consequences of their withholding, limiting or withdrawal of consent.

3. Higher Levels of Confidentiality (Use of Aliases)

3.1 organization's name serves clients periodically that require a higher level of confidentiality. For example: public figures; staff of organization's name funder; former staff, students and volunteers, who may not wish it to be known that they are accessing organization's name services.
3.2 In such situations, programs will provide clients an opportunity to select and use an alias. The alias will be used in the client record and in the client's interactions with organization's name.
3.3 A list of the aliases, clients' real names and file numbers will be confidentiality maintained by a designated person in each department with a copy to the organization's name Privacy Officer.
3.4 A higher level of confidentiality designation does not invalidate the normal legal limits to confidentiality, which includes subpoenas, search warrants and the right of government funders to audit client records. Clients must be informed of these limitations on confidentiality.
3.5 The Human Resources Department will provide names of new staff members, volunteers and students to the organization's name Privacy Officer so that a check of the client database can be completed. If the individual has received service from organization's name in past, an alias will be assigned to the record in order to maintain the privacy of the new staff member, volunteer or student.

4. Disclosure without Consent Including Responding to Summons/Subpoenas/Court Orders and Requests from Police

4.1 Organization's name will not disclose the personal information of clients without their consent, except where:

- It is believed the client or someone else is in imminent danger of serious physical harm (see *Duty to Warn* policy)
- A child under the age of 16 is at risk of or has been abused or neglected (see *Child Abuse Reporting and Documentation* policy)
- organization's name is subpoenaed or is otherwise served with a court order, summons, warrant or a similar requirement issued by a person who has jurisdiction to compel the production of information in a proceeding
- It is otherwise permitted or required by law.

4.2 If organization's name employee, student or volunteer is served with a warrant, summons, subpoena, order or similar requirement issued in a proceeding, the individual must immediately notify their supervisor, who will provide advice and direction as to how to respond. Organization's name employees, students or volunteers should follow the same procedure in response to requests by police officers for client information.
4.3 In general, where an order, summons, warrant, subpoena or other requirement to produce documents has been served on organization's name, organization's name will:

- Make every attempt to respond in a way that is respectful of the order or other requirement, while at the same time taking steps to preserve the client's right to confidentiality

- Make an exact copy of the file to remain at organization's name and deliver the documents to the court or other proceeding in a sealed enveloped marked "private and confidential".

4.4 Where organization's name discloses personal information without the client's consent, the client will be notified of such disclosure as soon as reasonable, practical, safe and/or legally possible in the circumstances.

5. Release of Information with Client Consent

5.1 Subject to Section 4, personal information, whether all or part of a client record, will not be released to third parties without the written consent of the client or the client's substitute decision maker, where applicable. Clients are required to complete the organization's name *Authorization to Request or Release Information* Form, depending on the nature of the request. Consents provided on these forms are valid for one year, unless otherwise limited or withdrawn by the client in advance of that date. Organization's name may disclose a client's personal information, provided that the disclosure, to the best of organization's name knowledge, is for a lawful purpose.

5.2 Reports from third parties contained in a client record may not be released without the written consent of the third party. Clients will be encouraged to pursue access to this information directly with the third party.

5.3 In exceptional circumstances, where written consent is not possible, the oral consent of the client to the release of personal information will be accepted and will be recorded in the client's file.

5.4 In response to requests to release information to third parties, the organization's name service provider will ensure that the client understands the purpose for which the information is being released and to whom the information is being released. The organization's name service provider will also explain that organization's name cannot guarantee the confidentiality of the information once it has been released.

6. Safeguarding of Personal Information

6.1 Client information stored electronically is protected by password. Access to the organization's name electronic database is limited on a need to know basis for added security.

6.2 Client information collected in hard copy form is stored in locked cabinets accessible only by the counsellors or other organization's name employees, students and volunteers providing service to the client, and the relevant program managers.

6.3 Access to client information will be limited to those who need to know the information for the purposes set out in the client's consent or as otherwise permitted or required by law.

6.4 organization's name employees will never leave client personal information, in paper or electronic form, unattended or exposed to anyone other than the client.

6.5 organization's name will not send confidential personal information to clients by email without the client's prior consent. Personal information sent to clients or about clients will employ secure email. (Note that secure e-mail ensures messages are encrypted. organization's name regular e-mail program is not secure email.)

6.6 Web-based counselling will use an encrypted website to protect client privacy and confidentiality.

6.7 organization's name requires external agents, such as third party auditors, to maintain the confidentiality of client information and to refrain from using client information for any purpose other than the purposes for which consent was provided by the client. Where appropriate and necessary, organization's name will obtain the consent of the client to disclosure of information to external agents. (External agents are persons or companies with which organization's name has contracts and that may come into contact with personal information.)

6.8 When disposal is permitted or required, records of client personal information will be disposed of in a secure manner such that reconstruction of the records is not reasonably foreseeable in the circumstances.

7. Notice to Clients of Theft, Loss, Unauthorized Access, Use or Disclosure of Personal Information

7.1 Employees are required to report to their supervisor and to the organization's name Privacy Officer any theft, loss, unauthorized access, use or disclosure of personal information of organization's name clients. In programs where funders require it, managers will file a serious occurrence report in this situation.

7.2 In the event of such theft, loss, unauthorized access, use or disclosure of personal information of a organization's name client, organization's name will notify the client as soon as possible.

7.3 Oral contact with the clients will be logged in the client record and will be followed up by a letter, which will be included in the client record.

7.4 In the case of former clients, contact will be made orally, if possible, and also in writing, at the last known address for the client recorded in organization's name database.

8. Client Access to and Correction of Personal Information

8.1 Clients wishing to review their records should contact the organization's name service provider, relevant program manager or Privacy Officer.

8.2 Within 30 days of any such request, an appointment will be made for the client to review his/her personal information in a confidential manner on organization's name premises, in the presence of a organization's name employee, unless organization's name is entitled to refuse the request, in which case written notice will be given. Clients may bring a support person to this appointment if they wish. Up to 60 days may be required in the case of complex searches for records. In exceptional circumstances (e.g., a client is unable to come to the organization's name office due to health issues), a copy of the record may be sent to the individual with consent.

8.3 organization's name is required to retain client personal information that is the subject of a request for access for as long as necessary to allow the client to exhaust any recourse under the *Personal Health Information Protection Act, 2004* that he or she may have with respect to the request. This may require organization's name to maintain the record for longer than the typical client record retention period.

8.4 Clients who wish an explanation of their records may contact their organization's name service provider, the relevant program manager or the organization's name Privacy Officer.

8.5 Clients will not be permitted to access third party records without the consent of the third party. In such cases, the organization's name service provider will direct the client to obtain the requested information directly from the third party.

8.6 Clients wishing to correct information in their file shall provide the correction in writing to organization's name. The written correction will be included in the client's record and, within three weeks of receipt, organization's name will notify the client of its response to the correction.

9. Appointment of Privacy Officer

9.1 The Privacy Officer for organization's name is [Title of Staff Person].

9.2 The name and contact information for the Privacy Officer is available on the organization's name website, in the *Client Rights and Responsibilities Statement* and in the organization's name Employees Directory.

9.3 The duties of the Privacy Officer include:

- Maintaining knowledge of privacy legislation and regulations
- Ensuring that all employees and volunteers have training on the privacy policy
- Monitoring employee compliance with organization's name privacy policy
- Responding to privacy-related complaints and concerns
- Responding to requests for access and correction
- Responding to inquiries from the public about organization's name privacy practices
- Liaising with other organizations, the public and government, as necessary, on privacy-related issues

10. Inquiries and Complaints

10.1 Questions, comments or complaints about the organization's name privacy policies and procedures or about the collection, use or disclosure of personal information will be directed to the Privacy Officer.
10.2 The Privacy Officer will follow the procedures set out in the *Service User and Community Member Complaints* policy in responding to, resolving and recording privacy-related complaints.
10.3 If the client is not satisfied with the response provided by the Privacy Officer, the client may contact the *Office of the Information and Privacy Commissioner of Ontario*, in writing, at 2 Bloor Street East, Toronto, Ontario, M4W 1A8 or by calling 416-326-3333.

[Organization's Name/Address/Logo]

AUTHORIZATION TO REQUEST OR RELEASE INFORMATION

Client's Name:

Client's Address:

Date of Birth (day/month/year):

I hereby authorize the following designated office or person of [Organization's Name] to release or request the following personal information about me:

___Request verbal report(s) from: _____

___Request written report(s) from: _____

___Release verbal information to: _____

___Release written information to: _____
(agency, organization, school, hospital, professional, etc.)

The following information:

For the purpose of (specify):

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year

Signed:_____ _____ _____
(Client 12 years of age and older) Date Witness

Signed:_____ _____ _____
(Parent or legal guardian) Date Witness

Policy Name and Number:	**1.9 Consent & Information Sharing- Children**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

Organization's name deems individuals 12 years of age and older capable of consenting to service. Information about the service provided to individuals 12 years of age and older will not be released to a parent or any other person without the consent of the young person.

Service to children under the age of 12 will be provided with the consent of a parent or guardian who has the right to make decisions about the care of the child or children. Children will only be released to a parent or guardian who has custody of the child(ren) or on the instruction of the parent/guardian with such rights, to another individual. Information about service provided to children under age 12 will only be provided to a parent or guardian who has the right to have access to this information.

Organization's name staff are neutral unbiased third parties who do not take the side of either parent but work to focus on the child's best interests.

SCOPE

This policy applies to all organization's name staff, volunteers and students providing service to children and youth.

PROCEDURES

1. Establishing Who Has the Right to Make Decisions

1.1 organization's name will determine the legal arrangements regarding custody, access and decision-making for all children for whom a service request is made or to whom organization's name delivers services.

1.2 The determination of parenting arrangements (whether legally agreed-upon in a custody arrangement, by de-facto agreement or by court order) is first made at intake. The information about who makes decisions on behalf of the child is recorded in the service request form (as reported by the person requesting service). Other issues related to decision-making, notably if there are difficulties with enforcement or if there is a parenting plan that is under review, will also be noted here.

1.3 If the parent/guardian making the service request has the right to make decisions, organization's name will accept the request for service directly for children.

1.4 The right of the parent/guardian to make decisions should be confirmed at the time of the first appointment and in an ongoing fashion (notably if there is a conflict situation).

1.5 organization's name will seek to involve the appropriate parent/guardian and as many parent/guardians as possible in service related to the child in accordance with the best interests of the child standard and being mindful of any issues related to the safety of the child and/or parent. Organization's name will work with the parents to discern the current family situation, and to determine the best way to provide service and share decision-making and information.

1.6 If a parent is entitled to access the child, this parent also has the right to make inquiries and to be given information as to the health, education and welfare of the child (as defined in the *Children's Law Reform Act, R.S.O. 1990*, c. C.12, s. 20 (5). Organization's name must determine the access rights of all parents involved and record this information in the client record.

1.7 If no parenting plan or formal arrangement exists, staff will explain *de facto* custody and status quo and its implications as well as refer clients to independent legal counsel where appropriate.
1.8 Staff may support a client in seeking independent legal counsel (e.g., to obtain an interim custody order).
1.9 If there is any reason for concern or ambiguity about rights, organization's name will strive to ensure that the organization has accurate and up-to-date information.

2. Sharing Information

2.1 In family situations with relatively open communications and positive relations, staff will ask the parent who requested the service for permission to contact the other parent(s). The parent's agreement will be noted in the client record.
2.2 In difficult or conflict family situations, employees will determine if contacting or informing the other parent(s) is in the best interests of the child and safe for everyone involved. Any concerns will be noted in the client record and serve to determine the course of action. If the employee identifies a risk of imminent harm to the parent or the child exists, action steps in Section 3 below will be followed.
2.3 If the parent who requested service does not want to share information with another parent who has access to the child:

- Employees will work with that parent to understand their viewpoint and assess whether there is any risk of harm to the child or to the parent.
- If there is no danger of imminent harm, organization's name will explain the organization's obligation to give information and will provide the information to the other parent as per his/her legal rights.

If the employee identifies a risk of imminent harm to the parent or the child exists, action steps in Section 3 below will be followed.
2.4 If the parent who requested service does not want to share information with another parent who does not have access to the child organization's name will accept this decision.

3. Acting when there is a Risk of Harm

3.1 If there is reason to suspect that a child or a parent is at risk of harm (e.g., in danger of being abducted by a parent, risk of abuse), employees have a duty to alert all parties of the risk of imminent harm. Staff will follow the ***Duty to Warn*** policy in such situations.
3.2 If there is reason to suspect the child(ren) has been abused, staff will follow the ***Child Abuse Reporting and Documentation*** policy.

DEFINITIONS

Best interests of child: As defined in Section 24(2) of the *Children's Law Reform Act, 1990*:

"The court shall consider all the child's needs and circumstances, including,
(a) the love, affection and emotional ties between the child and,
(i) each person entitled to or claiming custody of or access to the child,
(ii) other members of the child's family who reside with the child, and
(iii) persons involved in the child's care and upbringing;
(b) the child's views and preferences, if they can reasonably be ascertained;
(c) the length of time the child has lived in a stable home environment;
(d) the ability and willingness of each person applying for custody of the child to provide the child with guidance and education, the necessaries of life and any special needs of the child;
(e) any plans proposed for the child's care and upbringing;
(f) the permanence and stability of the family unit with which it is proposed that the child will live;
(g) the ability of each person applying for custody of or access to the child to act as a parent; and

(h) the relationship by blood or through an adoption order between the child and each person who is a party to the application. 2006, c. 1, s. 3 (1)."

Convention on the Rights of the Child **(Article 3.1) and application of the best interests of the child principle:** "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."

De-facto custody: One parent has custody of the child and has been making decisions about their care and upbringing as if s/he had legal custody. The other parent has accepted this arrangement. This de-facto custody arrangement, however, is not legally binding until the parents sign a separation agreement that sets out custody or a court order makes this determination

Policy Name and Number:	**1.10 Discriminatory Requests for Service**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
All service users (clients, groups or communities) have the right to expect professional, non-judgmental service that is sensitive and appropriate to their needs and consistent with organization's name *Equity and Inclusion* policy. These values also guide the organization in dealing with a service request that is discriminatory towards our staff, students, volunteers or other clients.

Clients or referral sources who insist on being served by a certain type of provider or refuse certain types of providers (e.g., a person of a certain culture, race or sexual orientation) will be evaluated carefully. Requests that are deemed discriminatory and/or counter to organization's name policy will be denied.

Organization's name recognizes that people can encounter systemic barriers to full access and participation in the broader community on the basis of their ability, ethnicity, gender, race and sexual orientation. These barriers may lead a client or referral source to make a specific request in order to allow for full access and participation. Organization's name is committed to balancing the inequities and increasing access to services while still maintaining its values.

SCOPE
This policy applies to all organization's name programs, services and clients.

LIMITATIONS
Organization's name ability to respond to client requests may be limited by:
- available resources
- funding contracts that limits service to a particular community or group
- organizational policies and procedures

PROCEDURES
1. Requests for service by a potential client or referral source which seem to be discriminatory in nature will be reviewed carefully by the manager of the program where service is being requested.

2. When a service request is discriminatory, for example, the client or referral source will not accept an appointment with an employee from a different racial or ethnic background or sexual orientation, the request will not be honoured.

2.1 Staff will explain the refusal and organization's name *Equity and Inclusion* policy.
2.2 If the client changes his/her mind and is open to service, staff will offer the first available appointment and encourage the potential client to meet with this assigned counsellor.
2.3 If the potential client or referral source continues to refuse the assigned counsellor (e.g., says does not want someone with a foreign-sounding name), they will be deemed to have refused organization's name services.

3. A group that refuses to hold an activity in one of organization's name meeting rooms unless guaranteed that another group will not be in the building at the same time, is told this cannot be done.

4. At any point in service, client concerns about organization's name staff or practices will be handled using the established complaints protocol.

5. At any point in service, organization's name employees, students or volunteers can involve their manager if they feel they are being affected by discrimination. A decision will then be made about the most appropriate outcome (e.g., termination of service, assignment to a new staff member).

Policy Name and Number:	**1.11 Assessment & Service Planning**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
Assessment and service planning is an ongoing, collaborative and continuous process at organization's name .This process is a mutual exploration of the client's issues and strengths, complemented by the staff's professional perspective and recommendations resulting in a jointly created plan with mutually agreed on goals.

SCOPE
This policy applies to all organization's name employees involved in direct service.

PROCEDURES
1. Assessment begins in the initial interview and builds on the information and presenting issues gathered during intake.

2. The initial assessment seeks to gather basic information, to explore client strengths and issues, and determine the client's desired outcomes. Based on the assessment, staff will work with the client to jointly create a service plan with mutually agreed on goals which is documented in the client record.

3. Contextual information is gathered, as relevant and appropriate to the nature of the issues and outcomes desired, such as:
- the client's presenting issue
- history of the issues
- client's strengths and resources
- safety issues (e.g., abuse, current risk of self-harm, previous suicide attempts)
- physical and mental health issues
- social and environmental context (e.g., social supports, work situation, income, living situation, neighbourhood, family background)
- formulation of the problem/issue

4. The Settlement Worker and client will agree on the service goals to be achieved, the expected length of service and any potential interventions that may be required to achieve the stated goals. This plan for the service will be documented in the assessment.

5. Safety issues must be explored as appropriate. If there are any concerns, staff should follow the appropriate policy (e.g., child abuse, adult abuse, dealing with child custody situations, client suicide). Where there is a risk of imminent harm, the assessment of risk and the development of a safety plan takes precedence over all other activities.

6. Staff will summarize or formulate the issues to the client in a way the client can understand for their consideration.

7. If more than one service provider is involved, staff should clarify who is ensuring service coordination, if needed, along with a clear direction from the client about the nature of communication among service providers. If needed, consents for the release of information should be obtained.

8. The fee should be confirmed, where applicable, along with the payment expectations.

9. The assessment will be documented for each client receiving service in their client record within five working days of the assessment interview.

Policy Name and Number:	1.12 Referrals to Community Services
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

Organization's name creates and maintains linkages and relationships with other service providers, organizations and professionals in the community in order to ensure clients have the opportunity to access the most effective, coordinated and comprehensive services available.

Organization's name, with the informed consent and participation of the client, may make referrals to another service within organization's name or to external resources, at any time in service delivery (i.e., prior to offering service, while service is ongoing or when service is being terminated).

SCOPE

This policy applies to all organization's name personnel (employees, students and volunteers).

PROCEDURES

1. Internal Referrals – Within Programs

1.1 If staff determine that clients would be better served by another team member or where it is indicated that more than one counsellor is needed (i.e., to work with a couple separately), staff negotiate this with other staff and ensure that they have the informed consent of the client. The manager must be informed.

1.2 Once this new arrangement has been made staff must be notified and asked to book the appointment or the staff members must negotiate who will call the client to establish the first interview.

2. Internal Referrals – Between Programs

2.1 Generally, internal referrals are made between programs to a worker or program that offers specialized expertise.

2.2 The appropriateness of the referral and the availability of the service will be discussed between staff.

2.3 The client will be provided information on the expected waiting time, plans for follow-up and the type of service, in order to make an informed decision.

2.4 The program should be notified of the internal referral. Upon receipt of the referral, the program staff create an attention message with the information in the client database and waits for the client to request the new service. If asked by the counsellor, staff may open a case for the client in the new program.

2.5 Staff will advise the program to which the client is referred of the referral.

2.6 The client will be asked to phone staff to request the service from the second worker or program. Staff may offer greater support to facilitate the referral if needed.

2.7 When service is currently being provided by two or more organization's name programs, service co-ordination must be provided. In the situation of one program referring a client to another program, the referring person will assume the responsibility of co-ordination. If the client has initiated receiving the second service, then staff should negotiate the service co-ordination in the interests of the client and with the client's involvement.

3. External Referrals

3.1 The referral of an ongoing client to a service outside of the organization involves an active role for staff as a service co-ordinator.

3.2 The following guidelines apply to external referrals:

- Make a careful assessment of the client's expressed needs and the staff's perception of that need considering as well the work in progress at that time.
- Ensure the client's involvement in the process as well as in the decision made, including suggesting possibilities and alternatives.
- Support the referring staff member's active participation either through direct contact with the selected service or through encouraging the client's initiation of service.
- Ensure referring staff member's continued contact with the client and other service providers, as necessary, including plans for ongoing organization's name involvement, follow-up and the necessary steps to support the process.
- Make sure that there is a clear and documented approach to service co-ordination.
- Check that the necessary documents are signed with regards to ensuring informed consent to share information between service providers throughout the referral and service delivery process and/or verbal consent to do so is documented in the client record.

3.3 When referring to private practitioners, wherever possible, provide clients a minimum of three appropriate referral resources. If it is not possible to satisfy this minimum requirement, the client must be informed as to why and this information must be documented in the client record.

4. Referrals to organization's name

4.1 organization's name asks that clients phone the Settlement Department requesting service for themselves as much as possible.

4.2 Where it is not possible for a client to phone requesting service, professionals or persons in the community may contact the Settlement Department requesting service on behalf of a client. The client's permission must be obtained before a client case will be opened by the Settlement Department.

4.3 organization's name does not typically follow-up with referring agents to advise them that the person they referred has not called and arranged for service. The exceptions are referrals into organization's name mandated programs and programs where this is required by funders. In such situations, the referral source will be notified by telephone or fax that the client has not followed up on the referral and that the file will be closed within a certain period of time to allow the referral agent to contact the individual.

4.4 At times, professionals initiating the referral may have questions with regard to organization's name services. At this point, the service access staff may call upon [title of staff] to support the process of referral, client contact and overall service delivery.

4.5 The role of the referral sources should be addressed early in the process of service delivery. Clients should be made aware of these discussions and approve decisions made with regard to the coordination of services.

4.6 Follow-up with referral sources may be contracted, with client involvement and informed consent. Releases of information must be signed and entered into the client file.

Policy Name and Number:	**1.13 Urgent Service**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

Organization's name strives to provide immediate service to clients experiencing acute emotional distress during office hours. Recognizing that organization's name has limited capacity to respond to such emergencies, staff will involve community resources (e.g., 911, mental health outreach teams) as required and will communicate clearly the limitations of organization's name resources. Duty day assignment is one mechanism by which urgent service and assistance is provided. All clinical staff are expected to serve as duty day workers on a rotational basis with rosters established by each team.

DEFINITIONS

Urgent Service: A system of "on call" staff to ensure immediate response to emergency or urgent service requests during open office hours. No support is offered after-hours (including holidays) although clients telephoning organization's name after hours are referred to 24/7 community resources.

Duty Day Worker: The primary role of the duty day worker is to respond to emergency or urgent service requests within the limits of their ability to do so. The duty day worker may also be asked to assess whether people requesting service or clients in crisis will be seen, referred elsewhere, placed on the wait list or provided with telephone counselling.

SCOPE

This policy applies to all program and service employees.

PROCEDURES

1. Assessing the urgency of the situation and calling the duty day worker

1.1 When a client is upset and requests immediate consultation with a counsellor, the staff involved will evaluate from the client's voice, appearance, or the content of the communication whether or not the situation is of an immediate serious nature. If it is apparent that a client is at risk of harming themselves or others, please refer to the *Duty to Warn* policy for guidance on how to proceed.

1.2 If there is any doubt about the severity of the situation, the duty day worker should be called.

1.3 If the situation does not appear urgent, the employee will advise the client that no counsellor is available at that moment. S/he may ask the client if the situation can wait until a counsellor is free or if they would like an alternative resource.

1.4 If the client insists on talking to a counsellor, or the support staff is convinced by the client's voice, appearance, or the content of the communication that the situation is of an immediate serious nature, a counsellor must be involved as soon as possible.

2. Establishing the Duty Day Roster

2.1 organization's name maintains a system of "on call" counsellors to ensure immediate response to urgent service requests during open office hours. Programs must clarify the expectations for staff to participate in sharing duty day responsibilities.

2.2 The existence of this system does not diminish the responsibility of other counselling staff and managers to provide immediate response to clients and consumers when needed.

2.3 Counsellors are drawn from the participating programs and the program managers are jointly accountable for ensuring the roster is maintained.

3. Serving as the Duty Day Worker

3.1 The duty day worker will accept urgent interruptions, including interruption during an interview. If it is necessary to have Voice-Mail Call Forward on during an interview, it may be necessary to reach the staff member by knocking on the door instead.

3.2 Telephone calls must be returned on the day they are received. Non-urgent telephone requests which require counsellor consultation may be returned the next day by the staff person who was on duty the day the request was received.

3.3 The duty day worker is responsible for ensuring coverage when s/he must leave the office or is unable to be on duty and for advising relevant staff of the change.

4. Finding emergency support if the duty day worker is unavailable

4.1 If the duty day worker is busy or out of the office, other staff may be called for back-up. Staff who are not seeing clients should be called first; otherwise the manager may be called.

4.2 During evening hours, there is no schedule for duty day coverage. Requests may come directly to programs that are open. In case of need for back-up counsellor support, it will be provided by counsellors on the premises. Program managers and/or directors will be available via cell phone to respond to urgent situations requiring additional supports/consultation.

Policy Name and Number:	**1.14 Collecting & Storing Client Data**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

Organization's name maintains an electronic database of information regarding clients and the services provided. Client and service data is collected, summarized and analysed in order to report to funders, monitor and evaluate organization's name work, understand who organization's name is serving and the nature of the services being provided, and advocate for funding. Employees involved in providing direct service or supporting direct service are responsible for ensuring that client and service data is complete, accurate and up to date.

SCOPE

This policy applies to employees, students and volunteers who provide direct service or support the provision of direct service.

PROCEDURES

1. Employees, students and volunteers responsible for providing direct service to clients will enter complete, accurate and up to date information about the client and/or service provided into the electronic database as soon as possible after the service event/information is collected and no later than five working days after the service event/information is collected. This includes client demographics, assessments, activity notes, record of community initiatives, etc.

2. Employees, students and volunteers must ensure that client appointments are entered into the client and service database prior to clients being seen to ensure accurate records of client service.

3. Employees, students and volunteers supporting direct service will ensure that information that they are responsible for collecting is complete and timely (e.g., client demographics).

4. Direct service employees, students and volunteers as well as relevant managers and support staff will monitor the information in the electronic database about clients and services to ensure that information is complete and timely.

Policy Name and Number:	**1.15 Dealing with Emergencies**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
Organization's name staff, volunteer, student and client safety takes precedence over all other concerns. Organization's name will endeavour to ensure that all staff are trained and ready to address emergency situations when they arise. This policy covers medical emergencies such as cardiac arrest, seizures or loss of consciousness. The individual who first responds to the call for help is responsible for coordinating emergency activities.

SCOPE
This policy applies to all organization's name staff, students and volunteers.

PROCEDURES
When a health emergency occurs the following steps are to be taken (adapt as necessary based on the location and the circumstances):

1. Stay with the person to the greatest extent possible. Do not move the person if possible until they have been assessed by medical personnel or someone with first aid training.

2. Page, shout or get help or ask someone to do this. Explain that there is an emergency and the nature of the problem.

3. Call 911 or have someone call 911. When the call is answered indicate if you need police, fire or ambulance or a combination. The 911 caller should identify him/herself, the office location and the room location where the incident has occurred. Follow the 911 operator's instructions.

4. Notify reception that 911 have been called so that the receptionist can direct emergency response staff upon arrival. If reception is not available and there are other people present on site, delegate someone to direct emergency response staff.

5. Page for an individual with first aid training or have reception issue the page:
"An individual with first aid training is needed in [LOCATION] immediately." Repeat twice.

6. Ensure immediate attention is provided to the client and organize first aid attention until emergency services arrive, if necessary.

7. If the emergency occurs in the reception area:

7.1 Depending on the nature of the emergency, one reception staff member may usher spectators away from reception or may remove the person concerned to a quiet room nearby.
7.2 The other reception staff will either attend to the individual of concern or the other people remaining in the reception area.
7.3 Follow steps above (1 – 6).

8. Management staff should be advised of the situation at the first available opportunity (if they were not onsite or not involved in managing the emergency).

9. An *Incident Report* should be completed and left for the manager.

10. The relevant manager, in consultation with the person who acted as crisis manager, should coordinate appropriate post-incident measures, depending on the nature of the emergency and those involved. These steps may be appropriate immediately following the emergency:

10.1 Provide/organize immediate attention and support to all those involved in the emergency, including witnesses.

10.2 Provide brief information about the event to others on the site to allay fears and concerns.

10.3 Advise staff of support services available to them including EAP debriefing services, EAP Critical Incident Response Team (CIRT) or other supports. Arrange for supports if they are needed.

10.4 Determine the debriefing needs of any client(s) involved in the incident and make arrangements.

10.5 Ensure that transportation is available for individuals who have experienced a traumatic incident and wish to go home.

10.6 Ensure support from family and friends is available. While it can be helpful to alert those at home that support is needed, consent of the staff member (or client) is required.

10.7 A debriefing session should take place within 48 hours of an incident to provide staff with a brief update of the situation and discuss any follow-up. A critical incident debriefing may also be arranged.

SUSPECTED DRUG OVERDOSE POLICY

Source: http://www.toronto.ca/housing/pdf/toolkit05.pdf

If staff suspects that a participant has taken a drug overdose, they should take the following actions:

- Immediately notify another staff member of this suspicion (ideally the supervisor or coordinator of the program area involved)
- Clarify the kind of substance ingested
- Clarify the amount of the substance ingested. If it is a liquid, find out the amount in fluid ounces. If it is a medication, find out the number of pills taken and the dosage amount of each pill
- Clarify or estimate the time lapse since ingestion of the substance
- Call for an ambulance and provide basic response information:
    - Gender and age of the person
    - Description of substance and amount taken (if known)
    - Current physical status (e.g. conscious or unconscious)
    - Location/Address
- Document the time of the emergency response request
- Arrange for staff to meet the emergency response unit at the front door
- Make the person as comfortable as possible. Assign a staff to remain with the person and provide support. Your single responsibility at this point in time is to try to and link the person to emergency ambulance services for further assessment and transportation
- If staff are unsure of the validity of the reported overdose they should still respond in accordance with this protocol. They should not let their investigation slow down potential emergency response to the incident.
- In the event that emergency response services are unable to assist the person in difficulty, staff should continue to monitor the suspected overdose and take further action as necessary.

Crisis Intervention: A Step-By-Step Intervention Process

Source: Toronto Drop-In Network (TDIN) Toolkit; http://www.toronto.ca/housing/pdf/toolkit05.pdf

1. Make other staff on duty aware of the situation. Do not challenge the participant.

2. The first staff member on the scene becomes the "lead" staff, and the others act as back-up. If this is you and you feel that you are unable to handle the situation, ask reinforcement staff to act as the lead while you act as back-up.

3. Back-up staff should not rush into the situation, even if they assume they have a good relationship with the participant. It can be very intimidating for a participant to suddenly be surrounded by staff, and this may serve to escalate the situation rather than defuse it.

4. "Back-up" staff should provide exactly that – back-up. It is important for staff to present a united front. It is more useful for all staff to be working together on one solution, than for each person to try to implement their own solution. If you have a concern with the way the lead staff is handling the situation, this should be addressed later, in private, or during the debriefing.

5. Ensure that other participants are out of the way**.** This will both ensure their safety and may help prevent escalation of the situation. If other participants remain present, their "audience participation" may trigger the participant who is "ready to blow."

6. If another participant is the target, get them to a safe place, and if possible, have someone else stay with them.

7. Place yourself in such a way that you can leave the room without obstruction (look for the nearest exit).

8. Keep a safe distance from the participant (but not so far that you have to shout). Give participant space to move and do not reach out to touch the person if they are agitated or angry. Do not turn your back on participant.

9. Advise participant, in a calm, steady voice, of consequences if this behaviour continues. Give participant time to back down.

10. Use de-escalation techniques (described further below) as you engage the participant.

11. Encourage the person to leave so that they can cool down. Do not follow participant through the door as many violent incidents happen in a doorway. Your guard may be down and then there is a shift in power. Let them leave of their own accord.

12. If the participant refuses to go, warn them that you will have to call the police if they will not leave. Often, talking about calling the police is enough to convince the participant that it is in their best interest to leave. However, if they continue to refuse to leave, you should follow through with the call.

13. Do a debriefing with the targeted participant(s).

14. Do a debriefing with the staff involved.

15. Fill out an incident report.

As much as it is important for staff to train, prepare, and think through their responses to crisis situations ahead of time, it is also important for them to recognize that every conflict is unique, every person in crisis is an individual, and every conflict resolution approach needs to be tailored to the context of the situation and the particular people involved.

Crisis Intervention: De-Escalation Techniques

Source: Toronto Drop-In Network (TDIN) Toolkit; http://www.toronto.ca/housing/pdf/toolkit05.pdf

Communication:

Making other staff aware of the escalating crisis is, in some ways, the most important step. There needs to be mechanisms in place to facilitate your ability to make other staff on duty aware of the situation.
Often, a facility is small enough that staff elsewhere in the building can hear loud and agitated voices. Nevertheless, it is a good practice to have other communication mechanisms in place; for example, **walkie-talkies**, **intercoms** in each room, or "**floating staff**." The latter is a system where there is a worker in each room of the centre and one additional worker who moves from room to room. This means that if coworkers have messages for each other, they can communicate them through the "floating" worker.

De-Escalation Techniques:

Often, the best way to defuse an explosive situation is simply to talk to the person and give them some space to let off steam. Anger and belligerent behaviour require a lot of energy to maintain, and talking can be a kind of pressure-release valve that keeps these outbursts short. As people begin to talk, you can validate their feelings and help them find constructive solutions to their problems.

Engaging a participant in conversation:

Active listening: Show support in a way that is respectful and real, and not condescending. Explain to the agitated person that you want to understand what is going on, and that you want to hear both (or all) sides of the story. Give them supportive feedback, even as you are trying to make suggestions for modifying the behaviour. For example, "I understand why you became angry, but we need to find another way to resolve this situation."

Separate space: If at all possible, take the agitated person to a separate space that provides confidentiality and allows the participant to "save face" when they back down. It is best to take the person to a neutral area, like outside of the room, or down a hall, or to go get a coffee, or out for a smoke. Taking them into an office can feel punitive, humiliating, and infantilizing.

Avoid "why" questions: Avoid asking participants "why" questions, because this can exacerbate aggression and frustration.

Tone of voice: While it is a good practice to speak in a calm voice and not get agitated in response, be wary of being too calm or too soothing. Appearing too calm can seem like an inappropriate emotional response to an intense situation, while being soothing can be perceived as condescending and can trigger participants further. Further, these soft tones of voice are often part of a therapeutic approach that individuals who have been recipients of mental health services have experienced before, and this as well may trigger them further.

Panic spots: Recognize and take advantage of "panic spots" – these are moments where the person loses steam and is unsure how to continue or end the conflict. Staff may be able to use this hesitation to make their own suggestion of the direction this interaction should take, and participants may be more willing to agree at these times.

Writing it down: Depending on the explosiveness or intensity of the outburst, it may be helpful to offer the person a piece of paper and a pen and ask them to write down their concerns. This may help them calm down and focus, and it can help you demonstrate that you are committed to working with them on the particular issues they are having.

Talking someone down: As you are talking someone down, use their name, and your name. This shows that you see them as a person and encourages them to see you the same way. Keep your points short and simple. You may find it effective to repeat the same point.

Slow things down: You may feel that you need to act quickly, but it is critical to take a few moments to reflect, order your thoughts, and bring coworkers in. Often situations can ignite by sudden movements, noise, gestures, or obvious displays of nerves. Tell the other person what you're going to do before you do it, particularly if it means moving about and certainly if you have to move out of sight.

Documentation:
After an incident occurs, a report must be filled out as a record of what happened, who was involved, what staff interventions took place, and any required follow-up that needs to be done.
The incident report form should be a **standardized template**, rather than a blank piece of paper. This will ensure that important details do not get lost and forgotten, and will help to standardize the information that gets recorded and how it is used. Further, staff will be less vulnerable to individual criticism or accusations of bias if the matter ever goes to court or becomes part of an inquiry.

It is important that this record be **filled out as soon after the event as possible**, so that the memory of all the details is still fresh. It should be signed, not only by the staff who completed the form, but also by a staff who witnessed the situation occur as well.

If the manager is present, the manager should also sign the report. If the manager is not present, they should be given the report the next time they are in and they should sign it at that point.

EMERGENCY PROTOCOL

Source: Adapted from http://www.toronto.ca/housing/pdf/toolkit05.pdf

Calling 911 is appropriate in the following situations:

- Someone has become violent or aggressive with staff or others;
- Someone is seriously ill (e.g. seizure, bleeding, or injury);
- Someone is actively suicidal (they have threatened to kill themselves or have already taken steps to harm themselves);
- You believe that you or others are in immediate danger; or
- Another staff requests that you call 911.

Calling 911: Tips for Frontline Staff

When you call 911:

- The operator will ask you which emergency service you require: police, ambulance, or fire.
- They will ask the address. Say the address clearly and give them the nearest major intersection.
- Give them your name and explain that you are staff.

Answering 911 Operator Questions

- 911 will ask a series of questions about the location of the incident, how many people are involved, and for a description of the individual(s) in question. Answer as calmly as possible and give as much detail as you know. If the incident is happening in another part of the building, explain to the operator that you are communicating with other staff onsite and must have information relayed.
- When 911 asks what the problem is, stick to the facts but ensure that they understand the urgency of the situation. If someone is violent or has a violent history, tell them. If someone has issued a threat of any kind of violence, tell them.

Managing Communications with 911 Operator

- Communicate urgency. If they do not believe the situation is serious, they will give the call a low priority. The 911 operator may make judgmental statements about the situation: simply reiterate that it is very serious, that you would not have called otherwise, and urge them to send help.
- 911 may ask questions that we cannot answer (i.e. do you know the person's name). If it is not reasonable to obtain this information safely, explain that you can't provide it but reiterate that help is still needed.
- If the situation escalates, call 911 back immediately and tell them. If emergency crews do not respond, call back and ask for a re-call. Continue to do this until the situation is completely resolved to staff satisfaction.
- Do not cancel police calls, even if an individual leaves the building. The person may stay in the area and it is important to make a report.

Staff Back-up

- Make sure that you are safely able to make a 911 call. Front Desk staff must be able to stay on the line uninterrupted with 911 during an incident. If you are being threatened directly, call maintenance or other staff for back up and maintain a safe distance.

Documentation & Reporting of 911 Calls

- Document all dealings with 911 in an incident report and a report to the Manager. Give details about how the operator treated you, whether or not emergency crews responded, and what the outcome of the incident was.
- Any contact with 911 is considered an incident and requires an incident report to be filled out and filed with the appropriate managers.

EMERGENCY SEARCH AND EVACUATION PROCEDURES
Source: Adapted from http://www.toronto.ca/housing/pdf/toolkit05.pdf

Basic Emergency Evacuation Procedure:

- Pick up client sign-in sheets (if any) and leave the area immediately (so you know who is/was in the building).
- Ensure that all disabled persons have the assistance they need to evacuate the building.
- Designated staff must check washrooms, offices, meeting rooms, etc.

Our designated staff for each program/floor/etc. are:

- Go to the nearest exit and leave the building. DO NOT use elevators.
- Close all doors behind you. Take keys with you.
- Call 911 as soon as possible. Give the correct name and address of the building, the type of emergency, and your name.
- Meet at a designated nearby location and verify that all program participants, staff and volunteers are accounted for. (When conducting drills or discussing evacuation procedures with participants, volunteers, and staff, emphasize the importance of meeting at this designated spot and not leaving the area until others have been able to account for your whereabouts. Explain that if others do not know you are safe, someone may risk their lives to try to find you.)

Our designated location is:

- Advise emergency officials of any missing person, their age, physical description, and possible whereabouts in the building.
- Notify the Executive Director and/or supervisor.
- No employee other than the Executive Director or his/her designate may speak to the public or the media about the emergency or evacuation.
- Do not re-enter the building until you are given permission to do so by emergency officials on the scene.
- Complete any reporting required as per your organizational policies.

Unidentified and suspicious object:

- If you find a suspicious object, DO NOT TOUCH IT.
- Note the description of the object, its location, and any other important pieces of information, and report it immediately to the authorities.
- If an unidentified and suspicious object is found in the building, a quiet and systematic evacuation of the building is required.
- In such an event, staff must direct people to quickly and quietly leave the building, maintaining control and minimizing panic. Use the *Basic Emergency Evacuation Procedure.*

FIRE SAFETY POLICY AND PROCEDURES

Source: Adapted from http://www.toronto.ca/housing/pdf/toolkit05.pdf

In the event of a fire:

- Before opening any door, feel the knob for heat. If it is not hot, brace yourself against the door slightly and open it. If you feel air pressure or a hot draft, close the door quickly.
- If you encounter smoke, consider taking an alternate stairwell/exit. Crawl low under the smoke.
- Activate fire alarm and call 9-1-1 regardless of the size of the fire. Never assume that this has already been done. Give the correct name and address of the building, the location of the fire, and your name.
- If parents are meeting in a separate room from their children, the staff who are with the children are responsible for evacuating them

If you cannot leave your room or have returned to it because of fire or heavy smoke:

- Close your door.
- Be sure the door is unlocked so that firefighters can reach you.
- If you require assistance and can call 9-1-1, do so and let the Fire Department know where you are in the building.
- If smoke comes into the room, seal the base of the door with a wet towel or blanket and crouch down low to the floor.
- Move to the most protected area you can, and partially open a window if possible. (Keep the window closed if smoke comes in).
- Wait to be rescued.
- Listen for any instructions by emergency personnel.

Fire Drill Procedures:

- Fire drills will be conducted by a designated staff person in coordination with the local Fire Department. Drills will be done on a regular basis to ensure that all participants, staff, and volunteers are familiar with building evacuation procedures.
- After each drill a designated person will complete a Fire Drill Report.
- Fire extinguishers will be placed throughout the facility and will be tested annually and logged by a designated person.
- Fire extinguishers do not replace the need to call Toronto Fire Services. Always call 9-1-1 when a fire occurs, even a small fire. Fire extinguishers are not designed to fight large or spreading fires.
- All staff and volunteers must be familiar with the location and operation of fire extinguishers.
- All new staff, volunteers, and program participants must be oriented to fire exits and building evacuation procedures.
- At least one staff member per shift, and, where possible, all staff members, is required to have a recognized First Aid and cardiopulmonary resuscitation (CPR) certification and should be trained in basic First Aid and emergency procedures. This will be updated every two years.
- If an individual is injured, staff will ensure that the person receives appropriate First Aid and medical attention. An accident report will be completed and filed in the program's records.
- The program must complete any reporting required as per organizational policy.

INCIDENT REPORT

Date of incident: _____ Time: _____ Duration: _____

Location and Program: _____

Participant(s) involved: _____

Staff involved: _____

Name of Ambulance Attendant / Police Officer and badge # (if applicable): _____

_____

Type of Incident

Behavioural ☐ Medical ☐ Injury ☐ Property damage ☐

Emergency ☐ Specify: _____

Other ☐ Specify: _____

DESCRIPTION OF INCIDENT *(attach another page if more space needed)*

_____

_____

ACTION TAKEN *(attach another page if more space needed)*

_____

_____

FOLLOW-UP / NEXT STEPS: _____

_____

Staff completing report:

[Print name] _____

[Signature]_____

Witness:

[Print name] _____

[Signature]_____

Supervisor / Manager:

[Print name] _____

[Signature]_____

Policy Name and Number:	1.16 Aggressive or Threatening Behaviour
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

Organization's name promotes a safe and secure environment and does not tolerate aggressive or threatening behaviours. This policy covers how to deal with aggressive or threatening behaviour on the part of clients, people associated with clients or the public. Staff, students and volunteers do not have to tolerate such behaviour and should report it immediately. Zero tolerance of aggressive or threatening behaviour extends to all organization's name locations, including offsite, home and community settings.

A series of steps can be taken to ensure a safe and secure work environment including:

- Physical precautions in the work setting to prevent or safeguard against aggressive or threatening behaviour
- Safety precautions in advance of problems including minimum coverage and case review in advance of an interaction with a high-risk client
- Limiting, refusing or withdrawing service in the face of aggressive or threatening behaviour
- Using co-leadership for groups where there may be safety issues
- Implementing service alerts or email alerts for clients who pose a safety concern
- Managing aggressive or threatening behaviour.

Every effort will be made to ensure that clients are not stigmatized by inaccurate information. However, in ambiguous situations the safety needs of staff, volunteers, students and other clients must take precedence.

DEFINITION

Aggressive or threatening behaviour can include:

- menacing, angry, loud and/or abusive language
- communicating a threat of bodily harm or injury to property, either verbally or through physical behaviour
- brandishing any object as a weapon
- any threat, real or implied
- any behaviour that makes a staff person, student or volunteer feel unsafe
- loss of control

The aggressive or threatening behaviour may be exhibited by the client or by someone associated with the client (e.g., a partner, relative or friend).

SCOPE

All organization's name staff, volunteers and students are covered by this policy.

PROCEDURES

1. Precautions to take PRIOR to interacting with individuals or groups who pose a safety risk or concern

1.1 Review client file and determine which safety precautions to take, including:

- Using an alternative interview room rather than personal office
- Reviewing the Safety Alert System at your location and request panic button if required
- Speaking with the referral source in advance of the initial meeting with the client
- Scheduling the appointment with the client or group session at peak staffing level periods to ensure the availability of support and back-up

- Advising support staff and management of the time and location of the interview with the client or group session concerned
- Preparing the room for safety (e.g., clear out objects that could be used as weapons, leave the door ajar)
- Arranging to have staff colleagues monitor the interview room
- Bringing a second staff member to assist in the interview.

1.2 Provide service, to the greatest extent possible, in a safe interview room that:

- Does not have objects that can be thrown or used as weapons
- Provides the option of leaving the door and/or window blinds open
- Allows staff to easily leave the room.

1.3 Ensure minimum staff coverage for any service provided to a client who poses a safety risk (i.e., Service Alert on his/her file related to problematic behaviour, concern based on clinical experience): One other staff must be in close proximity to the interview location while the interview is underway and aware of the situation.

1.4 Develop a support plan with support staff, other staff and management, including alternate safety strategies such as call-in to manager or staff colleague at break and at the conclusion of the session.

2. Precautions to take DURING and AFTER an interaction with individual client or group session

- Staff should position themselves so that they may easily exit the room if required.
- Negotiate a contract with the client regarding unwanted behaviours and resulting consequences.
- Escort client out of the building and ensure that doors are locked, if possible.
- Request to be observed or accompanied when leaving.

3. WHEN the client is aggressive or threatening

- If staff, students or volunteers feel they are not safe at any point in providing service, follow the principle of **safety first**. Do not minimize a situation that may be getting out of control. Trust your gut feelings.
- Terminate the interview and ask the individual to leave the office.
- If the person is willing to do so, escort him/her out of the building and ensure that the doors are locked (if possible).
- If the person is unwilling to leave, becomes volatile, disruptive or unpredictable, leave the room immediately (if possible).
- Activate the safety alert system to summon help from other staff.
- If needed, create noise and disturbance to attract the attention of other staff.

4. ONCE the Safety Alert System has been activated

4.1 Staff directly involved in the incident must advise the program manager of the situation. If the program manager is not available, assume the role of crisis manager or find another staff person to do so.

4.2 Upon hearing the safety alert system:

- Staff who are not directly involved in the incident should follow the safety alert system for their location (e.g., stay in office or leave their office and proceed to the predefined area).
- Staff at reception will follow the safety alert system for their location (e.g., leave one person to ensure the safety of reception clients or visitors while another staff leaves to find out what is happening and returns with more information).

4.3 The person acting as crisis manager determines the location of the disruption and whether any contact has been made with the staff that activated the safety alert system.

4.4 If no contact has been made, the crisis manager:

- Opens a line into the office where the incident is occurring
- Listens to what is happening in the office to determine what to do
- If possible and it makes sense, speaks to the people involved.

4.5 Once contact has been made, the crisis manager will determine the best course of action, organize first aid and arrange to call 911 as needed.
4.6 If the safety alert system has been activated in error, the staff member must call reception immediately to advise them.

5. Call 911

- Dial 911 and request police, fire, ambulance or a combination.
- Inform the 911 operator if there is an immediate threat of harm. Such calls are higher priority and receive a fast police response.
- Identify yourself, the office location and the room location where the incident is occurring.
- Get a report number from the 911 operator to follow-up if needed.
- Advise management staff at the first available opportunity.

6. AFTER the aggressive or threatening behaviour

6.1 Staff involved should document the behaviour in the client file and determine whether a service alert, organization-wide alert or trespass notice is required.
6.2 The aggressive or threatening incident should be reported within the "Attention" button in the electronic record. The Manager of the Service Access Unit should also be informed.
6.3 If there is reason to believe the aggressive or threatening behaviour will continue, an organization-wide alert should be issued by email.
6.4 Debrief on the situation with the manager, the crisis manager and witnesses. Determine whether follow-up or support is required (e.g.,EAP debriefing services, transportation for staff involved in any traumatic incident).
6.5 If required, obtain additional supports for staff, volunteers, students and/or clients involved in the aggressive or threatening incident (e.g., EAP debriefing, outside counselling, legal assistance, financial reimbursement or time off).
6.6 Complete an *Incident Report* once the situation has abated (see policy on *Incident Reporting / Accident Investigation*).
6.7 Determine if service to the client should be limited or withdrawn.

7. Laying criminal charges

7.1 In cases of aggressive and/or threatening behaviour, the police may decide to lay charges against the client. In such cases, staff are expected to cooperate fully. If staff members wish, they may discuss ethical issues with their supervisor.
7.2 Affected managers and staff may ask their program director for approval to seek legal counsel through the organization's solicitors.
7.3 If the police consider the evidence insufficient to lay a charge, organization's name may support the presentation of evidence to a Justice of the Peace. The legal consultation process to make this decision will involve the Executive Director, director, program manager and involved staff. Organization's name will provide legal services as part of this process. Decisions will be made on a case by case basis.

Policy Name and Number:	**1.17 Duty to Warn/Report**
Date last reviewed:	
Approval or last revision:	
Approved by:	

PREAMBLE
The *Personal Health Information Protection Act (PHIPA) 2004* stipulates that an individual's personal information may be released without consent for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or a group of persons.

The *Mental Health Act (MHA) 1990* sets out circumstances in which a physician, justice of the peace or police officer may detain a person for psychiatric assessment (i.e., an involuntary assessment) and the procedures for doing so.

POLICY
Organization's name protects the confidentiality of information related to clients within limits. These limits are discussed with all clients prior to beginning service and clients are asked to sign a document acknowledging that they have had the limits explained to them. This document also outlines the types of situations in which organization's name may breach confidentiality.
Organization's name reserves the right to breach confidentiality to notify authorities, persons who know the client and/or persons who are at risk of harm in situations where the individual presents a significant and imminent risk of harm to himself/herself or others. This right is known as "duty to warn". Employees are not under a duty to voluntarily inform authorities regarding a client's past or intended criminal act, except where there is a risk of imminent physical harm. Involving authorities may lead to the determination that the client needs to be detained for an involuntary assessment.

SCOPE
This policy covers all employees, students and volunteers who provide service to clients.

PROCEDURES
1. The criteria for determining whether a disclosure of information is warranted should be based on the following guidelines:
- there is a clear risk to an identifiable person or group of persons
- there is a risk of serious bodily harm or death **and**
- the danger is imminent

2. **Suicidal Clients**

2.1 Wherever possible, employees/students/volunteers will obtain the client's voluntary agreement to seek medical assistance.

2.2 When a client is not willing to seek assistance, employees/students/volunteers have a duty to disclose a client's active suicidal ideation and/or plan to commit suicide. The employee's disclosure may include, without being limited to:
- immediately reporting the suicidal intent to a organization's name manager and/ or director
- notifying a family member, a physician or other appropriate person who can ensure the safety of the client
- contacting the police or a mental health crisis team with a request to escort the person to a hospital for a psychiatric examination (i.e., a voluntary or involuntary assessment).

2.3 Employees should proceed according to organization's name policy on *Suicidal Behaviour.*

3. **Clients who present a risk of violence or harm to others**

3.1 Employees/students/volunteers have a duty to warn the intended potential victims of threatened violence.
3.2 Employees should immediately report the threat to a manager or director.
3.3 The threat should be reported to the police when the intended victim cannot be reached or in situations of immediate danger. The police will determine the most appropriate next steps, including whether there are grounds to detain the client for an involuntary assessment (as per the *Mental Health Act (MHA) 1990*).

4. **Clients who threaten or present a risk of violence to** organization's name **staff or property**
Employees should proceed according to the organization's name policy on *Dealing with Aggressive or Threatening Behaviour* if they encounter a client who threatens or presents a risk of violence to them, other employees or organization's name property.

5. **Assaultive Partners**

5.1 When abusers are referred by Domestic Violence Courts or by probation officers to the PAR Program funded by the Ministry of the Attorney General, organization's name is required to initiate contact with their partners in accordance with the conditions set out in the contract.
5.2 Abusers entering the program must consent to partner contact as a condition of entering the program to satisfy the requirements of informed consent.
5.3 Written consent is the expectation; however, there may be occasions when verbal consent is acceptable (e.g., literacy issues, language issues). Documentation of this verbal consent must be recorded in the file.
5.4 In accordance with the guidelines set out by the Ministry of the Attorney General regarding court or probation mandated services, contact with the partner is limited to:

- conveying information re: potential risk by the abuser
- obtaining information re: the partner's abusive behaviour
- informing partners of organization's name obligation to report violations of the probation or court order
- providing assistance with safety planning
- informing the partner of available community supports
- offering support or other services

5.5 Should consent be revoked by the abuser, organization's name services will be terminated.
5.6 The duty to warn will have precedence in guiding the worker's actions regarding informing the partner of this termination.
5.7 Persons who are assaultive may be seen on a voluntary basis. Consent for partner contact must be obtained. Organization's name remains obligated to initiate contact with the partner (or others threatened) where there is a risk of imminent harm to the partner.

6. In all situations, employees/students/volunteers should document the situation, including their assessment of the risk of harm or death, the information on which their assessment is based and any actions taken, in the client file.

Policy Name and Number:	**1.18 Child Abuse Reporting/Documentation**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
All persons performing professional or official duties at organization's name have a duty to report a child's need for protection, in compliance with the *Child and Family Services Act*.

The duty to report child in need of protection is outlined in Section 72 (1) of the Act, and states that where there are reasonable grounds to suspect that a child may be in need of protection (see definition section for complete list), the person must immediately report his/her suspicions and the information on which the concern is based to a children's aid society. In cases where there is doubt or ambiguity, a children's aid society should be consulted.

Duty to report is a personal duty and cannot be delegated to another (e.g., manager or director cannot report on behalf of an employee, rather the employee must make the report directly).

The duty to report takes precedence over all organization's name policies. The professional's duty to report overrides the provisions of any other Provincial Statute, specifically those provisions of other Statutes that would otherwise prohibit disclosure by the professional. The only privilege not subject to reporting is that between a solicitor and his/her client.

Failure to report is an offence under the Act. Any professional who fails to report his/her suspicion of a child's need for protection is liable on conviction to a fine of not more than $50,000 or to imprisonment for a term of not more than two years, or to both.
Organization's name will ensure that all employees, volunteers, students are trained in child abuse reporting policies and procedures prior to providing service.

SCOPE
All organization's name employees, volunteers and students are covered by this policy.

LIMITATIONS
Duty to report is a personal duty and cannot be delegated to another (i.e., manager or director cannot report on behalf of an employee; rather the employee must make the report directly).

PROCEDURES
1 Informing the client about the limits of confidentiality and the duty to report

1.1 All clients must be informed of the limits of confidentiality and the legal requirement to report child abuse or neglect at intake.

1.2 At the first face-to-face appointment, employees will remind clients of the limits of confidentiality and the duty to report child abuse. Clients must sign a form which signals that they are aware of these limits. For clients who are only served on the phone, employees will verbally explain the limits of confidentiality and write a note in the client record indicating this has been discussed with the client.

2 Acting on a suspicion of child abuse or neglect

2.1 If child abuse is suspected, determine from the client record if there have been prior consultations with a children's aid society.

If yes (i.e., there have been prior consultations and/or if the society has given directions not to inform particular individuals), any previous direction from a children's aid society must be followed.

If no, proceed to the next step.

2.2 If child abuse is suspected, all personnel are encouraged to discuss the situation with their supervisor/manager to determine the best way to proceed (e.g., whether to inform the client prior to making the call to the children's aid society).

2.3 Every reasonable effort will be made to first inform the service user (both adult and child) in a sensitive manner of the intention to report, prior to contacting the children's aid society.

2.3.1 The adult client in charge of the child can be given the option of making the first contact with the children's aid society.

2.3.2 However, the adult client should not be encouraged to make the first contact with the society if this may put the child at greater risk, if this risks prejudicing the investigation or there are CAS directions not to inform a particular person.

2.3.3 The fact that the parent or guardian reports the child abuse does not relieve the staff person of his/her duty to report.

2.4 Document the conversation about the intent to report with the service user in the client file.

3 Reporting to a Children's Aid Society

3.1 Any organization's name employee, volunteer or student must inform their immediate supervisor of any abuse allegations they have reported at the first possible opportunity.

3.2 The person who suspects that a child needs protection must make the report personally to the children's aid society and make every effort to facilitate the children's aid society investigation. The duty to report cannot be delegated.

- If possible, consider the child's religious or cultural affiliation in making the report. Contact: Peel Children's Aid Society at 905-363-6131.

3.3 Staff will maintain contact with the children's aid society as appropriate, whether to facilitate the investigation or ensure that the report is addressed.

3.4 Management and other team members will support the employee, volunteer or student making the report.

3.5 During the course of a children's aid society investigation, personnel will ask the children's aid society for guidance on how to relate to the client (e.g., whether or not to discuss the investigation) and follow that direction as much as possible.

4 Documenting and reporting

4.1 The person reporting to a children's aid society must document the following information in the client record:

- Date and time of the report
- Name of the person reporting the abuse and relationship to the child
- Name and telephone number of the children's aid society person who received the report
- Name, age and religion (if known) of the child
- Nature and known details of the suspected abuse
- Name or identity of the alleged abuser
- Content and outcome of discussion with the adult client (parent/guardian)
- Children's aid society response and follow-up to the report
- Revised service plan, if any
- Any further follow-up or contact with the children's aid society.

DEFINITIONS from the *Child and Family Services Act*

Duty to report child in need of protection s. 72 (1): if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society:

1. The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,
    i. failure to adequately care for, provide for, supervise or protect the child, or
    ii. pattern of neglect in caring for, providing for, supervising or protecting the child.
2. There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
    i. failure to adequately care for, provide for, supervise or protect the child, or
    ii. pattern of neglect in caring for, providing for, supervising or protecting the child.

3. The child has been sexually molested or sexually exploited, including by child pornography, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

4. There is a risk that the child is likely to be sexually molested or sexually exploited as described in paragraph 3.

5. The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment.

6. The child has suffered emotional harm, demonstrated by serious,
i. anxiety,
ii. depression,
iii. withdrawal,
iv. self-destructive or aggressive behaviour, or
v. delayed development, and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

7. The child has suffered emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.

8. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

9. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and that the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.

10. The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition.

11. The child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody.

12. The child is less than 12 years old and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, those services or treatment.

13. The child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately.

Note of Clarification on Reportable Grounds:
Patterns of neglect are now included as grounds for reporting and the threshold for "emotional harm" has been lowered from substantial risk to the risk that the child is likely to suffer emotional harm.

The section does not specifically include children who witness violence and the issue is currently under discussion between children's aid societies and the Ministry. However, the sections relating to neglect and emotional harm could apply in domestic violence situations (e.g., when the children appear to be traumatized). A consultation with a children's aid society is recommended in these situations.

Ongoing Duty to Report, s. 72 (2): A person who has additional reasonable grounds to suspect one of the matters set out in subsection (1) shall make a further report under subsection (1) even if he or she has made previous reports with respect to the same child.

Person to report directly, s. 72 (3): A person who has a duty to report under subsection (1) or (2) shall make the report directly to the society, a person who has a duty to report under subsection (1.1) shall make the report directly to any organization, agency or person designated by regulation to receive such reports, and such persons shall not rely on any other person to report on their behalf.

Offence s. 72 (4): A person referred to in subsection (5) is guilty of an offence if,

(a) he or she contravenes subsection (1) or (2) by not reporting a suspicion; and
(b) the information on which it was based was obtained in the course of his or her professional or official duties.
(4.1) A person is guilty of an offence if the person fails to report information as required under subsection (1.1).
(4.2) A person is guilty of an offence if the person,
(a) discloses the identity of an informant in contravention of subsection (1.4); or
(b) dismisses, suspends, demotes, disciplines, harasses, interferes with or otherwise disadvantages an informant in contravention of subsection (1.5).

Persons to whom s. 72 (4) applies (s. 72(5): Subsection (4) applies to every person who performs professional or official duties with respect to children including,

(a) a health care professional, including a physician, nurse, dentist, pharmacist and psychologist;
(b) a teacher, school principal, social worker, family counsellor, operator or employee of a day nursery and youth and recreation worker;
(b.1) a religious official, including a priest, a rabbi and a member of the clergy;
(b.2) a mediator and an arbitrator;

(c) a peace officer and a coroner;
(d) a solicitor; and
(e) a service provider and an employee of a service provider.

Penalty s. 72 (6.1) A director, officer or employee of a corporation who authorizes, permits or concurs in a contravention of an offence under subsection (4) or (4.1) by an employee of the corporation is guilty of an offence.

Penalty s. 72 (6.2) A person convicted of an offence under subsection (4), (4.1), (4.2) or (6.1) is liable to a fine of not more than $50,000 or to imprisonment for a term of not more than two years, or to both.

Policy Name and Number:	**1.19 Adult Abuse**
Date last reviewed:	
Approval or last revision:	
Approved by:	

PREAMBLE

Organization's name recognizes that abuse in intimate adult relationships is a complex issue. Men are the perpetrators of most adult abuse and women are the most frequent victims. Abuse also has significant impacts on children. Organization's name also recognizes that some groups within society, such as people who are older, people living with a disability, immigrant communities and people who are members of the LGBTQ community are made more vulnerable to abuse due to a variety of intersecting oppressions.

Organization's name programs and services are based on the premise that violence is a systemic issue rooted in the inappropriate and coercive use of power and control in personal relationships. Organization's name recognizes that the type and nature of personal relationships varies and can include abuse perpetrated by a partner, an adult child, close family friend, neighbour and/or other trusted person.

POLICY

Organization's name adult abuse policy is founded on the following principles:

- All forms of abuse are unacceptable. Organization's name adopts a zero tolerance policy for abusive behaviour.
- The safety and well-being of the abused individual is of primary concern in the delivery of services.
- Organization's name services shall reflect a belief in the dignity and self-determination of all people.
- Organization's name strives to provide culturally sensitive and respectful services which are responsive to the needs of all clients.
- Services to abused clients are provided within an equity and inclusion framework that recognizes and incorporates the impact of factors such as race, culture, age, gender, ability, sexual orientation and economic status into work with clients, and is sensitive to the power dynamic/hierarchy in the counselling relationship.
- Abuse is a societal and community issue. A comprehensive community response must be developed if abuse is to be reduced and ultimately stopped. As such, effective services to end violence must include public education, coordination and networking among service delivery systems within and across sectors.
- Organization's name will intervene promptly if there is reason to suspect a client is mentally incapable and is at risk of suffering serious personal or financial harm.
- Services to adults will routinely include an assessment of the risk of abuse.

SCOPE

This policy applies to all organization's name staff, students and volunteers who serve adult clients.

DEFINITION

Organization's name defines abuse as an expression of the misuse of power and control in a relationship. Abuse is any action or inaction that jeopardizes the health or wellbeing of an individual. This can include physical, emotional, psychological, financial/economic, sexual, spiritual or medication abuse, as well as passive or active neglect and denial of civil or human rights. Abuse is a deliberate act, neglect or withholding for which the perpetrator is responsible and accountable.

PROCEDURES

1. **Screening for risk of abuse**

1.1 Services to adults will routinely include an assessment of the risk of abuse as part of the intake screening process.

2. **When abuse is detected or suspected**

2.1 Staff, volunteers and students will communicate to abused adults and/or the alleged perpetrators that abuse of any type is unacceptable behaviour and that no one deserves to be treated this way.
2.2 Staff working with abused adults will make every effort to connect them to the justice system should they wish to take legal action (e.g., connecting clients to community relations or domestic violence liaison officers).

3. **Safety planning**

3.1 When in contact with abused adults, the safety and well-being of the abused adult is of primary concern in the delivery of services. As such, staff will:

- Evaluate the level of danger to the client and any other persons in the home and/or connected to the person being abused, if applicable.
- Assist the client to plan for his/her safety and advise him/her that all safety planning will be kept confidential.
- Inform the client of his/her right to police intervention.
- Offer services designed to meet the client's needs.
- Urge the client to contact organization's name staff should abuse recur and reiterate that their information will be kept confidential, within the confines of the law.
- Review the safety plan periodically and amend it as needed.
- Ensure that any issues of child abuse are dealt with in legal and ethical ways.
- Identify resources and community services available to the client.
- Liaise, as necessary, with other services within organization's name (e.g., Violence Against Women program, Seniors program) or outside the organization to assist the client. If it is not possible to gain client consent for external consultation, anonymous consultations within and outside organization's name will be permitted on a limited basis.

3.2 The safety plan will include the following elements:

- Establishing how the client will know they are at risk.
- Establishing what a client will do in the situation (e.g., when s/he is able to leave home, when s/he should remain in the home).
- Identifying important keepsakes and documents the client might need to remain safe and/or to leave a situation (e.g., Social Insurance Number, health card, immigration documents, bank book, cheques, list of medications, name and phone number of doctor(s), name and phone number of pharmacy) and preparing an emergency supply of medications.
- Developing plans on how to safely leave a situation if this need arises (e.g., how to safely remove children from the home).
- Determining a way for the client to connect with the counsellor should the situation change.

3.3 All safety planning discussions will be documented in the client's file and will include:

- The name of the alleged perpetrator if the client will provide it.
- A summary of the content of the discussion with the client.
- An assessment of the risk to the client.
- The safety plan that was developed.
- The name of the client's ongoing organization's name contact person.
- Any restrictions on follow up with the client.

4. **Supporting client choice**

4.1 Staff will work to support clients to empower themselves to make choices and control their lives to the full extent of their abilities.

4.2 Clients will be encouraged to make changes in their lives after reviewing the full range of options available to them. Staff will never insist on their own timetable for change unless the client is at imminent risk.

4.3 Staff will attempt to maintain connections with hesitant or resistant clients but, at the same time, will respect the wishes of the client.

5. **When dealing with clients involved in criminal proceedings**:

5.1 Staff working with perpetrators and alleged perpetrators will observe all relevant court orders where organization's name has been directly implicated, including bail orders, restraining orders and peace bonds.

5.2 Staff working with abused adults will advise clients to observe all relevant court orders including bail orders, restraining orders and peace bonds.

5.3 Where needed and possible, staff will provide support to abused adults throughout the court process and/or connect clients to external resources.

6. **Participating in community initiatives**

6.1 Staff will actively participate in initiatives addressing the abuse of adults and make linkages to other sectors and organizations working on these issues.

6.2 Staff will work to encourage various levels of government to provide comprehensive funding to problem resolution and prevention services for individuals at risk of abuse or who are being abused.

7. **Dealing with homicide or serious injury caused by interpersonal violence**

7.1 When a staff person learns that a organization's name client has been killed or seriously injured or that a client has committed such an offence the staff person will immediately notify his/her manager.

7.2 The manager will review the case with the staff person who provided service to the client involved. Together they will document the following in the case record:

- history of service received
- identification of risk factors
- safety planning that took place in response to the identified risk
- precipitating factors to the suicide or circumstances of the death
- police or other legal involvement
- follow-up plan

7.3 The director and Executive Director will be immediately notified of all preliminary information and kept informed throughout the process including follow-up.

7.4 The Manager of Communications will be informed by the director or Executive Director that there has been an incident involving a organization's name client that may result in media calls. A plan is developed to deal with this contingency.

7.5 The director will support the local manager in ensuring that posttraumatic support is provided to staff, volunteers, students and clients affected by a homicide or serious injury.

Policy Name and Number:	**1.20 Suicidal Behaviour & Client Suicide**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
All forms of suicidal ideation or suicide threats will be taken seriously. Action must be taken in the case of every person contemplating suicide – whether it is a chronic or an acute ideation. When in doubt whether a situation is high or low risk, the response must be in line with the high-risk possibility.

Management will be immediately informed (regardless of hour or time of day) and will provide advice in all cases of suicide threats, attempts or actual client suicide.

SCOPE
All employees, students and volunteers are covered by this policy.

DEFINITION
Suicide Risk Factors: Individuals may be more likely to contemplate suicide at certain points in their lives or if certain conditions exist. The following factors should be considered in assessing suicide risk:

- **Means** is what the client intends to use to commit suicide. The more lethal the means, the more serious the risk (e.g., a gun is a more serious threat than pills). Moreover, the more available the method, the more serious the risk (e.g., loaded gun).
- **Plan** is how the client will carry out his/her suicide. A more detailed and specific suicide plan indicates a greater risk.
- **Intent or motivation** reflects whether the client has a reason to live or not. The greater the motivation to die, the greater the risk.
- **History**: An individual who has attempted suicide in past may be at higher risk of achieving their goal than someone who has no history of suicide attempts.
- **Age:** There is an increased rate of suicide in persons under 20 years of age and elderly persons also present a serious risk.
- **Gender:** Men have a higher rate of suicide than women. Men tend to seek help only when problems have reached serious proportions.
- **Stress:** Someone with a lot of stress in their life is at greater risk for suicide.
- **Resources:** A person with fewer resources and supports is at greater risk than a person with considerable resources. The more socially isolated the individual, the greater the risk.

PROCEDURES
1. Assess suicide risk

1.1 Client's suicide risk will be assessed at intake (e.g., by the Service Access Unit, by the EAP Contact Centre). If there are any concerns with respect to this, the duty day staff person will be contacted immediately.
1.2 Staff working with clients will continue this assessment during service and respond accordingly.
1.3 To determine the seriousness of the suicide risk, assess the client against the suicide risk factors (see definition above).

2. Serving clients with suicidal ideation (on the phone or in the office)

2.1 Staff will establish a relationship with clients presenting a suicide risk and will continually assess for means (what they will use), plan and motivation/intention (reasons to live or die) to commit suicide. When in doubt whether a situation is high or low risk, pursue a response that assumes high-risk possibility (that the client has means, plan and motivation).
2.2 In high-risk situations of a client with active suicidal ideation (i.e., client has the means, plan and motivation), the client must be continuously engaged while the staff person tries to get help (whether the client is on the phone or in your office). Clients who are in organization's name offices must be continuously engaged and not left alone.
2.3 Communicate clearly that you do not want the person to take his/her life.
2.4 Help the person identify the problem and reframe it. Do not offer unrealistic outcomes.
2.5 Establish a suicide prevention plan with the client (e.g., direct the person to hospital, to a supportive friend or family member).
2.6 Go with the client or make direct contact with a resource (e.g., police, family doctor, psychiatrist) to ensure follow-up happens.
2.7 Get the assistance of 911 (e.g., if available, asks a colleague to make this call).
2.8 Immediately consult the manager (or first available manager) with respect to the situation and the prevention plan.
2.9 Document all actions and responses in the client record.

3. Reporting a client suicide

3.1 Upon learning that a current organization's name client has committed suicide, a staff person should immediately notify his/her manager.
3.2 The manager reviews the case with the service provider. Together, they review the client record and service history (e.g., identification of risk factors; suicide prevention planning; precipitating factors to the suicide; circumstances of the death; police or other legal involvement). Ensure that the client record is as complete as possible, given the available information.
3.3 Where funders require, the manager will notify the funder using a serious occurrence report within an hour of being advised of the client suicide.
3.4 The director is immediately notified of all preliminary information and updated throughout the follow-up process. The director will determine whether or not to advise the Executive Director.

4. Arranging for case debriefing and support to staff involved

4.1 The manager will organize a follow-up session with involved staff to discuss the client's case and possible changes in policy or procedure.
4.2 The director and manager will ensure that post-traumatic support is provided to staff and clients affected by a suicidal death or injury. How this debriefing support is provided will be decided on a case by case basis.

Policy Name and Number:	**1.21 Client Autonomy**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY
Services provided by organization's name are client-directed. The service plan responds to a client's stated needs and is developed in consultation with him/her.

As active partners in their service, clients have the right to make decisions regarding their well-being, to state their preferences and to refuse service. Organization's name will respect the client's choice unless there is a concern that the client's ability to make decisions is impaired and that this decision will result in imminent harm to the client or others. In addition, organization's name reserves the right to refuse requests that are discriminatory (see *Discriminatory Requests for Service* policy).

SCOPE
This policy applies to all organization's name staff, volunteers and students.

PROCEDURES
1. Clients have the right to state their preference to a service provider within the confines of available resources and the organization's service approach. Organization's name will strive to match client preference to service provider within reasonable limits.

2. Staff will attempt to maintain connections with hesitant or resistant clients but, at the same time, will respect the wishes of the client.

3. If the client decides to end service within a session, this decision should be respected. If appropriate, the client should be asked if the counsellor can follow up in the future.

4. When a client drops out of service, cancels or fails to show up for an appointment, staff will attempt to make direct contact with the client to clarify the situation. This should not be an attempt to persuade the client to return to service but to make it safe for the client to express his/her views and receive validation. This contact should include acceptance of any feedback that the work was not helpful in whole or in part.

5. If the client no longer wants the service or does not want a particular treatment that has been recommended by the provider, the discussion will be recorded in the client file.

Policy Name and Number:	**1.22 Concerns with Client Capacity**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

Organization's name staff do not conduct capacity assessments. Rather, organization's name defers to legally-authorized capacity assessors (See O. Reg. 460/05 Capacity Assessors. *Substitute Decision-Maker's Act at http://www.elaws. gov.on.ca/html/regs/english/elaws_regs_050460_e.htm)*

Organization's name programs and services are largely voluntary and client participation implies consent. Client's will be asked to sign a form that confirms that the client consents to service and has seen and understood the organization's policies. In all cases, organization's name presumes the capacity of persons over 12 years of age to give or refuse consent to service (see *Consent and Information Sharing Regarding Children* policy).

Nevertheless, practice may reveal a concern about a client's capacity to make certain decisions (e.g., decisions about finances, living arrangements and personal care). If such concerns arise, employees or students may need to involve qualified health professionals to assess capacity or the person with Power of Attorney for Personal Care or a Power of Attorney for Property (if one exists) to make the ultimate decision.
It is imperative to remember an individual may not be capable of making certain types of decisions (e.g., financial decisions) but capable of making other types of decisions (e.g., health or treatment decisions) or vice versa. Even when there are concerns about capacity, organization's name will always strive to involve the client in all decision making processes and discussions.

SCOPE

This policy applies to all staff, volunteers and students working directly with clients.

DEFINITIONS

Capacity: The definition of capacity in the *Health Care Consent Act, 1996* is very helpful to general understanding: "A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision." 1996, c. 2, Sched. A, s. 4 (1).

Note: Psychologists are the only professionals who are subject to the Health Care Consent Act, 1996 (i.e., the Act does not apply to social workers).
Capacity assessment: Capacity assessment is the formal assessment of a person's mental capacity to make decisions about property and personal care.
Under the *Substitute Decisions Act*, many situations require capacity assessments to be conducted by specially qualified assessors who must follow specific guidelines.

Capacity assessors: Regulated health professionals who are qualified, under O.Reg. 460/05, to carry out a capacity assessment. They include physicians, psychologists, nurses, social workers and occupational therapists who are trained and certified as capacity assessors by the Ministry of the Attorney General.

Continuing Power of Attorney for Property: A Continuing Power of Attorney is a legal document in which a person gives someone else the legal authority to make decisions about their finances if they become unable to make those decisions themselves. The person who is named as the attorney does not have to be a lawyer. The power of attorney is called "continuing" because it can be used after the person who gave it is no longer mentally capable. Some people use the word "durable" which means the same as "continuing".

Evaluators: Regulated health professionals defined in the *Health Care Consent Act, 1996* who may determine that an individual is incapable of giving informed consent. Within the context of the Act, evaluators are defined as audiologists and speech-language pathologists, nurses, occupational therapists, physicians, physiotherapists, psychologists and social workers.

Power of Attorney for Personal Care: A Power of Attorney for Personal Care is a legal document in which one person gives another person the authority to make personal care decisions on their behalf if they become mentally incapable.

PROCEDURES

1. For clients served in-person, employees will ensure that the client has signed the form indicating that they understand the policies relevant to their service. The signed form is placed in the client's file or filed centrally by program.

2. Clients served only by telephone will also be advised of the relevant policies and their acknowledgement will be recorded in an activity note.

3. If capacity concerns arise at any point in the course of service, staff should:
- consider whether the client understands the decision they are being asked to make
- question whether the person understands the reasonably foreseeable consequences of the decision or lack of decision
- consult with their supervisor

4. If the answer to either question is negative, staff will first determine if a Power of Attorney (whether for Personal Care or for Property) or some other legal guardian is named. Staff will tell the client that s/he is concerned about the client's capacity to make the requested decision and will request permission to speak to the appointed substitute decision-maker and see a copy of the power of attorney (if one exists).

5. If a Power of Attorney has been signed by the client, organization's name shall follow the terms, if any, of the Power of Attorney with respect to determining capacity and providing service to the client. Any conversations should strive to also involve the client to the greatest extent possible.

6. If no Power of Attorney has been signed by the client, staff will exercise extreme caution in advising the client on significant decisions prior to a capacity assessment of the client with a capacity assessor authorized in accordance with the laws of Ontario or in the case of FSEAP the laws of the province where service is being provided.

6.1 Staff will explain the purpose of the capacity assessment to the client and offer to facilitate the assessment arrangement.

6.2 With the client's consent, staff will arrange for the assessment at a time and place agreeable to the client.

6.3 If there is family involvement and no Power of Attorney, staff will help the client identify a family member who is capable, available and willing to take that role and provide the information required.

6.4 If there are no relatives and there is a friend who is willing to take that role, staff will provide information regarding the Consent and Capacity Board so that they can start the process.

6.5 If no one is willing and capable to take this responsibility or if there are concerns about abuse (e.g., financial, emotional or physical), staff will involve the Office of the Public Guardian and Trustee.

7. It must be noted in the client file that the assessment has been requested.
Any document related to the assessment and its results should also be entered into file.

8. Organization's name continues to provide service to the client, even while the capacity assessment is pending. Once the results of the capacity assessment are received (and potentially shared with organization's name) service will adhere to the results.

Policy Name and Number:	**1.23 Limiting, Refusing or Withdrawing Service**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

organization's name has the responsibility and right to make judgments about the advisability of providing service and reserves the right to limit, refuse or withdraw service when:

- There is a perceived danger to staff, whether a risk to their personal safety or to their health
- A client demonstrates a risk of harm or violence to self or others – behaviour or situations of concern include when:
    - There is or has been physical or verbal abuse including threatening or intimidating behaviour by the client (e.g., record of criminal violence in client's history, previously recorded behaviour)
    - Behaviour dangerous to self or others
    - Illegal behaviour by the client has been witnessed by staff
    - There is concrete evidence (e.g., through a referral source) that demonstrates potential for high-risk behaviour by the client
    - Where the client's mental health status indicates counselling would not be helpful
- A client breaks the trust of the organization (e.g., theft or vandalism of organization's name property)
- Staff cannot sustain a productive relationship with the client
- organization's name programs and services are no longer beneficial to the client
- Clients who can pay choose not to pay fees for services where fees exist
- A client lives and works outside [city] or does not meet organization's name program and/or service eligibility requirements
- A client uses discriminatory or harassing language or exhibits discriminatory or harassing behaviour, including the refusal to work with a particular counsellor because of race, sexual orientation, creed, sex, gender identity, ethnic origin or any other grounds prohibited under the *Human Rights Code*
- The request for service is beyond the limits of organization's name resources
- A communicable disease is present and there is a risk of transmission.

Organization's name stands behind a staff decision to limit, refuse or withdraw service or to refer people to alternate community resources for safety reasons provided the circumstances are documented and the approved policies and procedures are followed.

SCOPE

All staff, volunteers and students are governed by this policy.

DEFINITIONS

Limit Service: To restrict service to certain types, locations and hours of the day.

Refuse Service: To refuse service during initial contact with the client.

Withdraw Service: To terminate provision of service.

LIMITATIONS

Staff, volunteers and students will inform the appropriate program manager of any decision to limit, refuse or withdraw service.

PROCEDURES

1. **Assessment at Intake on Limiting or Refusing Service**

1.1 Staff conducting intake will advise the referral source and/or the potential client that service may be limited, refused or withdrawn if the client has a history of high-risk behaviour or if organization's name is not able to provide the required service. If possible, referrals to other services will be made.
1.2 Staff conducting intake will raise concerns about the need to limit or refuse service during the intake process to the relevant program manager and flag the concern in the electronic client database.
1.3 The program manager receiving the notice of the concern will review the client's situation to determine whether service should be limited or refused.
1.4 Staff conducting intake may make the decision to refuse service in consultation with the appropriate manager. If service is refused at assessment, staff will attempt to refer the client to other resources that may suit his/her needs.
1.5 If a client record exists, the refusal and reasons for it will be indicated in the electronic client record.
1.6 A service alert to all staff may be activated in the electronic client database at this point for refused clients who present safety concerns. All service alerts will include an explanation of the reason for the refusal, limitation or withdrawal of service.

2. **Refusing Service**

2.1 Immediately after assessment and before service begins, staff may determine that organization's name cannot provide service to a client. If this situation arises, staff will discuss the refusal with their manager and document the decision in the client record. If possible, referrals to other services will be made.
2.2 A service alert to all staff may be activated in the electronic client database at this point for refused clients who present safety concerns. All service alerts will include an explanation of the reason for the refusal, limitation or withdrawal of service.
2.3 If service is refused, staff will explain the reasons for the refusal to the client and attempt to refer him/her to other resources that may suit his/her needs.

3. **Limiting or Withdrawing Service**

3.1 Staff with concerns about providing service to a client may decide to temporarily limit or refuse service.
3.2 Any temporary limitation or withdrawal of service must be subsequently discussed with the immediate manager. The situation may also be brought to the program team to generate alternatives or ensure a consistent approach.
3.3 Ongoing limitation or withdrawal of service must be approved by the manager.
3.4 Behaviours such as intimidation, threats or verbal abuse are not to be tolerated by any staff person. If the staff person has concerns about threatening or intimidating behaviour, these concerns should be reported to the manager and the police if necessary.

4. **Documentation and Notification**

4.1 The client record must include:

- Description of the action taken and the reasons for action
- Documentation of any contract with the client concerning their behaviour
- Documentation of consultation with immediate manager
- Issuance of a service alert in cases of clients posing a potential risk to staff.

Whenever possible or advisable, the manager will contact the client to inform him/her that service may be limited or withdrawn if their behaviour continues. Any phone or in-person discussion with the client will cover the following points:

- I have been informed of your contact with your counsellor and my understanding of the situation is…
- I understand the difficulty of your situation and would be pleased to assist you in finding appropriate professional help.
- If client exhibits high-risk or threatening behaviour: Our policy on these matters is to request your cooperation in refraining from further high-risk/threatening behaviour. If you do not cooperate, we will issue a Trespass Notice under the *Trespass to Property Act*.

The manager will inform the program director about any service restrictions. If the client is participating in several organizations' name programs and one program makes the decision to withdraw service, the manager of other program(s) involved must be informed of the withdrawal decision and the reasons for it.

Other concerned programs must consider whether some action is required of them as a result of the service restriction information.

5. **Issuing a Trespass Notice**

5.1 The manager may determine that the client should be issued a trespass notice to prohibit his/her appearance on organization's name premises. The manager must consult with the director and provide case documentation prior to implementing a trespass notice.
5.2 Once approved, the manager will complete the *Notice under Trespass to Property Act Form*, send it to the client by registered mail and post it at organization's name offices.
5.3 The notice must be readily available to present to police if the notice is violated.
5.4 If a trespass notice is served, all organization's name staff should be informed.

6. **Reviewing Cases where Service is Limited, Refused or Withdrawn**

6.1 If a client for whom service has been refused, limited or withdrawn makes a new request for service or the client's situation changes, the staff member and manager will discuss the request, make a decision and document it in the client's file.

Policy Name and Number:	**1.24 Harassment & Discrimination**
Date last reviewed:	
Approval or last revision:	
Approved by:	

POLICY

Organization's name recognizes the dignity and worth of every person and is committed to a policy of equal rights and opportunities without discrimination or harassment. Every individual has the right to work in an environment free from discrimination and harassment. No personnel may be discriminated against or harassed on the basis of the following prohibited grounds: race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, age, record of offences, marital status, same-sex partnership status, family status, physical/mental /intellectual disability or economic status.

Organization's name seeks to create a climate of understanding and mutual respect.
Discrimination, harassment and racist incidents or behaviour will not be tolerated.
All supervisors shall ensure that this policy is communicated to personnel within their team(s).

All individuals have the right, as defined in the *Ontario Human Rights Code*, to file a complaint with the Human Rights Commission of Ontario. This right is not limited in any way by this policy. As required by the Code, organization's name will investigate all allegations of harassment and discrimination.

SCOPE

This policy applies to all management, unionized and excluded employees.
Bargaining unit employees may elect to have their complaints resolved through either this policy or may elect to use the procedures in the *Collective Agreement*.

DEFINITIONS

Workplace Discrimination: Discrimination includes, but is not limited to unequal treatment based on one or more of the prohibited grounds under this policy.
Workplace discrimination can be intentional, unintentional, direct or indirect and can take many forms including:

- refusal of employment
- employment/contracting requirements, which are not essential to the performance of the job, which have an adverse impact on members belonging to a protected group under this policy
- refusal of promotion or workplace opportunities
- creating and contributing to or condoning a poisoned work environment
- failure to provide appropriate employment accommodation
- failure of management to respond to allegations of harassment

Workplace Harassment: Harassment is a form of discrimination. Harassment means engaging in a course of comment or conduct which is known or ought reasonably to be known to be unwelcome. Harassment can be one or a series of unwanted, unsolicited remarks, behaviours, or communications in any form, via any medium, that is directed toward a member of a group protected under this policy. The following are some examples of harassment:

- abusive behaviour, racist or homophobic comments, demeaning jokes
- displaying or distributing pornographic or hate-based pictures or email
- unwelcome sexual attention, contact or comments; sexual innuendoes or gestures; unsolicited physical contact

- taunting about a person's clothes, customs, accent
- refusing to converse or work with a service user or organization personnel because of his or her racial/ethnic background or gender/sexual orientation or disability
- interfering with, threatening or intimidating an individual for exercising their rights under this policy

Poisoned Work Environment: The presence of behaviour, comments or a work environment that ridicules, belittles or degrades people or groups identified by one or more of the prohibited grounds of this policy. A poisoned work environment could result from a series and/or a single event, remark or action and need not be directed at a particular individual.

PROCEDURES

1. While personnel cannot be required to report experiences of discrimination and harassment, they are strongly encouraged to bring forward complaints regarding violations of this policy.

2. If an individual believes they are being harassed or discriminated against, they can talk to the person on their own or with the support of a peer or supervisor.

3. The individual should notify the first level of management not involved in the complaint (free of bias or conflict of interest).

4. The individual can seek information or assistance from the Human Resources (HR) Department in bringing a complaint to management's attention. The HR Department is committed to responding neutrally and confidentially to any individual's request for information about this policy and aspects of managing workplace discrimination and harassment issues.

5. **Supervisor's Responsibilities:** In responding to allegations of discrimination and harassment, all organization's name supervisors are responsible for:

- informing the relevant program director of the complaint as soon as possible
- acting quickly and appropriately
- determining the method by which to deal with the allegations based on the nature and complexity of the issue, needs, interests and goals of the parties involved -- possible methods include direct management action, informal or formal dispute resolution (i.e., mediation, investigation), and may involve both internal and external "service providers" (i.e., mediators, investigators)
- recognizing that harassment and discrimination conflicts often involve power imbalances between the parties and ensuring that the power can be balanced in the process selected
- ensuring contracted service providers have the required expertise
- exercising proactive, prevention-oriented and cost-effective practices
- effectively managing workplaces in which there are possible policy violations
- declaring a potential conflict of interest in relation to an allegation where the supervisor is, or may be perceived to be, either condoning or directly involved with the allegation; in such a case, another supervisor will be appointed to respond to the complaint
- consulting with the HR Department regarding administering and enforcing this policy
- ensuring discrimination and harassment responses/remedies that aim to correct identified problems, prevent repeated violations and restore the workplace
- imposing penalties, as appropriate to the circumstances of each case, up to and including termination of employment

6. **Mediation:** The following situations may not be appropriate for mediation:

- a significant power imbalance exists between the parties (e.g., status, position, authority, knowledge, resources)
- one or both parties has revenge or punishment as a primary goal
- hostility is so high that communication and problem-solving is impossible
- there is little desire to establish or mend a working relationship
- there is a need to have a determination of guilt or innocence, such as where the alleged offender has a history of similar behaviour or where discipline is an obvious remedy

7. **Timeframes:** While every effort must be made to comply with the following, failure to do so does not void the process.

1. Unless the situation warrants immediate referral for formal dispute resolution or investigation, supervisors will attempt to resolve complaints themselves (in consultation with HR) within 30 days of becoming aware.
2. Dispute resolution must be completed within 15 days after assignment of a service provider, unless extenuating circumstances exist.
3. An investigator must be assigned within 15 days after management's decision that the complaint will be investigated.
4. An investigation must be completed and final report submitted to management within 60 working days after assigning a complaint to an investigator, unless there are extenuating circumstances.
5. Parties and managers involved must be notified of the outcome of an investigation within 30 days of receiving the final report; and where an allegation is upheld, a statement regarding discipline imposed and/or other appropriate action taken.

8. **Penalties/Discipline:** Individuals found to have violated this policy will receive penalties/discipline, as appropriate to the circumstances of each case, up to and including termination of employment.

9. **Confidentiality and Privacy:**

- During the resolution of possible violations, all information must remain confidential subject to the rules below, except where sharing information is required by law.
- Complainants, respondents (the person against whom the complaint is made) and witnesses have access to statements they have made and information that they have provided.
- Respondents and complaints must have access to enough information about the allegations and responses of other parties and witnesses to enable them to make a defence or rebuttal.
- If a complaint is found to be unsupported, provided the complaint was not made in bad faith, no documentation will be placed on the personnel files of the individuals involved.