Outlook

**Réponse - Demande d'accès à l'information - N/D AI2026-038 (Courriel 1/3)**

**From** Accès Information (CUSM) <Acces.Information@MUHC.MCGILL.CA>
**Date** Thu 10/1/2026 1:08 PM
**To** [redacted]
**Cc** [redacted]

15 attachments (23 MB)

DYP how to call 2024.pdf; DYP Intake form.docx; DYP presentation SHORTENED 2026.pptx; Entente Multsectorielle.docx; Information Documents on Lame de reserve pour l'analyse d'ADN.pdf; List of hand outs for SA course 2025.docx; Manuel d auto formtion Service conseil 2023.pdf; MRC 9714 2026 09 02 DM-7247.pdf; MRC 9724 2026 08 26 DM-7232.pdf; POST NON-OCCUPATIONAL EXPOSURE TO BLOODBORNE PATHOGENS MCH PROTOCOL_JUNE 2026 PGA.pdf; Algorithm for the Management of Sexual Abuse Victims in the Pediatric ED 8th Juner 2026.docx; Algorithm for the Management of Sexual Abuse Victims in the Pediatric ED 16th october 2023.docx; Chain of custody log for trousse or Medico-social kit 2024 (1).docx; DYP articles of compromission.pdf; DYP guide 19-838-03A.pdf;

Bonjour,

Le Centre universitaire de santé McGill (CUSM) fait suite à votre demande d'accès à l'information du 27 août 2026 au sujet de *l'Entente multisectorielle relative aux enfants victimes d'abus sexuels ou de négligence grave*.

**Réponse du CUSM :**

Suivant un repérage sérieux et complet auprès des directions concernées du CUSM, vous trouverez ci-joint les documents qui correspondent à votre demande.

Veuillez noter qu'en vertu des articles 1 et 15 de la *Loi sur l'accès aux documents des organismes publics et sur la protection des renseignements personnels*, le droit d'accès aux documents n'emporte pas pour les organismes publics l'obligation de confectionner un document, de compiler des renseignements ou de comparer des renseignements afin de satisfaire le libellé précis d'une demande.

Néanmoins, un document intitulé « CUSM_Entente_Multsectorielle » a été confectionné afin de satisfaire au mieux à votre demande. Nous suggérons que vous en preniez connaissance en premier.

Conformément à l'article 51 de la Loi sur l'accès, nous vous informons que vous pouvez faire une demande de révision en vous adressant à la Commission d'accès à l'information du Québec. Ce recours est prévu aux articles 135 et suivants de la Loi sur l'accès. Votre demande doit être présentée dans les trente (30) jours qui suivent la date de la présente décision. À cet effet, vous trouverez ci-joint le document intitulé « Avis de recours ».

Nous vous prions d'agréer l'expression de nos sentiments distingués.

NOUS SOMMES LE CUSM | WE ARE THE MUHC

**Jane Ghoussoub**
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Outlook

**Réponse - Demande d'accès à l'information - N/D AI2026-038 (Courriel 2/3)**

**From** Accès Information (CUSM) <Acces.Information@MUHC.MCGILL.CA>
**Date** Thu 10/1/2026 1:09 PM
**To** [redacted]
**Cc** [redacted]

12 attachments (24 MB)

SA documentation sheet PDF.pdf; SA Interview flow cheat sheet.docx; Sexual Assault Pamphlet EngFr.pdf; SI Safety plan Jan 2025.pdf; Teaching day swabs exercise June 2026.docx; Trousse Medicolegale - Sexual Assault Forms.pdf; Youth Protection (1).pptx; SA sim scenario.docx; SA Triage June 8th 2026.pptx; SA verification checklist 2025.docx; Sexual Abuse Tip Sheet (1).docx; Quebec DYP contact information by territory.pdf;

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**Réponse - Demande d'accès à l'information - N/D AI2026-038 (Courriel 3/3)**

**From** Accès Information (CUSM) <Acces.Information@MUHC.MCGILL.CA>
**Date** Thu 10/1/2026 3:41 PM
**To** [redacted]
**Cc** [redacted]

1 attachment (14 MB)
SA Nursing Response to Sexual Assault in the PED April 2025.pptx;

Bonjour,

Le Centre universitaire de santé McGill (CUSM) fait suite à votre demande d'accès à l'information du 27 août 2026 au sujet de *l'Entente multisectorielle relative aux enfants victimes d'abus sexuels ou de négligence grave*.

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CUSM – Entente multisectorielle
AI2026-038

**L'Hôpital de Montréal pour enfants**

*l'Entente multisectorielle relative aux enfants victimes d'abus sexuels ou de négligence grave, pour la période du 1er avril 2024 au 19 août 2026.*

Pour la période du 1er avril 2024 au 19 août 2026, le CUSM souhaite préciser la nature de son rôle relativement à l'Entente multisectorielle relative aux enfants victimes d'abus sexuels, d'abus physiques ou de négligence grave. Le CUSM tient à préciser que, bien que la demande porte sur la période comprise entre le 1er avril 2024 et le 19 août 2026, notre réponse et nos fonctions ne se limitent pas à cette période.

En tant qu'établissement de soins tertiaires, le CUSM, et particulièrement l'Hôpital de Montréal pour enfants (HME), joue un rôle important dans l'identification, le signalement, l'évaluation médicale et psychosociale, l'intervention médicosociale et médicolégale ainsi que la prise en charge des enfants victimes ou présumés victimes de maltraitance.

Il importe toutefois de distinguer le signalement au Directeur de la protection de la jeunesse (DPJ) du déploiement de l'Entente multisectorielle.

**1. Signalement au DPJ**

À l'HME, lorsqu'une situation d'abus sexuel, d'abus physique ou de négligence grave est identifiée ou soupçonnée, le travailleur ou la travailleuse sociale est généralement la personne qui effectue le signalement au DPJ, en collaboration avec l'équipe clinique concernée.

Toutefois, le signalement n'est pas une responsabilité exclusive du service social. Tout professionnel ou membre du personnel assujetti aux obligations prévues par la Loi sur la protection de la jeunesse doit effectuer un signalement lorsqu'il a les motifs requis par la loi. Le fait que le signalement soit généralement effectué par un travailleur social à l'HME constitue donc une pratique organisationnelle et ne limite pas le droit ou l'obligation de signaler des autres professionnels lorsque les conditions prévues par la loi sont réunies.

Le signalement au DPJ constitue la première étape du processus d'intervention sociojudiciaire prévu dans le cadre de l'Entente multisectorielle.

**2. Rôle du CUSM dans le déploiement de l'Entente multisectorielle**

Le CUSM n'est pas l'instance responsable de la coordination.

Le DPJ assume la coordination de l'Entente multisectorielle. Lorsqu'une situation est susceptible de nécessiter une intervention sociojudiciaire, le DPJ, les services policiers et le Directeur des poursuites criminelles et pénales (DPCP) déterminent, conformément à leurs rôles respectifs et aux modalités prévues par l'Entente, les étapes d'intervention ainsi que les partenaires devant être impliqués.

Le CUSM agit donc comme partenaire clinique et institutionnel lorsque son expertise ou ses services sont requis.

Selon la situation, son rôle peut notamment comprendre :

- effectuer ou soutenir le signalement au DPJ;
- assurer l'évaluation médicale et psychosociale de l'enfant;
- assurer les soins et traitements requis;
- procéder, lorsque requis, à l'intervention médicosociale et médicolégale;
- documenter les constatations cliniques pertinentes;
- collaborer avec le DPJ, les services policiers et le DPCP lorsque requis;
- transmettre les renseignements pertinents conformément aux dispositions législatives applicables;
- assurer le suivi médical et psychosocial de l'enfant.

**3. Rôle de l'HME en matière d'intervention médicosociale et médicolégale**

L'HME joue également un rôle particulier dans la prise en charge des enfants et adolescents victimes ou présumés victimes d'agression sexuelle.

L'Hôpital de Montréal pour enfants (HME) est un centre désigné par la province qui propose des évaluations médicales spécialisées, des traitements et des soins coordonnés aux enfants et aux adolescents victimes d'agressions sexuelles. l'HME peut être appelé, lorsque requis, à assurer l'évaluation médicale et médicolégale de l'enfant ainsi que la collecte des éléments médicolégaux pertinents, conformément aux protocoles et pratiques applicables.

Dans les situations de suspicion d'agression sexuelle pour lesquelles une intervention médicolégale est indiquée, l'équipe désignée peut notamment procéder à l'examen médicolégal et à la trousse médicolégale, selon les circonstances cliniques et les protocoles applicables.

Le *Guide d'intervention médicosociale* du MSSS décrit notamment l'intervention auprès des victimes d'agression sexuelle, incluant l'accueil et le soutien, l'histoire médicale, l'examen médical et médicolégal, les tests et prélèvements, les soins et traitements, ainsi que les démarches de signalement et les références appropriées.

Cette responsabilité doit être distinguée du rôle du DPJ dans l'Entente multisectorielle : le CUSM peut être appelé à assurer une intervention médicale, médicosociale ou médicolégale sans être responsable de la coordination ou du déploiement de l'Entente multisectorielle.

**4. Documents et références encadrant l'intervention médicosociale**

Dans le cadre de la présente demande, les documents pertinents ne se limitent pas aux documents produits par le CUSM. Le personnel clinique s'appuie également sur des documents provinciaux du MSSS qui encadrent l'intervention médicosociale et médicolégale.

Parmi les principaux documents de référence figurent notamment :

- le Guide d'intervention médicosociale du MSSS;
- le Protocole d'intervention médicosociale – Organisation des services et grandes lignes de l'intervention;
- le Guide d'information à l'intention des victimes d'agression sexuelle;
- le Guide d'intervention pour soutenir les pratiques professionnelles en matière d'agression sexuelle;

- l'Entente multisectorielle relative aux enfants victimes d'abus sexuels, d'abus physiques ou de négligence grave – Guide de pratique;
- Loi sur la protection de la jeunesse;

Le *Guide d'intervention médicosociale* précise notamment les orientations applicables à l'organisation des services et à l'intervention auprès des victimes d'agression sexuelle, en collaboration avec les différents partenaires concernés.

Le MSSS décrit également les fonctions associées aux centres désignés, notamment en ce qui concerne les services médicaux ainsi que l'intervention médicolégale et médicosociale auprès des personnes victimes d'agression sexuelle.

**5. Formation et soutien aux professionnels**

Le personnel peut également avoir accès aux formations et outils provinciaux portant sur l'intervention auprès des victimes d'agression sexuelle, notamment aux formations disponibles dans l'Environnement numérique d'apprentissage (ENA) sur l'intervention psychosociale en matière d'agression sexuelle.

Il convient toutefois de distinguer les formations et outils provinciaux des formations, présentations, directives, procédures ou autres documents produits spécifiquement par le CUSM.

Compte tenu de l'évolution de la gouvernance du réseau et de l'arrivée de Santé Québec, certains mécanismes provinciaux de soutien et de coordination des services sont également en évolution. Les questions relatives à l'organisation des services peuvent, au besoin, être adressées aux instances provinciales compétentes.

**6. Personnes au CUSM pouvant jouer un rôle**

Il n'existe pas nécessairement au CUSM une personne unique portant le titre de « responsable de l'Entente multisectorielle »

Selon la nature de la situation et les responsabilités professionnelles concernées, plusieurs personnes peuvent jouer un rôle dans l'identification, le signalement, l'évaluation, l'intervention ou la prise en charge d'un enfant victime ou présumé victime de maltraitance.

Pour la période visée, les personnes occupant notamment les fonctions pertinentes comprennent :

- **Cindy McCartney**, Directrice de l'Hôpital de Montréal pour enfants;
- **Dre Tanya DiGenova**, DMSP adjointe de l'HME;
- **Dre Suzanne MacDonald**, responsable médicale de l'intervention en matière d'agression sexuelle;
- **Dre Laurel Chauvin-Kimoff**, responsable médicale de l'intervention en matière de négligence et de maltraitance envers les enfants, incluant negligence
- **Dre Franziska Baltser**, experte médicale et personne-ressource en matière d'agression sexuelle, de négligence et de maltraitance envers les enfants;
- **Melinda DiMinno**, gestionnaire des services psychosociaux;
- **Kelly Cummins**, gestionnaire du Service des urgences de l'HME.

**Commented [WC1]:** 1001, boulevard Décarie
Montréal (Québec) H4A 3J1
514 412-4400
Cindy.mccartney@muhc.mcgill.ca

**Commented [WC2]:** 1001, boulevard Décarie
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Laurel.Kimoff.med@ssss.gouv.qc.ca

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Montréal (Québec) H4A 3J1
514 412-4400
Kelly.Cummins@muhc.mcgill.ca

D’autres professionnels peuvent également être appelés à jouer un rôle selon la situation, notamment :

- les travailleurs sociaux, qui effectuent généralement le signalement au DPJ à l’HME;
- les médecins participant à l’évaluation et à la prise en charge des enfants victimes ou présumés victimes;
- les professionnels spécialisés en intervention médicosociale et médicolégale;
- les infirmières et autres professionnels de la santé;
- les gestionnaires cliniques des secteurs concernés;
- tout autre professionnel qui identifie une situation nécessitant un signalement ou une intervention.

L’identification de ces personnes repose sur leurs fonctions et responsabilités professionnelles et ne signifie pas qu’elles sont individuellement responsables de l’activation, de la coordination ou du déploiement de l’Entente multisectorielle au nom du CUSM.

**7. Responsabilité de l’application de l’Entente au CUSM**

À la connaissance du CUSM, aucune fonction institutionnelle spécifique intitulée « responsable de l’Entente multisectorielle » ou « responsable de l’activation de l’Entente multisectorielle » n’est attribuée à une personne unique au sein de l’établissement.

La coordination de l’Entente multisectorielle relève du processus sociojudiciaire coordonné par le DPJ, en collaboration avec les autres partenaires prévus à l’Entente.

Le CUSM intervient comme partenaire lorsque la situation nécessite son expertise ou ses services cliniques, médicaux, psychosociaux ou médicolégaux.

**Algorithm for the Management of Sexual Abuse (SA) Victims in the Pediatric ED**

**Pre-Triage**

Ask : "Is it a confidential matter?"

Ensure confidentiality and gather information **in** pre-triage room

**DO NOT gather information in the presence of the child**

Enter presenting complaint: "concern for patient's welfare SA" Code them T2

**Triage**: Collect a brief history of the SA from the most appropriate source (police, SW, parent)

Child (less than 14 years old): **NEVER collect history** in the presence of the child

Adolescent: Collect information privately without asking any probing questions. If necessary, additional information can be obtained from the accompanying adult once consent from adolescent is obtained

**Information to be collected:**

- Time of assault or last contact with suspected abuser (less than 7 days or 7 days and more)
- Type of contact (genital, oral, anal, digital)
- Patient's physical sexual assault complaints, examples: ano-genital injury, vaginal or ureteral discharge, anal pain, genital bleeding, etc.
- Patient's psychosocial and behavioral complaints examples: new apparently sexualized behaviors in a child, more general behavior changes, suicidal ideation (complete ASQ), etc.
- Parent's or caretaker's excessive distress
- Patient's safety concerns: alleged abuser living in the same household, alleged abuser having shared custody, inability of parent's or caretaker to ensure child's safety, suspicion of human trafficking etc.
- DYP and/or police involvement

| Triage category | P1 | P2 | P3 |
|---|---|---|---|
| Patient's physical /mental health<br>Family status | Unstable | Occurrence of suspected sexual assault equal or less than 7 days from the ED visit<br>OR concerns for the following:<br>• Patient's physical sexual assault complaints<br>• Patient's psychological or behavioral complaints<br>• Parent's or caretaker's excessive distress<br>• Patient's safety concerns | Occurrence of suspected sexual assault more than 7 days from the ED visit<br>WITHOUT<br>Any physical, psychological, or safety concerns for child or family |
| Orientation | Red | GREEN 16 | WR in front of GR17 |

**Note: P1 patient with altered level of consciousness and/or hemodynamically instability**

PED physician and Assistant Nurse Manager to determine when SA team should be called in to evaluate patient

**Triage Interventions**

- Keep NPO if fellatio less than or equal to 24 hours
- Ask patient to refrain from urinating or defecating
- Provide a safe, quiet area for the patient and caregivers while waiting for further medical services.
- Inform Assistant nurse manager of patient's presence
- Document FACTS only, do not include interpretations
  - Accompanied by (parents, police, DYP)
  - Referred by DYP, social service, family physician
  - History taken from (parents, police, teenager…)

## SA nurse on call Interventions

Triage nurse call SA nurse on-call (schedule and phone numbers with nurse's schedule)
Triage nurse provides details SA nurse determine if SA team presence is required
If yes: Triage nurse ask clerk to page psychosocial team (8h00-22h59 social services, 23h00-7h59 spiritual care)
SA nurse and SA psychosocial arrive within 30 -60 minutes of call
SA nurse and SA psychosocial together assess patient and/or family
SA team determine if a medico-legal trousse is required

### Is a medico-legal exam indicated?

**ALL of the following 4 conditions must be met:**

1) The victim (≥ 14 years) or their legal guardian (< 14 years) provides consent to have a medico-legal exam done
   AND
2) Based on the history, patient was in contact with assailant's DNA (sperm, blood, saliva)
   AND
3) The sexual abuse occurred within the previous 7 days for cases of vaginal penetration; ≤ 3 days for anal penetration; ≤ 3 days for samples from the surface of the body; ≤ 1 day for oral penetration
   AND
4) A police report is done, or likely to be done or patient/parent/guardian is undecided

**YES**

SA team prepare for medico-legal kit
SA nurse collect oral and skin specimen when indicated
PED physician to do medical exam and collect rest of specimen
PED physician prescribe emergency contraception and SSTI prophylaxis when indicated

**NO**

Presence of any of the following:

- Symptoms of STI or need for screening
- Pregnancy test and emergency contraception needed
- Genital bleeding
- Sexual contact (including touching) within last 2 weeks
- Psychological or safety concerns

**YES**

Medical exam by PED physician
Timing of medico-social kit to be determined

**NO**

Medical exam by PED physician, but a genital/anal exam is **not** indicated
Refer to SA clinic

### Discharge Planning & Instructions

SA team flag patient to DYP for SA
If patient is evaluated between 23h00-7h59, SA nurse and PED physician to determine if patient is safe to be discharged or needs to remain in PED until social work evaluates patient
PED physician refer patient to SA clinic for follow-up

- Send a consult by fax (24319) **and** by mail to the SA clinic**. Ensure correct/confidential contact info for patient/family**
- Reassure patient/family that they will be contacted by SA clinic for follow-up
- Provide information sheet with contact information and the location of the SA clinic (see attached)

# Chain of Custody log for Medico-legal kit (Trousse) or Medico-social kit

All Medico-legal kit (Trousse), lame de réserve or Medico-social kit must be locked in the SA fridge to prevent tempering of the legal evidences. A chain of custody log will document what type of evidence, who had possession the evidence and where the ML kit, lame de reserve or MS kit were during transportation to it's final location (Gillman pavilion or Police).

## PED SA LOG – Locked SA fridge MCH Emergency Department

| Date of the Event | Patient MRN and Name | Type of evidence # trousse, Lame de réserve or MS kit | Date and time of evidence storing | Name, licence number and signature of person storing the evidence | Date and time of evidence transferred | Location of Trousse transfer (I.e: police or Gilaman) | Name, licence number and signature of person transporting the evidence |
|---|---|---|---|---|---|---|---|
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |

This is a legal document and must be archived and kept for legal purposes. Once completed please give to SA Social Worker at 1040 Atwater (Gilman Pavilion).

PED SA LOG – Locked SA fridge MCH Gilman Pavilion

The evidence is to be kept at the MCH Gilman pavilion until the police officers pick up the evidence or until the SA nurse destroys it 6 months following the event date.

| Date of the Event | Patient MRN and Name | Type of evidence # trousse, Lame de réserve or MS kit | Date and time trousse received | Name, licence number and signature of person transporting the evidence | Name, licence number and signature of person receiving the evidence | Date and time trousse destroyed | Name, licence number and signature of person receiving the evidence |
|---|---|---|---|---|---|---|---|
| | | | | Name:<br>Licence:<br>Signature: | Name:<br>Licence:<br>Signature: | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | Name:<br>Licence:<br>Signature: | | Name:<br>Licence:<br>Signature: |
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This is a legal document and must be archived and kept for legal purposes. Once completed please give to SA Social Worker at 1040 Atwater (Gilman Pavilion).

Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal
Québec
Les Centres de la jeunesse et de la famille Batshaw
Batshaw Youth and Family Centres

# SUMMARY LIST OF SITUATIONS
# VENTILATION OF SECTIONS 38 AND 38.1 OF THE YOUTH PROTECTION ACT

## 38 A) ABANDONMENT

**38 a) Responsabilités parentales non assumées par une autre personne (parental responsibilities not assumed by another person)**

- ◊ **Décès des parents (parents are deceased)**
  The child is considered an orphan if the only legally recognized parent or both parents are deceased or if the tutor who was named for the child is deceased.

- ◊ **Absence des parents (absence of parents)**
  The only legally recognized parent or both parents are alive but do not assume responsibility in relation to their parental authority.

- ◊ **Incapacité permanente des parents (permanent incapacity by parents)**
  The only legally recognized parent or both parents are alive but do not assume responsibility in relation to their parental authority. This situation is the direct result of a permanent incapacity in relation to physical health problems, mental health problems or intellectual deficiency.

## 38 B) NEGLECT

**38 b) 1.i° Négligence sur le plan physique (physical neglect)**

- ◊ **Besoin d'ordre alimentaire (food)**
  The child is considered neglected in terms of food, if the person(s) with the custody do(es) not provide sufficient or adequate food, according to their means/resources.

- ◊ **Besoin d'ordre vestimentaire (clothing)**
  The child is considered neglected in terms of their clothing, if the person(s) with the custody do(es) not provide appropriate and adequate clothing for the season, according to their means/resources.

- ◊ **Besoin d'hygiène (hygiene)**
  The child is considered neglected in terms of their hygiene, if the person(s) with the custody do(es) not attend to the child's proper hygiene, or the child's living environment is unhealthy, according to their means/resources.

- ◊ **Besoin de logement (living conditions)**
  The child is considered neglected in terms of their living environment, if the person(s) with the custody do(es) not ensure that the child's living conditions are safe and adequate, according to their means/resources. The neglect may ensue from a lack of essential services (running water, heating, isolation, lighting), hazardous substances or objects accessible to the child, or the home environment poses a risk of injury for the child.

**38 b) 1.ii°Négligence sur le plan de la santé (Neglect in terms of health)**

- ◊ **Soins pour sa santé physique non assurés (physical health care not ensured)**
  The child is considered neglected in terms of their physical health, if the person(s) with the custody do(es) not ensure that the child receives adequate health care (respecting prescriptions and other recommendations, collaboration for the follow-up), according to their means/resources. The health problem may be related to an illness or injury, a trauma or a handicap, as well as severe malnutrition that could lead to health problems or improper use of medicine that could lead to serious consequences for the child.

- ◊ **Soins pour sa santé mentale non assurés (mental health care not ensured)**
  The child is considered neglected in terms of their mental health, if the person(s) with the custody do(es) not ensure that the child receives adequate mental health care (respecting prescriptions and other recommendations, collaboration for the follow-up), according to their means/resources. The mental health problem may be related to a mental illness, a psychiatric disorder or the presence of an organic emotional, affective or situational problem which may be the reason for a psychiatric intervention. It could also be associated with an emotional difficulty (sensory motor stimulation for a young child, emotional difficulties related to a trauma, a death or separation) or an intellectual deficiency.

- ◊ **Soins pour sa santé physique refusés (physical health care refused)**
  The child is considered neglected in terms of their physical health, if the person(s) with the custody do(es) not allow the child to receive adequate health care (cavities, problems with vision, hearing, motor skills, refusal of care, necessary medical interventions or hospitalization). The health problem may be related to an illness or injury, a trauma or a handicap.

- ◊ **Soins pour sa santé mentale refusés (mental health care refused)**
  The child is considered neglected regarding his mental health if the person(s) who assume(s) his care do not permit him to receive the required care (refusal of services, necessary medical care or hospitalization). A mental health problem is generally tied to a mental illness, psychiatric problem, or the presence of an organic emotional, affective or situational problem which may be the reason for a psychiatric intervention. It could also be associated with an emotional difficulty (sensory motor stimulation for a young child, emotional difficulties related to a trauma, a death or separation) or an intellectual deficiency.

**38 b) 1.iii Négligence sur le plan éducatif (Neglect in terms of Education)**

- ◊ **Problème de surveillance (lack of supervision)**
  The supervision is not appropriate due to a lack of vigilance from the parent(s), who are directly in charge of the child (ex : inside or around the residence or during outings).

◊ **Choix non judicieux au niveau du gardiennage (Non judicious choice of caretaking)**
The supervision is not appropriate given the inadequacy of the caregiver chosen to care for the child in the temporary absence of one or both parents.

◊ **Enfant laissé seul (Child left alone)**
The supervision is not appropriate given the absence of any person watching over the child in his home in the absence of the parent(s).

◊ **Non-respect des durées de gardiennage (duration of caretaking not respected)**
The supervision is not appropriate given the carelessness of the parent(s) to go and retrieve the child at the agreed upon time with the temporary caregiver.

◊ **Attitudes parentales non appropriées (inappropriate parental attitude)**
Inappropriate behaviours (criminal activities other than the ones covered in sections 38 c), d) et e), prostitution, driving under the influence, etc.) or an inadequate upbringing (absence of a routine, inappropriate role model, marginal values) to the needs of the child.

◊ **Tolérance de comportements inappropriés de tiers (Tolerance of inappropriate behaviour by a third party)**
Tolerance, in the living environment, of behaviours from person(s) manifesting disorders/difficulties affecting the child's functioning (criminal activities, substance abuse, gambling, instability, social adjustment, mental health, intellectual or physical deficiency).

◊ **Réactions non appropriées aux comportements de l'enfant (inappropriate reactions to the child's behaviour)**
A supervision that is not adapted (lack of firmness, too much inflexibility in exercising authority, minimizing the child's deviant behaviour) to the behavioural difficulties displayed by the child.

◊ **Défaut de prendre les moyens pour que l'enfant reçoive une instruction adéquate et, le cas échéant, pour qu'il remplisse son obligation de fréquentation scolaire prévue à la Loi sur l'instruction publique (chapitre I-13.3) ou à toute autre loi applicable. (Failing to take steps to ensure an adequate education for the child).**
The child is considered to be neglected if his parent(s) do not take steps to ensure he receives an adequate education. It is compulsory for a child to attend school according to the *Loi sur l'instruction publique* (chapitre I-13.3) or to any other applicable law. This problematic refers to the neglect of the parent(s) to offer to the child and promote his academic development, whether it is in a private or public school or an alternative manner (home schooling).

◊ **Manque de stimulation de l'enfant (lack of stimulation of the child)**
The child is considered neglected , if his parent(s) do not take steps to adequately stimulate a child under 6 years old in regards to his speech, motor, social and intellectual skills.

## 38 B) 2 RISQUE SÉRIEUX DE NÉGLIGENCE (serious risk of neglect)

- ◊ **Problème de toxicomanie chez le parent ou la personne qui en a la garde (Substance abuse problems of the parent or person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody manifest(s) a substance abuse problem such as drugs, excessive alcohol use, prescribed medication or other psychotropic/illegal drug.

- ◊ **Problème de jeu excessif chez le parent ou la personne qui en a la garde (gambling problems of the parent or person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody manifest(s) a gambling problem. This would indicate a continued or periodic lack of control and a progressive increase in the amounts played and the frequency of gambling.

- ◊ **Problème d'instabilité chez le parent ou la personne qui en a la garde (Problem of instability of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody manifest(s) instability with regard to residence (frequent moves, transiency), with regard to the choice of partner and to the people assuming the care of the child. These unpredictable and erratic characteristics of the parents could have an impact on the care offered the child.

- ◊ **Problème d'adaptation sociale chez le parent ou la personne qui en a la garde (social adjustment problem of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their social adjustment problems. It would translate into conflicts with most people, professionals or institutions with whom or which the parent interact(s).

- ◊ **Problème de santé mentale chez le parent ou la personne qui en a la garde (Mental health problems of the parent or person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their mental health problems. Mental health problems are generally connected to a mental illness, psychiatric difficulties, organic, affective or situational emotional problems, which may be the subject of a psychiatric intervention. This problem must generally be medically diagnosed, but it may also be considered in a context of concerning symptoms.

- ◊ **Problème de déficience intellectuelle chez le parent ou la personne qui en a la garde (Intellectual deficiency of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their intellectual delays. Intellectual delays must generally be the subject of a professional diagnosis, but may be considered in a context of concerning symptoms.

- ◊ **Problème de santé physique chez le parent ou la personne qui en a la garde (Physical health problems of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their physical limitations. Physical limitations must generally be medically diagnosed but may be considered in a context of concerning symptoms.

- ◊ **Antécédents de négligence non résolue chez le parent ou la personne qui en a la garde (unresolved antecedents of neglect by the parent or the person with the custody)**

The child is at risk of being neglected if the person(s) who assume(s) his custody has already seriously neglected the care of the child or another child in the past. The situation was or not the subject of an intervention which corrected the situation. The child is particularly exposed to this risk considering his recent birth, or a re-integration into his parent(s)' home.

## 38 C) MAUVAIS TRAITEMENTS PSYCHOLOGIQUES (Psychological Ill-Treatment)

- **Indifférence de la part du parent ou d'une autre personne (Indifference)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or any other person who live(s) with him, demonstrate indifference towards him or do(es) not show concern for his emotional needs.

- **Dénigrement de la part du parent ou d'une autre personne (Denigration)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or any other person denigrate(s), humiliate(s), demonstrate(s) excessive despising behaviour or language towards him.

- **Rejet affectif de la part du parent ou d'une autre personne (Emotional rejection)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or any other person manifests emotional rejection towards the child. The emotional rejection can be demonstrated by a lack of affection, favoritism towards another child or negative emotional behaviours towards the child. The rejection must be severe and on-going; and assumes the non-acceptance of the child and the parents' attitude as compromising his development.

- **Menaces de la part du parent ou d'une autre personne (Threats)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or another person threaten(s) the child. This situation is disruptive towards his psychological integrity, but does not constitute a threat to his physical integrity (we do not anticipate them acting on the threat). Acting on the threat would be covered under Section 38e)

- **Contrôle excessif de la part du parent ou d'une autre personne (Excessive control)**
  The child is considered to be the victim of psychological ill-treatment if the parent(s) or another person exercise(s) excessive control over him. The excessive control may be demonstrated through control over the child by manipulation or abuse of power. The child is subjected to constant interdictions and constraints.

- **Exploitation de la part du parent ou d'une autre personne (Exploitation)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or another person force(s) him to work disproportionately according to his capacity, to beg, to make an exhibition of him in an unacceptable fashion or to participate in illegal activities for a third party.

- **Conflits entre le parent et la personne qui en a la garde (Conflicts between a parent and a person with the custody)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) expose(s) him to the conflicts between the parent(s) and a person who has custody of him.

◊ **Exposition à la violence familiale de la part du parent ou d'une autre personne (Exposure to family violence by a parent or another person)**
The child is considered to be a victim of psychological ill-treatment due to exposure to family violence demonstrated by the parent(s) towards a family member or to another person living in the home. He is therefore witness to verbal and/or physical abuse which is not aimed at him directly. This situation disturbs him psychologically, but is not considered a direct threat to his physical integrity covered under Section 38e).

◊ **Problème de santé mentale chez le parent ou la personne qui en a la garde (Mental health problems of the parent or a person with the custody)**
The child is considered to be a victim of psychological ill-treatment if the parent(s) or the person who assumes his custody exposes him to the effects of their mental health problems. Mental health problems are generally connected to a mental illness, psychiatric difficulties, organic, affective or situational emotional problems, which may be the subject of a psychiatric intervention. This problem must generally be medically diagnosed, but it may also be considered in a context of concerning symptoms.

◊ **Isolement (isolation)**
The child is considered to be a victim of psychological ill-treatment if he is isolated in his living environment, such as being deprived of minimal social contacts, with respect to his age and condition.

◊ **Renversement des rôles (role reversal/parentified child)**
The child is considered to be a victim of psychological ill-treatment if he is the object of role reversal (parentified), such as being entrusted with responsibilities disproportionate for his age, including playing a supportive and caring role to one of his parents.

◊ **Conflits de couple (couple's conflict)**
The child is considered to be a victim of psychological ill-treatment if he is exposed to conflicts between partners in his living environment. In this case, it is not a question of exposure to conjugal violence but to a heavily emotionally charged relationship which is creating a strong hostility between the parents and to which the child is a witness on a regular and persistent basis; or in which the child is used as a means of negative communication or to put the child under pressure, to the benefit of one or the other parent (which could turn into parental alienation or abduction).

◊ **Conflits de séparation (conflict of separation)**
The child is considered to be a victim of psychological ill-treatment if he is exposed to the conflicts between ex-partners in his living environment. In this case, it is not a question of exposure to conjugal violence but to a heavily emotionally charged relationship which is creating a strong hostility between the parents and to which the child is a witness on a regular and persistent basis; or in which the child is used as a means of negative communication or to put the child under pressure, to the benefit of one or the other parent (which could turn into parental alienation or abduction).

◊ **Problème de santé mentale chez une autre personne (mental health problems of another person)**
The child is considered to be a victim of psychological ill-treatment if a person exposes him to the effects of their mental health problems. Mental health problems are generally connected to

a mental illness, psychiatric difficulties, organic, affective or situational emotional problems, which may be the subject of a psychiatric intervention. This problem must generally be medically diagnosed, but it may also be considered in a context of concerning symptoms.

**C.1) Exposition à la violence conjugale de la part du parent ou d'une autre personne (Exposure to domestic violence by a parent or another person)**

The child is considered to be a victim of psychological ill-treatment due to the exposure to violence between partners (or other persons) whether they are living together or not. "In addition to being a witness to violence, the child may also live a perpetual atmosphere of tensions and conflicts" (Manuel de référence sur la protection de la jeunesse, MSSS, fiche 4.2). He is thus witness to verbal and/or physical abuse which is not aimed at him directly. This situation disturbs him psychologically, but is not considered a direct threat to his physical integrity, in which case the situation used in Section 38e would be more appropriate.

## 38 D)1 ABUS SEXUELS (Sexual Abuse)

- ◊ **Gestes avec contact physique de la part du parent ou d'une autre personne (Gestures with physical contact by the parent or another person)**
  The child is considered to be a victim of sexual abuse by the parent or a third party if any contact of sexual nature involving any form of physical contact with the parents or a third party continues. This situation may be recent or not. It is only considered if there has never been an intervention to correct the situation.

- ◊ **Gestes sans contact physique de la part du parent ou d'une autre personne (Gestures without physical contact by the parent or another person)**
  The child is considered to be a victim of sexual abuse if behaviours of sexual nature continue, but not involving any form of physical contact by the parents or a third party. It may include exhibitionism, voyeurism, etc. This situation may be recent or not. It is only considered if there has never been an intervention to correct the situation.

- ◊ **Indicateurs d'abus sexuels (Indicators of sexual abuse)**
  The child is considered to be a victim of sexual abuse in the presence of indicators implying that such a situation exists, despite the absence of verbalization to that effect. Specific physical conditions must, however, be confirmed by a medical expertise in these rare cases.

- ◊ **Exploitation sexuelle (Sexual exploitation)**
  Sexual exploitation is a form of sexual abuse. Juvenile pornography, prostitution, striptease, trafficking for sexual purpose, sexual tourism and cyber-exploitation are examples of sexual exploitation. A child, whatever their age, canoot consent to any form of sexual exploitation. In many situations, sexual exploitation is characterized by the use of a child's body for sexual purposes through the exchange of compensation in nature (place to sleep, affection) or paid in cash to the child or to one or more third party.

## 38 D)2 RISQUE D'ABUS SEXUELS (risk of sexual abuse)

- ◊ **Abus sexuels envers des mineurs de la part du parent ou d'une autre personne (Sexual abuse against a minor by the parent or another person)**

The child is considered to be at risk of being a victim of sexual abuse considering the imposed and abusive behaviours, of sexual nature, involving a physical contact or not, by the parent or another person living with the child, towards a minor other than the child. This situation may be recent or not. It is only considered if there has never been an intervention to correct the situation.

◊ **Abus sexuels envers des majeurs de la part du parent ou d'une autre personne (Sexual abuse against an adult by the parent or another person)**
The child is considered to be at risk of being a victim of sexual abuse considering the imposed and abusive behaviours, of sexual nature, involving a physical contact or not, by the parent or another person living with the child, towards an adult. This situation may be recent or not. It is only considered if there has never been an intervention to correct the situation.

◊ **Climat non approprié entretenu par le parent au plan sexuel ou d'une autre personne (Inappropriate environment maintained by a parent or another person)**
The child is considered to be at risk of being a victim of sexual abuse considering the ambiguous and intrusive environment, on a sexual level, maintained by a parent or another person (exposure to explicit material, inappropriate sexual comments, lack of respect for the child's intimacy, the parent's tolerance of the sexual deviance of the child).

◊ **Risque d'exploitation sexuelle (risk of sexual exploitation)**
The child is considered to be at risk of being a victim of sexual abuse in relation to an issue of sexual exploitation. The risk must be serious and imminent. It differs from the presence of behavioral disorders that may be associated with the issue, with the presence of specific indicators leading to serious concerns for the emergence of a situation of sexual exploitation.

## 38 E)1 ABUS PHYSIQUES (Physical Abuse)

◊ **Sévices corporels de la part du parent ou d'une autre personne (Corporal punishment by a parent or another person)**
The child is considered a victim of physical abuse if the parent(s) or another person is intentionally subjecting the child to gestures (stricking, burning, hitting, shaking, whipping, making the child ingest something, etc.), that are inflicting injuries, lesions or physical trauma. Ex: use of a belt or any blunt object.

◊ **Méthodes éducatives déraisonnables de la part du parent ou d'une autre personne (Inappropriate means of discipline by a parent or another person)**
The child is considered a victim of physical abuse if the parent or another person subjects the child to physical or corporal punishment (food, sleep, and physical care deprivation, of accommodation, and other conditions essential to his physical well-being, etc). The unreasonable methods of upbringing are given with the intention to educate him, but threaten his physical or psychological integrity which are essential to his physical integrity, without inflicting an injury.

◊ **Autres formes d'abus physiques de la part du parent ou d'une autre personne (Other forms of physical abuse by a parent or another parent)**
The child is considered a victim of physical abuse if the parent, or another person, threatens his physical integrity by using other forms of physical mistreatment (i.e. Münchhausen

Syndrome by Proxy).

- **Blessures inexpliquées (Unexplained injuries)**
  The child is considered a victim of physical abuse if suspicious or unexplained injuries are observed, and evidently appear to be the result of excessive, immoderate or unreasonable means towards him.

## 38 E)2 RISQUE D'ABUS PHYSIQUES (Risk of Physical Abuse)

- **Menaces de la part du parent ou une autre personne (Threats by the parent or another person)**
  The child is considered at risk of becoming a victim of physical abuse due to threats uttered by the parent or another person. This situation disturbs his psychological integrity but is not considered a serious threat to his physical integrity; as acting on the threat is not anticipated.

- **Exposition à la violence familiale de la part du parent ou une autre personne (Exposure to family violence by a parent or another person)**
  The child is considered at risk of becoming a victim of physical abuse due to exposure to family violence demonstrated by one (or both) parent(s), or another person, towards a sibling or a third party residing in the home environment. Although he is not the subject of the verbal and/or physical violence, this constitutes a threat to his physical integrity as he could reasonably become a victim of this violence.

- **Exposition à la violence conjugale de la part du parent ou une autre personne (Exposure to conjugal violence by a parent or another person)**
  The child is considered at risk of becoming a victim of physical abuse due to exposure to the verbal and/or physical violence between the partners in his living environment.

- **Antécédents de violence non résolue chez le parent ou une autre personne (History of unresolved violence by the parent or another person)**
  The child is considered at risk of becoming a victim of physical abuse due to a history of violence, criminal or not, by the parent or another person, towards one or all of his children, which was the subject or not of an intervention to correct the situation.

- **Autres comportements à risque de la part du parent ou une autre personne (At risk behaviour by a parent or another person)**
  The child is considered at risk of becoming a victim of physical abuse due to the parent's or another person's behaviour, which is directly threatening the child's life. In this case, it is not the neglect of ordinary preventive measures such as wearing a helmet while riding a bike, skiing or the seat belt in the car. Instead, the behaviour could be such as administering strong medication or dangerous driving of a motor vehicle with limited faculties in the company of the child.

## 38 F) TROUBLES DE COMPORTEMENT SÉRIEUX (Serious Behavioural Disturbance)

- **Problème de toxicomanie (substance abuse problems)**
  The child undermines his physical or psychological integrity by regularly and excessively consuming alcohol, drugs, medication or other psychotropic drugs.

- **Problème de jeu excessif (gambling problems)**
  The child undermines his physical or psychological integrity due to a problem with excessive gambling. This problem would manifest itself in a continuous or periodic loss of control or by the progressive amounts played and the frequency of the plays.

- **Problème de fugue (runaway)**
  The child undermines his physical or psychological integrity by running away from his regular residence, and his educational supervision by responsible adults towards him.

- **Problème de fréquentations à risque (risky association)**
  The child undermines his physical or psychological integrity by associating with people, minors or adults, whose previous behaviours, present lifestyle or established reputation leads to believe that the influence that they have over him is negative. This influence can generate or increase the child's behavioural problems.

- **Problème de comportements sexuels inappropriés (inappropriate sexual behaviour)**
  The child undermines his physical or psychological integrity by adopting behaviours which present a risk on a sexual level. It includes having unprotected sexual relations or a sexual deviance.

- **Problème de comportement suicidaire (suicidal behaviour)**
  The child undermines his physical or psychological integrity by demonstrating suicidal gestures (actual gestures or not to commit suicide, that may be minimally threatening or very serious) or verbalizing suicidal ideations or threatening to commit suicide.

- **Problème de refus des soins pour sa santé mentale (refusal for mental health care)**
  The child aged 14 or more, undermines his physical or psychological integrity, by refusing interventions aiming to correct a mental health problem.

- **Problème de refus des soins pour sa santé physique (refusal for physical health care)**
  The child aged 14 or more, undermines his physical or psychological integrity, by refusing interventions aiming to correct a physical health problem.

- **Problème d'autres comportements inappropriés pour l'enfant (other inappropriate behaviour for the child)**
  The child undermines his physical or psychological integrity by adopting dangerous behaviours, such as knowingly placing himself in contact with a serious contagious disease, driving a vehicle under the influence, playing Russian roulette, walking on the railings of a bridge or demonstrating cruelty against animals.

- **Problème de vol (theft)**
  The child undermines the physical or psychological integrity of others through stealing. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- ◊ **Problème de vandalisme (vandalism)**
  The child undermines the physical or psychological integrity of others by vandalizing objects in order to damage or to destroy them intentionally. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- ◊ **Problème de pyromanie (arson)**
  The child undermines the physical or psychological integrity of others by starting a fire intentionally, in an inappropriate location and without concern for danger, with the purpose of pathological self-satisfaction. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- ◊ **Problème de violence verbale (verbal violence)**
  The child undermines the physical or psychological integrity of others by being verbally threatening towards people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- ◊ **Problème de violence physique (Physical violence)**
  The child undermines the physical or psychological integrity of others by being physically threatening towards people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- ◊ **Problème de violence sexuelle (sexual violence)**
  The child undermines the physical or psychological integrity of others by exhibiting inappropriate gestures of sexual nature towards people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- ◊ **Problème de commerce de drogue (drug dealing)**
  The child undermines the physical or psychological integrity of others by drug dealing with people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- ◊ **Problème d'autres comportements inappropriés pour autrui (other inappropriate behaviours towards others)**
  The child undermines the physical or psychological integrity of others by adopting dangerous behaviours such as driving under the influence, playing dangerously with a weapon, having unprotected sexual intercourse knowing he has an STI, etc. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

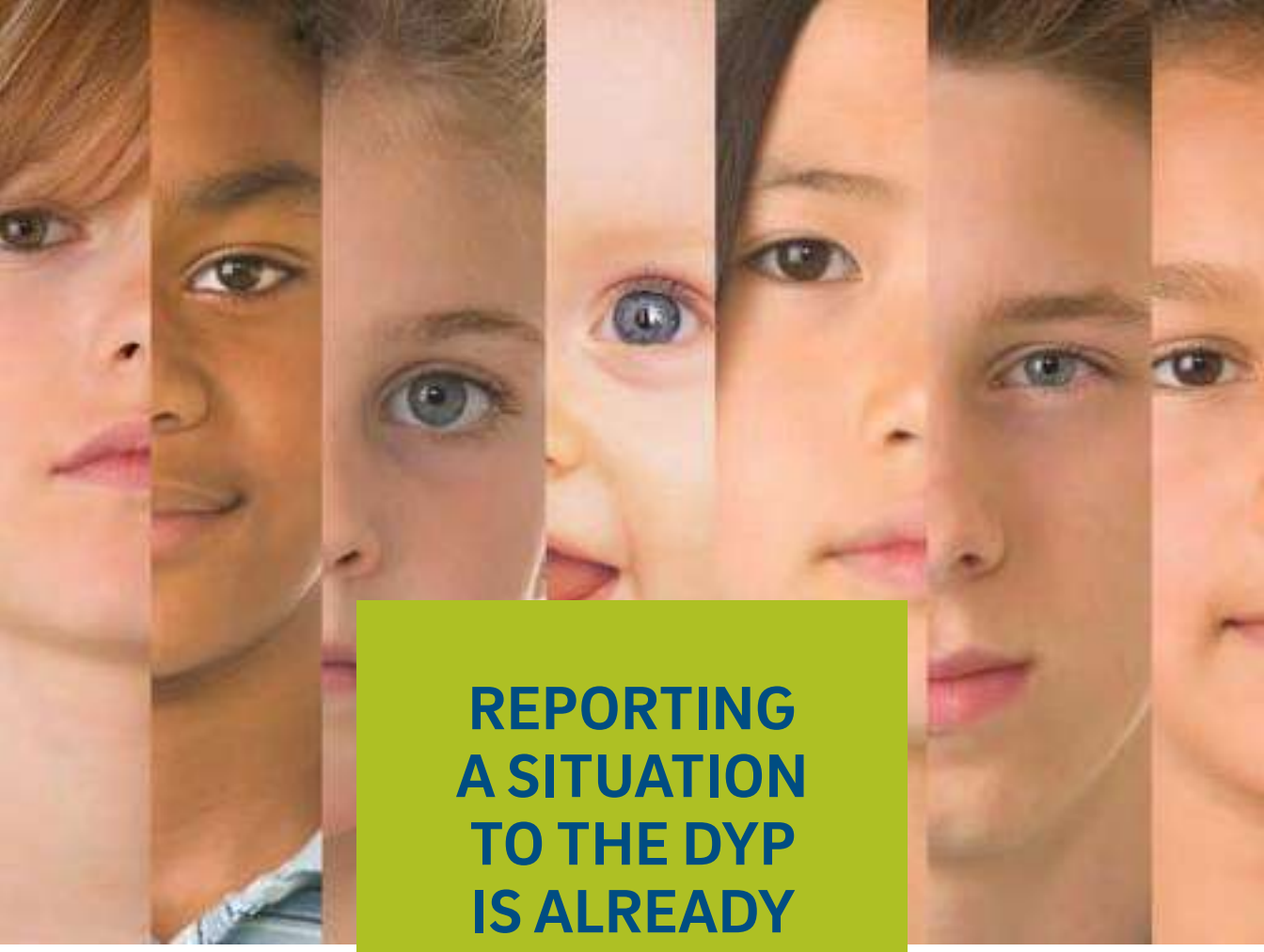
## Section 38.1

### 38.1 A) FUGUE (Runaway)

- **De son propre foyer :** The child leaves his family home without permission.
- **De sa famille d'accueil :** The child leaves his foster home without permission.
- **Du centre de réadaptation :** The child leaves his rehabilitation centre without permission.
- **Du centre hospitalier :** The child leaves the hospital without permission.

## 38.1 C) DÉLAISSEMENT DE L'ENFANT PLACÉ (Abandonment while being placed)

Refers to the absence of involvement or an insufficient involvement by the parents in the placement of their child, if this placement lasts more than one year. The evaluation of this situation should preferably be dealt with in subsection a) of section 38 (absence of the parents).



# REPORTING A SITUATION TO THE DYP IS ALREADY PROTECTING CHILD

## When and how to report?

YOUTH PROTECTION ACT

Votre gouvernement

Québec

This document is largely inspired by a brochure entitled « Signaler, c'est déjà protéger » which was previously published by Commission des droits de la personne et des droits de la jeunesse.

Ministère de la Santé et des Services Sociaux (MSSS) wishes to thank everyone who helped draft the first version of this guide, published in 2008:

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Masculine pronouns are used generically in this document.

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## Listen to the child and break the silence

Children who are abandoned; neglected; abused psychologically, sexually, or physically; or who present serious behavioural problems often keep their secrets and suffering buried deep inside and sometimes fear the consequences of telling someone about what they're going through. Some manage to talk to an adult about their situation while others develop attitudes and behaviours that offer clues about their situation. Unfortunately, many are the victims of their own silence or the silence of those around them.

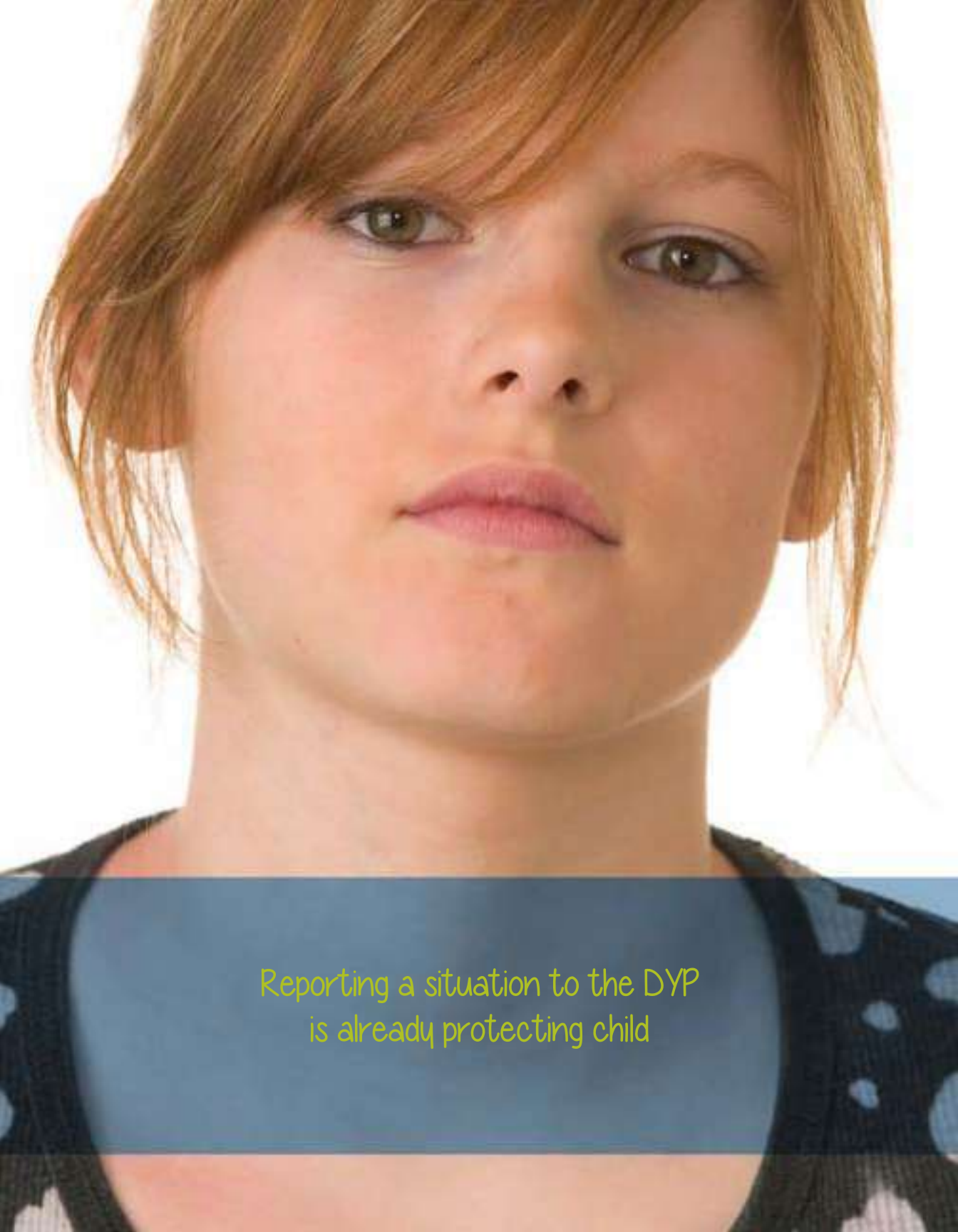
Protecting children is not just the responsibility of parents, but also that of the child's friends and family, members of the community, and the municipality where they live.

As someone who is close to a child, you have an important role to play in keeping them safe. If you work in a daycare, school, hospital, integrated centre*, or community organization, or if you are a police officer, you have an important role to play in identifying and helping children in great difficulty.

This guide is for the general public and for people who work with children, in particular. It is designed to be a tool to provide information and raise awareness by answering the most frequently asked questions when someone wants to report the situation of a child to the Director of Youth Protection (DYP).

Reporting a situation to the DYP is the most important step in protecting a child. When you report a situation of a child to the DYP, you're breaking the silence.

* The term "integrated centres" includes both integrated health and social services centres (CISSS) and integrated university health and social services centres (CIUSSS).


Reporting a situation to the DYP
is already protecting child

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Every child has a right to the protection, security, and attention that his parents or the persons acting in their stead are capable of providing. Every human being whose life is in peril has a right to assistance.

(*Charter of Human Rights and Freedoms*, sections 39 and 2)

## To whom does the *Youth Protection Act* apply?

The *Youth Protection Act* (YPA) applies to children in situations that endanger or may endanger **their security or development**. It applies to children deemed to be in great difficulty and in need of protection.

Under the *Youth Protection Act*, a child is defined as a person under the age of 18. Therefore, teenagers are also covered by the act.

Moreover, the YPA supplements the provisions in the *Civil Code* governing the adoption of a child, these provisions are not discussed in the brochure.

## Who is in charge of enforcing the YPA?

The Director of Youth Protection (DYP) is responsible for enforcing the YPA. However, the DYP does not act alone but with a team of caseworkers who carry out a number of duties, including receiving reports, determining whether the report should be accepted for assessing the situation, determining and enforcing corrective measures, and reviewing the child's situation.

The DYP must work with a child and their parents to end the situation that is endangering the child's security or development and prevent the situation from recurring, in the best interest of the child and in accordance with their rights.

There is a DYP in each region of Québec. The DYP works in an integrated centre offering youth protection services and rehabilitation services for youth with adjustment problems.

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Under Section 37.5 of the YPA, the government can enter into an agreement with a First nation, a Native community, or a group of communities and create a special youth protection program to better adapt the application of the YPA to the realities of Native life.

For example, in February 2018, the Québec government and the Council of the Atikamekw Nation entered into such an agreement regarding a youth protection program for Atikamekw children in the Manawan and Wemotaci communities. The Atikamekw Director of Social Protection performs the role of the DYP. This special youth protection program is called the SIAA (Système d'intervention d'autorité atikamekw).

For more information on the SIAA, visit the Council of the Atikamekw Nation website at **www.atikamekwsipi.com/fr/services/service-sociaux-atikamekw-onikam/services/systeme-dintervention-dautorite-atikamekw-siaa.**

The Québec government could enter into similar agreements in the future with a Native community to develop youth protection programs.

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## When must the DYP intervene?

Although parents have the primary responsibility for ensuring their child's protection, they may be dealing with certain difficulties that prevent them from assuming their responsibilities.

The YPA stipulates that the security or development of a child **IS** considered to be in danger in the following situations:

- → Abandonment
- → Neglect
- → Psychological ill-treatment
- → Sexual abuse, including sexual exploitation
- → Physical abuse
- → Serious behavioural problems
- → Serious risk of being neglected or sexually or physically abused

Moreover, the YPA stipulates that the security or development of a child **MAY BE** considered to be in danger if the child:

- → Runs away
- → Has been abandoned by their parents after being placed in foster care by virtue of the Act respecting health services and social services

These two situations are addressed differently because it is not automatically assumed that the child's security or development is in danger or that the child needs protection. However, depending on the circumstances, these situations may require the DYP's intervention.

> The YPA specifies that no ideological or other consideration, including considerations based on a concept of honour, can justify a situation that compromises or could compromise a child's security or development.

In the following situations[1], some indicators may help you determine whether you should report the situation of a child. In most cases, a combination of several indicators will lead you to believe that the child's security or development is or may be compromised. However, it is important to stress that the presence of a single indicator is sufficient to justify a report.

1. For each of these situations, the text in italics refers to the text of sections 38 and 38.1 of the *Youth Protection Act,* which define the grounds for endangering situations.

## Abandonment (s. 38a)

*A situation in which a child's parents are deceased or fail to provide for the child's care, maintenance or education and those responsibilities are **not assumed by another person** in accordance with the child's needs.*

Some indicators:

- → Child no longer lives with their parents and has no permanent address
- → Child says they were kicked out of the house
- → Parents are deceased and no one else has assumed parental responsibilities

## Neglect (s. 38b)

1° *A situation in which the child's parents or the person having custody of the child do not meet the child's **basic needs**:*

- i *failing to meet the child's **physical needs** with respect to food, clothing, hygiene or lodging, taking into account their resources;*
- ii *failing to give the child the care required for the child's physical or mental **health**, or not allowing the child to receive such care;*
- iii *failing to provide the child with the appropriate supervision or support, or failing to take the necessary steps to ensure that the child receives a proper education and, if applicable, that he attends **school** as required under the Education Act or any other applicable legislation.*

2° *A situation in which there is a **serious risk** that a child's parents or the person having custody of the child are not providing for the child's **basic needs** in the manner referred to in subparagraph 1 (in terms of physical needs, health, and schooling).*

Some indicators:

### Neglect in terms of physical needs

- → Lack of food or insufficient or inadequate food
- → Child seeks out food
- → Continual lack of hygiene
- → Inappropriate clothing for the season
- → Child's living environment is unhealthy
- → Child's living conditions are inadequate or pose a risk of injury for the child
- → Hazardous substances or objects accessible to the child
- → Lack of family home

According to the YPA, a neglected child is a child who is deprived of the things they absolutely need in order to develop normally.

### Neglect in terms of health

- → Severe malnutrition that could lead to health problems
- → Untreated illnesses or wounds
- → Refusal of or neglect by parents or the person with custody of the child to consult a healthcare professional for the child's essential needs (e.g., mental health problems, dental cavities, developmental delays, or problems with vision, hearing, or motor skills)
- → Improper use of medicine that could have serious consequences for the child

### Neglect in terms of upbringing: lack of supervision or support

- → Lack of age-appropriate stimulation for the child in terms of language, motor, social, or intellectual skills
- → Inappropriate choice of caregiver
- → Lack of stable routine
- → Lack of support by parents or the person with custody of the child
- → Insufficient supervision by parents or the person with custody of the child, based on the child's needs

### Neglect in terms of education or compliance with the requirement to attend school[2]

- → The child is school age but doesn't go to school.
- → The child is often absent for no reason so they are not learning as much as they should.
- → What the child learns at home or elsewhere is not teaching them what they need to know to integrate into society.

The notion of serious risk refers to the strong probability that the child is a victim of neglect.

Under the *Education Act*, all children in Québec must attend school starting at age 6 and until the end of the school year in which they turn 16.*

Parents must take steps to ensure their child meets the requirement to attend school.

**Before reporting a child's situation, the school principal must:**

- → Make every effort to ensure the child attends school or another institution in accordance with the *Education Act*
- → Take steps to encourage the child and their parents to correct the situation

**Before reporting a child's situation, the school board must:**

- → Contact the parents to find out about the child's situation and how to remedy it

* Native children may be subject to other laws.

2 The DYP intervenes only when parents do not take steps to ensure their child receives a proper education and meets the requirement to attend school.

## Psychological ill-treatment (s. 38c)

*A situation in which a child is **seriously or repeatedly** subjected to behaviour on the part of the child's parents or another person that could **cause harm** to the child, and the child's parents fail to take the necessary steps to put an end to the situation. Such behaviour includes in particular **indifference**, **denigration**, **emotional rejection**, **excessive control**, **isolation**, **threats**, **exploitation**, **particularly if the child is forced to do work disproportionate to the child's capacity**, **and exposure to conjugal or domestic violence**.*

Some indicators:

- → Child has low self-esteem or often says they are good for nothing
- → Child says they are not allowed to have friends, appears socially isolated
- → Child says they feel rejected by parents
- → Child seems sad and cries often
- → Child often fixates on death (through words or drawings)
- → Child says they are exhausted and must work at home
- → Child is constantly worried about how their parents will react or says they are afraid of a parent or someone living with them
- → Child is often exposed to conjugal or domestic violence (verbal, physical, or psychological violence)
- → Child witnesses criminal activities at home
- → A teenage girl cannot take part in any activities outside the house unless she has a chaperone
- → Parents frequently denigrate the child (e.g., they constantly blame them for things, always criticize and never give praise, make belittling comparisons, use negative nicknames)
- → Parents constantly threaten to abandon or place the child with others

In situations where the child is a victim of psychological ill-treatment by someone other than their parents, the DYP only intervenes if parents do not take the necessary measures to put an end to the psychological ill-treatment.

## Sexual abuse (s. 38d)

1° *A situation in which the child is subjected to gestures of a sexual nature by the child's parents or another person,* ***with or without physical contact****,* ***including all types of sexual exploitation****, and the child's parents fail to take the necessary steps to put an end to the situation;*

2° *A situation in which the child runs a* ***serious risk*** *of being subjected to gestures of a sexual nature by the child's parents or another person, with or without physical contact,* ***including all types of sexual exploitation****, and the child's parents fail to take the necessary steps to put an end to the situation.*

Some indicators:

- → Child says they have been subjected to sexual acts
- → Child complains of genital pain
- → Child exhibits precocious sexual behaviour
- → Child has knowledge of sexual behaviours that is not age-appropriate
- → Child suffers from a sexually transmitted infection (STI)
- → Child mentions pornographic experiences
- → Child is afraid to go home, prefers to stay at school or daycare
- → Child says their parents do not respect their privacy
- → Child refuses to undergo a medical exam
- → Child is afraid of a particular adult
- → Child displays abrupt changes in their usual behaviour (e.g., sudden drop in academic performance, loss of appetite)
- → Child suffers from incontinence, stomach aches, frequent vomiting, nightmares, insomnia
- → Child has in their possession objects or money of unknown origin
- → A teenager regularly runs away from home
- → An adult exhibits an unusual interest in the child

The notion of serious risk refers to the strong probability that the child is a victim of sexual abuse, including sexual exploitation.

Discovering one's sexuality is a normal step in a child's development. Sometimes, children engage in exploratory sexual games. This is not necessarily an indicator of sexual abuse.

Sexual abuse does not have to be occurring now or have occurred recently to be reported to the DYP. It can be reported even if it happened some time ago. The DYP will decide whether the current consequences of the abuse compromise the security or development of the child and put them at risk of further sexual abuse. In certain cases, the DYP will assess the risk of another child also being sexually abused.

> All situations believed to involve sexual or physical abuse of a child must be reported to the DYP, regardless of the perpetrator and the steps taken by the child's parents.

## Physical abuse (s. 38e)

1° *A situation in which the child is the victim of **bodily injury or is subjected to unreasonable methods of upbringing** by his parents or another person, and the child's parents fail to take the necessary steps to put an end to the situation;*

2° *a situation in which the child runs a **serious risk** of becoming the victim of bodily injury or being subjected to unreasonable methods of upbringing by his parents or another person, and the child's parents fail to take the necessary steps to put an end to the situation.*

Some indicators:

- → Child presents signs of having been struck, bodily injuries, or unexplained bruises
- → Child has one or more unexplained fractures or repeated injuries
- → Child says parents hit them for not listening and when things are not going well at school
- → Child says parents hurt another child in the family
- → Child cries inexplicably
- → Child is afraid to go home, prefers to stay at school or daycare
- → Child cringes when approached quickly, as if expecting to be hit
- → Child is aggressive towards adults or peers
- → Child refuses to undergo a medical exam
- → Child displays abrupt changes in their usual behaviour (e.g., sudden drop in academic performance, loss of appetite)
- → Parents use unreasonable methods to bring up or discipline their child (e.g., use of objects such as a belt or stick, isolation in a closed space for long periods of time)
- → Parents give evasive or contradictory explanations about the child's injuries or behaviours
- → Parents try to hide child's injuries

In situations where the child is being sexually abused by someone other than their parents, the DYP intervenes only when the parents don't take steps to end the situation.

The notion of serious risk refers to the strong probability that the child is a victim of physical abuse.

## Serious behavioural disturbance (s. 38f)

*A situation in which a child behaves in such a way as to **repeatedly or seriously undermine the child's or others' physical or psychological integrity**, and the **child's parents fail to take the necessary steps** to put an end to the situation or, if the child is **14 or over**, **the child objects to such steps**.*

Some indicators:

- → Child constantly isolates themself (e.g., passiveness, lack of friends, withdrawal)
- → Child displays frequent and uncontrollable aggression and violence
- → Child abuses drugs or alcohol or has compulsive gambling problems
- → Child engages in self-harm
- → Child has suicidal thoughts or demonstrates suicidal behaviour
- → Child develops an eating disorder (e.g., anorexia or bulimia)
- → Child exhibits inappropriate or risky sexual behaviours
- → Child runs away repeatedly
- → Child engages in bullying or other forms of intimidation
- → Child associates with people who have a bad influence and who accentuate their behavioural problems
- → Parents exhibit personal limitations (e.g., too permissive, inconsistent, or strict)
- → Parents deny or trivialize the situation
- → Parents give up on their child's behaviour

The DYP intervenes **only** in situations where there are indicators of serious behavioural disturbance

and if parents **do not take steps** to end the situation and protect their child

or if the child is aged **14 or older and objects to the proposed support services**.

> The DYP **may** also intervene in the following situations:

## Runaway (s. 38.1a)

*If the child leaves his own home, a foster family, a facility maintained by an institution operating a rehabilitation centre or a hospital centre without authorization while his situation is not under the responsibility of the director of youth protection.*

## Abandonment by parents after a placement by virtue of the act respecting health services and social services (s. 38.1c)

*His parents do not carry out their obligations to provide him with care, sustenance and education or do not exercise stable supervision over him, while he has been entrusted to the care of an institution or foster family for one year.*

## What should you do if a child confides in you?

- → Stay calm in front of the child.
- → Listen openly without judging the child.
- → Be reassuring.
- → Tell the child that they made the right decision by telling you about their problems.
- → Assure the child that you believe them or that you take what they are saying very seriously.
- → **Do not promise that you will keep the secret.**
- → **Do not interrogate the child unduly.** Let the child speak freely, **particularly in cases of sexual and physical abuse**, **because leading questions could influence the child or create confusion and thus undermine the DYP's ability to intervene.**
- → Write down the child's words as soon as possible.

## What does reporting a child's situation to the DYP entail?

Reporting a child's situation entails contacting the DYP about a situation you deem troubling based on things the child has told you or attitudes and behaviours exhibited by the child or their parents that lead you to believe the child is in danger or their development is endangered.

You may have concerns about a child but are uncertain whether or not you should report their situation. In such cases, you can contact the DYP, who will be able to answer your questions and guide you through the necessary steps.

### Am I required to report?

The decision to report a child's situation may stir up a slew of emotions. If you have reason to believe that the security or development of a child is or may be in danger due to one or more of the situations described above, it is important that you contact the DYP.

However, the obligation to report differs depending on the role of the person reporting the situation and the situation in itself. The YPA (s. 39 and 39.1) stipulates the following:

The DYP can intervene to ensure a child's protection only if the DYP is notified of the situation.

**Professionals who work with children, employees of institutions in the health and social services network, teachers, people working in a daycare, and police officers:**

- → **Must** bring to the attention of the DYP any situations covered by the YPA that they encounter while performing their duties
- → **Must** report any situation of sexual and physical abuse encountered outside of their duties, even if they deem that the parents are taking steps to put an end to the situation. It is up to the DYP to assess whether these steps are sufficient
- → **May** report, when not performing their duties, other situations that may endanger the security or development of a child

**Other people:**

- → **Must** report any situation of sexual and physical abuse even if they deem that the parents are taking steps to put an end to the situation. It is up to the DYP to assess whether these steps are sufficient
- → **May** report other situations that may endanger the security or development of a child

The obligation to report applies even to people **bound by professional secrecy**, except lawyers and notaries who, in the practice of their profession, receive information concerning a situation that could endanger the security or development of a child.

New information about the child's situation can be provided to the DYP, even after the report has been accepted.

It is important to stress that all adults are bound to provide the necessary assistance to children who wish to report a situation that endangers their security or development, that of their brothers and sisters, or that of any other child (s. 42 YPA).

## Is the identity of the person reporting confidential?

The YPA protects the act of reporting. No person shall disclose or be compelled to disclose the identity of a person who has reported (s. 44 YPA). Individuals who elect to identify themselves can rest assured that their identity will not be disclosed without their consent.

## Can I be prosecuted for reporting?

The YPA stipulates that no person may be prosecuted for providing information in good faith when reporting (s. 43 YPA).

## When must I report?

In order to report to the DYP, **it is not necessary to be certain** that a child needs protection. When your own observations or the words or secrets expressed by a child give you **reasonable grounds** to believe that their security or development is or may be in danger, you must **immediately** report the situation to the DYP in accordance with the obligations stipulated in the YPA (see page 15).

### How do I report?

You can report to the DYP **24 hours a day**, **7 days a week** by telephone or in writing. Information on how to reach the DYP in your area is given at the end of this brochure.

When reporting the situation of a child, you will be asked to provide certain information. Your cooperation is very important. To this effect, we have provided a fact sheet on page 22 that sets out the information the DYP will need.

- → The DYP will ask for your name and contact information as the person report. This information will remain confidential and cannot be disclosed. Although reports may be anonymous, knowing the identity of the person report makes it easier for the DYP to assess the situation and obtain additional information on the child's situation.
- → The DYP will ask you to provide any information you have to help identify the child.
- → The DYP will ask you to provide any information you have about the child's situation that leads you to believe that their security or development is or may be in danger.

## What happens after reporting to the DYP?

You may wonder what happens once you have reported a child's situation. The following explanations are intended to shed light on the steps taken once you have contacted the DYP.

Before coming to a decision, the DYP must analyze the information provided, notably by taking into consideration the following factors (s. 38.2 YPA):

- → The nature, gravity, persistence, and frequency of the facts reported
- → The child's age and personal characteristics
- → The capacity and will of the parents to put an end to the situation in which the security or development of the child is in danger
- → The community resources available to help the child and the child's parents

When assessing reports for educational neglect in connection with the schooling a child receives or with the child's obligation to attend school, the DYP will also take the following into account (s. 38.2.1 YPA):

- → The consequences for the child of skipping school or absenteeism
- → The child's level of development in relation to their age and personal characteristics
- → What the parents are doing to make sure their child receives a proper education, in particular, supervising their school work and partnering with local resources, including school resources
- → The ability of local resources to support the parents in carrying out their responsibilities and to help the child succeed at school

The DYP receives the report, conducts a summary analysis, decides whether it should be accepted for evaluation, and determines the degree of urgency of the intervention.

This analysis can yield two possible decisions:

- → The report is not accepted;
- → The report is accepted for evaluation.

## What happens if the report is not accepted?

This means that, based on the abovementioned factors, the situation reported does not require DYP intervention. In this case, the DYP's intervention ends. The DYP must notify you of the decision not to accept the report. The information you provided is important and will be kept for a period of two years or until the child has reached 18 years of age, whichever comes first.

However, if new information raises concerns about the child's security or development, you can report a child's situation to the DYP at any time.

## What happens if the report is accepted?

The DYP must evaluate the child's situation and living conditions and decide whether their security or development is in danger.

This evaluation can yield two possible decisions:

- → The security or development of the child is not in danger.
- → The security or development of the child is in danger.

**When the security or development of the child is not in danger**, the DYP's intervention ends. The DYP must notify you, the child, and their parents of the decision. The information gathered will be kept for a period of five years or until the child has reached 18 years of age, whichever comes first.

**When the security or development of the child is in danger**, the DYP takes charge of the child's situation and must determine the measures to implement to ensure the child's protection and help the parents to correct the situation.

If you reported a child's situation as a professional who works with children, an employee of an institution in the health and social services network, a teacher, a person working in a daycare, or a police officer, the DYP must inform you that the child's situation is being addressed.

> If the report is not accepted or if the security or development of the child is not in danger, it is possible that the child or their parents may still need help. In this case, the DYP must provide the child and their parents with information on the resources available in their region (local community service centre [CLSC], community organizations, etc.) and how to access them. In addition, with the parents' and child's consent, the DYP must make a personalized referral to these resources.

## What is the multisectoral agreement[3]?

The Multisectoral Agreement involves a commitment to take concerted action in certain situations that may require not only DYP intervention, but also that of the police, the legal community, or other partners such as the child's school or daycare. This is the case when there are reasonable grounds to believe that the security or development of the child is in danger and that a **criminal offence** has been committed against the child. The following situations fall under this category:

- → Children who are victims of **sexual abuse**, **including sexual exploitation**
- → Children who are victims of **physical abuse**
- → Children who are victims of **severe neglect**

In these situations, the Multisectoral Agreement applies. This agreement requires cooperation and collaboration between the DYP and all other concerned parties in order to make sure the children's needs for support and protection are adequately met on a continuous basis.

## What is the role of the service quality and complaints commissioner?

If you are not satisfied with the services provided, you can contact the service quality and complaints commissioner at the integrated centre that is handling your situation.

The commissioner is responsible for receiving and handling complaints about the services provided. Complaints can concern issues such as:

- → Access to services
- → Quality of the services provided
- → Relations with youth centre workers
- → Respect for users' rights

The commissioner cannot intervene in the DYP's decisions whether or not to retain or not a report or to declare that the security or development of a child is in danger. However, the commissioner can make sure the procedures leading up to the decision are compliant. The commissioner has the power to recommend any measures to improve the quality of the services provided to a specific user or to all users as a whole.

For information on how to reach your service quality and complaints commissioner, contact the integrated centre that is handling your situation.

3. Entente multisectorielle relative aux enfants victimes d'abus sexuels, de mauvais traitements physiques ou d'une absence de soins menaçant leur santé physique, MSSS, 2001.

## What is the role of Commission des droits de la personne et des droits de la jeunesse regarding reports?

Commission des droits de la personne et des droits de la jeunesse (CDPDJ) is responsible for upholding the rights of children, as recognized by the YPA and the *Charter of Human Rights and Freedoms*.

It intervenes when it has reason to believe that a child's rights have been violated, including in the context of a report to the DYP.

It may recommend any measure to rectify the situation.

It may also file a claim with a tribunal if the recommendations are not followed within the established time limit or if the child's rights have been violated by persons, bodies, or institutions.

If you have any questions about children's rights or wish to request an intervention, you can contact CDPDJ by phone at **514 873-5146** (Montréal area) or **1 800 361-6477** (elsewhere in Québec) or visit its website at **cdpdj.qc.ca.**

# Who do I call to report?

## Protection services and rehabilitation services for youth with adjustment problems:

### Bas-Saint-Laurent

1 800 463-9009
418 723-1255

### Saguenay–Lac-Saint-Jean

1 800 463-9188
418 543-3006

### Capitale-Nationale

1 800 463-4834
418 661-6951

### Mauricie–Centre-du-Québec

1 800 567-8520
819 378-5481

### Estrie

1 800 463-1029
819 566-4121

### Montréal

**French-speaking**
514 896-3100

**English-speaking (Batshaw)**
514 935-6196
514 989-1885

### Outaouais

1 800 567-6810
819 776-6060

### Abitibi-Témiscamingue

1 800 567-6405
819 825-0002

### Côte-Nord

1 800 463-8547
418 589-9927

### Nord-du-Québec

**Eastern portion, Chapais and Chibougameau**
See Saguenay–Lac-Saint-Jean

**Western portion**
See Abitibi-Témiscamingue

### Gaspésie–Îles-de-la-Madeleine

1 800 463-0629
418 368-1803

### Chaudière-Appalaches

1 800 461-9331

### Laval

1 888 975-4884
450 975-4150
450 975-4000

### Lanaudière

1 800 665-1414
450 756-4555

### Laurentides

1 800 361-8665
450 431-6885

### Montérégie

1 800 361-5310
514 721-1811

### Nunavik

**Baie d'Ungava**
819 964-2905

**Baie d'Hudson**
1 877 535-2345
819 988-2191 (day)
819 988-2957 (night)

### Terres-Cries-de-la-Baie-James

**Chisasibi**
1 800 409-6884
819 855-2844 (day)

**Waswanipi**
1 800 409-6884
819 753-2324 (day)

**Conseil de la Nation Atikamekw (Communities of Manawan and Wemotaci)**
1 877 477-3933

**In case of emergency, dial 911.**

# Report Fact Sheet

This fact sheet is a tool to help guide you through the process of reporting a child's situation. It will help you gather as much useful information as possible to submit to the DYP when you report.

You are not required to be able to answer all of the questions below to report a child's situation. They are provided for information purposes only.

### What is the child's identifying information?

- → What is the child's name? _____
- → What is the child's date of birth or age? _____
- → What is the child's address? _____
- → What is the child's telephone number? _____
- → What is the name of the child's mother? _____
- → What is the name of the child's father? _____
- → Who does the child live with? _____
- → What school or daycare does the child attend? _____
- → Are there other children concerned by this situation? _____
- → If so, what are their first and last names and dates of birth or age? _____

### What are the facts that have raised concerns?

- → Statements or secrets confided by the child _____
- → Actions or attitudes of the child or parents _____
- → Injuries or bruises observed on the child _____

### What is the nature of these facts?

- → Do these facts occur frequently? _____
- → Are these facts past or current? _____
- → Have the facts you are reporting been happening for a long time? _____
- → Do you believe the child is in any danger? _____
- → Have you witnessed these facts personally? _____

### What are the child's vulnerability factors?

- → What impact do you believe the events you reported have on the child? _____
- → Does the child have a physical or mental disability? _____
- → How has the child reacted to the situation? _____
- → Does the child have personal characteristics (strengths or weaknesses) you feel the DYP should know about? _____

### How able and willing are the parents to address the situation?

- → Are the parents aware of the problematic situation? _____
- → Do the parents have personal characteristics (strengths or weaknesses) or problems you feel the DYP should know about (e.g., alcoholism, drug addiction, compulsive gambling, mental health problems, violent behaviour)? _____
- → Have the parents tried to seek help to correct the situation?

  _____

### Do you know if the child or parents have already received help from community resources?

- → Is there someone around the child that can help the child or their parents (extended family, spouse, neighbour, friend, etc.)? _____
- → Are there resources that have already intervened with the child or their parents (CLSC, daycare, school, community organizations, etc.)? _____

### For situations of sexual or physical abuse only

- → Do you know who the suspected perpetrator of the abuse is (father, mother, brother, sister, spouse, extended family member, another adult, another minor)? _____
- → What is the name and age of the suspected perpetrator? _____
- → Is the child still in contact with this person? _____
- → Have the police been notified? _____

It could be useful to note down the **name of the DYP caseworker** with whom you communicated.

**You can consult this brochure at the following websites:**

Ministère de la Santé et des Services sociaux: **msss.gouv.qc.ca**, by clicking **Publications**

Commission des droits de la personne et des droits de la jeunesse: **cdpdj.qc.ca**

Reporting a child's situation to the DYP is already protecting a child.

**For more information:**
**Québec.ca**

19-838-03A

Santé
et Services sociaux
Québec

Centre intégré
universitaire de santé
et de services sociaux
de l'Ouest-de-
l'Île-de-Montréal
Québec

Les Centres de la jeunesse et de la famille Batshaw
Batshaw Youth and Family Centres

# SUMMARY LIST OF SITUATIONS

# VENTILATION OF SECTIONS 38 AND 38.1 OF THE YOUTH PROTECTION ACT

## 38 A) ABANDONMENT

**38 a) Responsabilités parentales non assumées par une autre personne (parental responsibilities not assumed by another person)**

- ◊ **Décès des parents (parents are deceased)**
  The child is considered an orphan if the only legally recognized parent or both parents are deceased or if the tutor who was named for the child is deceased.

- ◊ **Absence des parents (absence of parents)**
  The only legally recognized parent or both parents are alive but do not assume responsibility in relation to their parental authority.

- ◊ **Incapacité permanente des parents (permanent incapacity by parents)**
  The only legally recognized parent or both parents are alive but do not assume responsibility in relation to their parental authority. This situation is the direct result of a permanent incapacity in relation to physical health problems, mental health problems or intellectual deficiency.

## 38 B) NEGLECT

**38 b) 1.i° Négligence sur le plan physique (physical neglect)**

- ◊ **Besoin d'ordre alimentaire (food)**
  The child is considered neglected in terms of food, if the person(s) with the custody do(es) not provide sufficient or adequate food, according to their means/resources.

- ◊ **Besoin d'ordre vestimentaire (clothing)**
  The child is considered neglected in terms of their clothing, if the person(s) with the custody do(es) not provide appropriate and adequate clothing for the season, according to their means/resources.

- ◊ **Besoin d'hygiène (hygiene)**
  The child is considered neglected in terms of their hygiene, if the person(s) with the custody do(es) not attend to the child's proper hygiene, or the child's living environment is unhealthy, according to their means/resources.

- **Besoin de logement (living conditions)**
  The child is considered neglected in terms of their living environment, if the person(s) with the custody do(es) not ensure that the child's living conditions are safe and adequate, according to their means/resources. The neglect may ensue from a lack of essential services (running water, heating, isolation, lighting), hazardous substances or objects accessible to the child, or the home environment poses a risk of injury for the child.

**38 b) 1.ii°Négligence sur le plan de la santé (Neglect in terms of health)**

- **Soins pour sa santé physique non assurés (physical health care not ensured)**
  The child is considered neglected in terms of their physical health, if the person(s) with the custody do(es) not ensure that the child receives adequate health care (respecting prescriptions and other recommendations, collaboration for the follow-up), according to their means/resources. The health problem may be related to an illness or injury, a trauma or a handicap, as well as severe malnutrition that could lead to health problems or improper use of medicine that could lead to serious consequences for the child.

- **Soins pour sa santé mentale non assurés (mental health care not ensured)**
  The child is considered neglected in terms of their mental health, if the person(s) with the custody do(es) not ensure that the child receives adequate mental health care (respecting prescriptions and other recommendations, collaboration for the follow-up), according to their means/resources. The mental health problem may be related to a mental illness, a psychiatric disorder or the presence of an organic emotional, affective or situational problem which may be the reason for a psychiatric intervention. It could also be associated with an emotional difficulty (sensory motor stimulation for a young child, emotional difficulties related to a trauma, a death or separation) or an intellectual deficiency.

- **Soins pour sa santé physique refusés (physical health care refused)**
  The child is considered neglected in terms of their physical health, if the person(s) with the custody do(es) not allow the child to receive adequate health care (cavities, problems with vision, hearing, motor skills, refusal of care, necessary medical interventions or hospitalization). The health problem may be related to an illness or injury, a trauma or a handicap.

- **Soins pour sa santé mentale refusés (mental health care refused)**
  The child is considered neglected regarding his mental health if the person(s) who assume(s) his care do not permit him to receive the required care (refusal of services, necessary medical care or hospitalization). A mental health problem is generally tied to a mental illness, psychiatric problem, or the presence of an organic emotional, affective or situational problem which may be the reason for a psychiatric intervention. It could also be associated with an emotional difficulty (sensory motor stimulation for a young child, emotional difficulties related to a trauma, a death or separation) or an intellectual deficiency.

**38 b) 1.iii Négligence sur le plan éducatif (Neglect in terms of Education)**

- **Problème de surveillance (lack of supervision)**
  The supervision is not appropriate due to a lack of vigilance from the parent(s), who are directly in charge of the child (ex : inside or around the residence or during outings).

◊ **Choix non judicieux au niveau du gardiennage (Non judicious choice of caretaking)**
The supervision is not appropriate given the inadequacy of the caregiver chosen to care for the child in the temporary absence of one or both parents.

◊ **Enfant laissé seul (Child left alone)**
The supervision is not appropriate given the absence of any person watching over the child in his home in the absence of the parent(s).

◊ **Non-respect des durées de gardiennage (duration of caretaking not respected)**
The supervision is not appropriate given the carelessness of the parent(s) to go and retrieve the child at the agreed upon time with the temporary caregiver.

◊ **Attitudes parentales non appropriées (inappropriate parental attitude)**
Inappropriate behaviours (criminal activities other than the ones covered in sections 38 c), d) et e), prostitution, driving under the influence, etc.) or an inadequate upbringing (absence of a routine, inappropriate role model, marginal values) to the needs of the child.

◊ **Tolérance de comportements inappropriés de tiers (Tolerance of inappropriate behaviour by a third party)**
Tolerance, in the living environment, of behaviours from person(s) manifesting disorders/difficulties affecting the child's functioning (criminal activities, substance abuse, gambling, instability, social adjustment, mental health, intellectual or physical deficiency).

◊ **Réactions non appropriées aux comportements de l'enfant (inappropriate reactions to the child's behaviour)**
A supervision that is not adapted (lack of firmness, too much inflexibility in exercising authority, minimizing the child's deviant behaviour) to the behavioural difficulties displayed by the child.

◊ **Défaut de prendre les moyens pour que l'enfant reçoive une instruction adéquate et, le cas échéant, pour qu'il remplisse son obligation de fréquentation scolaire prévue à la Loi sur l'instruction publique (chapitre I-13.3) ou à toute autre loi applicable. (Failing to take steps to ensure an adequate education for the child).**
The child is considered to be neglected if his parent(s) do not take steps to ensure he receives an adequate education. It is compulsory for a child to attend school according to the *Loi sur l'instruction publique* (chapitre I-13.3) or to any other applicable law. This problematic refers to the neglect of the parent(s) to offer to the child and promote his academic development, whether it is in a private or public school or an alternative manner (home schooling).

◊ **Manque de stimulation de l'enfant (lack of stimulation of the child)**
The child is considered neglected , if his parent(s) do not take steps to adequately stimulate a child under 6 years old in regards to his speech, motor, social and intellectual skills.

## 38 B) 2 RISQUE SÉRIEUX DE NÉGLIGENCE (serious risk of neglect)

- ◊ **Problème de toxicomanie chez le parent ou la personne qui en a la garde (Substance abuse problems of the parent or person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody manifest(s) a substance abuse problem such as drugs, excessive alcohol use, prescribed medication or other psychotropic/illegal drug.

- ◊ **Problème de jeu excessif chez le parent ou la personne qui en a la garde (gambling problems of the parent or person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody manifest(s) a gambling problem. This would indicate a continued or periodic lack of control and a progressive increase in the amounts played and the frequency of gambling.

- ◊ **Problème d'instabilité chez le parent ou la personne qui en a la garde (Problem of instability of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody manifest(s) instability with regard to residence (frequent moves, transiency), with regard to the choice of partner and to the people assuming the care of the child. These unpredictable and erratic characteristics of the parents could have an impact on the care offered the child.

- ◊ **Problème d'adaptation sociale chez le parent ou la personne qui en a la garde (social adjustment problem of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their social adjustment problems. It would translate into conflicts with most people, professionals or institutions with whom or which the parent interact(s).

- ◊ **Problème de santé mentale chez le parent ou la personne qui en a la garde (Mental health problems of the parent or person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their mental health problems. Mental health problems are generally connected to a mental illness, psychiatric difficulties, organic, affective or situational emotional problems, which may be the subject of a psychiatric intervention. This problem must generally be medically diagnosed, but it may also be considered in a context of concerning symptoms.

- ◊ **Problème de déficience intellectuelle chez le parent ou la personne qui en a la garde (Intellectual deficiency of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their intellectual delays. Intellectual delays must generally be the subject of a professional diagnosis, but may be considered in a context of concerning symptoms.

- ◊ **Problème de santé physique chez le parent ou la personne qui en a la garde (Physical health problems of the parent or the person with the custody)**
  The child is at risk of being neglected if the person(s) who assume(s) his custody expose(s) him to the effects of their physical limitations. Physical limitations must generally be medically diagnosed but may be considered in a context of concerning symptoms.

- ◊ **Antécédents de négligence non résolue chez le parent ou la personne qui en a la garde (unresolved antecedents of neglect by the parent or the person with the custody)**

The child is at risk of being neglected if the person(s) who assume(s) his custody has already seriously neglected the care of the child or another child in the past. The situation was or not the subject of an intervention which corrected the situation. The child is particularly exposed to this risk considering his recent birth, or a re-integration into his parent(s)' home.

## 38 C) MAUVAIS TRAITEMENTS PSYCHOLOGIQUES (Psychological Ill-Treatment)

- ◊ **Indifférence de la part du parent ou d'une autre personne (Indifference)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or any other person who live(s) with him, demonstrate indifference towards him or do(es) not show concern for his emotional needs.

- ◊ **Dénigrement de la part du parent ou d'une autre personne (Denigration)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or any other person denigrate(s), humiliate(s), demonstrate(s) excessive despising behaviour or language towards him.

- ◊ **Rejet affectif de la part du parent ou d'une autre personne (Emotional rejection)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or any other person manifests emotional rejection towards the child. The emotional rejection can be demonstrated by a lack of affection, favoritism towards another child or negative emotional behaviours towards the child. The rejection must be severe and on-going; and assumes the non-acceptance of the child and the parents' attitude as compromising his development.

- ◊ **Menaces de la part du parent ou d'une autre personne (Threats)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or another person threaten(s) the child. This situation is disruptive towards his psychological integrity, but does not constitute a threat to his physical integrity (we do not anticipate them acting on the threat). Acting on the threat would be covered under Section 38e)

- ◊ **Contrôle excessif de la part du parent ou d'une autre personne (Excessive control)**
  The child is considered to be the victim of psychological ill-treatment if the parent(s) or another person exercise(s) excessive control over him. The excessive control may be demonstrated through control over the child by manipulation or abuse of power. The child is subjected to constant interdictions and constraints.

- ◊ **Exploitation de la part du parent ou d'une autre personne (Exploitation)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or another person force(s) him to work disproportionately according to his capacity, to beg, to make an exhibition of him in an unacceptable fashion or to participate in illegal activities for a third party.

- ◊ **Conflits entre le parent et la personne qui en a la garde (Conflicts between a parent and a person with the custody)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) expose(s) him to the conflicts between the parent(s) and a person who has custody of him.

- **Exposition à la violence familiale de la part du parent ou d'une autre personne (Exposure to family violence by a parent or another person)**
  The child is considered to be a victim of psychological ill-treatment due to exposure to family violence demonstrated by the parent(s) towards a family member or to another person living in the home. He is therefore witness to verbal and/or physical abuse which is not aimed at him directly. This situation disturbs him psychologically, but is not considered a direct threat to his physical integrity covered under Section 38e).

- **Problème de santé mentale chez le parent ou la personne qui en a la garde (Mental health problems of the parent or a person with the custody)**
  The child is considered to be a victim of psychological ill-treatment if the parent(s) or the person who assumes his custody exposes him to the effects of their mental health problems. Mental health problems are generally connected to a mental illness, psychiatric difficulties, organic, affective or situational emotional problems, which may be the subject of a psychiatric intervention. This problem must generally be medically diagnosed, but it may also be considered in a context of concerning symptoms.

- **Isolement (isolation)**
  The child is considered to be a victim of psychological ill-treatment if he is isolated in his living environment, such as being deprived of minimal social contacts, with respect to his age and condition.

- **Renversement des rôles (role reversal/parentified child)**
  The child is considered to be a victim of psychological ill-treatment if he is the object of role reversal (parentified), such as being entrusted with responsibilities disproportionate for his age, including playing a supportive and caring role to one of his parents.

- **Conflits de couple (couple's conflict)**
  The child is considered to be a victim of psychological ill-treatment if he is exposed to conflicts between partners in his living environment. In this case, it is not a question of exposure to conjugal violence but to a heavily emotionally charged relationship which is creating a strong hostility between the parents and to which the child is a witness on a regular and persistent basis; or in which the child is used as a means of negative communication or to put the child under pressure, to the benefit of one or the other parent (which could turn into parental alienation or abduction).

- **Conflits de séparation (conflict of separation)**
  The child is considered to be a victim of psychological ill-treatment if he is exposed to the conflicts between ex-partners in his living environment. In this case, it is not a question of exposure to conjugal violence but to a heavily emotionally charged relationship which is creating a strong hostility between the parents and to which the child is a witness on a regular and persistent basis; or in which the child is used as a means of negative communication or to put the child under pressure, to the benefit of one or the other parent (which could turn into parental alienation or abduction).

- **Problème de santé mentale chez une autre personne (mental health problems of another person)**
  The child is considered to be a victim of psychological ill-treatment if a person exposes him to the effects of their mental health problems. Mental health problems are generally connected to

a mental illness, psychiatric difficulties, organic, affective or situational emotional problems, which may be the subject of a psychiatric intervention. This problem must generally be medically diagnosed, but it may also be considered in a context of concerning symptoms.

**C.1) Exposition à la violence conjugale de la part du parent ou d'une autre personne (Exposure to domestic violence by a parent or another person)**

The child is considered to be a victim of psychological ill-treatment due to the exposure to violence between partners (or other persons) whether they are living together or not. He is thus witness to verbal and/or physical abuse which is not aimed at him directly. This situation disturbs him psychologically, but is not considered a direct threat to his physical integrity (Section 38e).

## 38 D)1 ABUS SEXUELS (Sexual Abuse)

- ◊ **Gestes avec contact physique de la part du parent ou d'une autre personne (Gestures with physical contact by the parent or another person)**
  The child is considered to be a victim of sexual abuse by the parent or a third party if any contact of sexual nature involving any form of physical contact with the parents or a third party continues. This situation may be recent or not. It is only considered if there has never been an intervention to correct the situation.

- ◊ **Gestes sans contact physique de la part du parent ou d'une autre personne (Gestures without physical contact by the parent or another person)**
  The child is considered to be a victim of sexual abuse if behaviours of sexual nature continue, but not involving any form of physical contact by the parents or a third party. It may include exhibitionism, voyeurism, etc. This situation may be recent or not. It is only considered if there has never been an intervention to correct the situation.

- ◊ **Indicateurs d'abus sexuels (Indicators of sexual abuse)**
  The child is considered to be a victim of sexual abuse in the presence of indicators implying that such a situation exists, despite the absence of verbalization to that effect. Specific physical conditions must, however, be confirmed by a medical expertise in these rare cases.

- ◊ **Exploitation sexuelle (Sexual exploitation)**
  Sexual exploitation is a form of sexual abuse. Juvenile pornography, prostitution, striptease, trafficking for sexual purpose, sexual tourism and cyber-exploitation are examples of sexual exploitation. A child, whatever their age, canoot consent to any form of sexual exploitation. In many situations, sexual exploitation is characterized by the use of a child's body for sexual purposes through the exchange of compensation in nature (place to sleep, affection) or paid in cash to the child or to one or more third party.

## 38 D)2 RISQUE D'ABUS SEXUELS (risk of sexual abuse)

- ◊ **Abus sexuels envers des mineurs de la part du parent ou d'une autre personne (Sexual abuse against a minor by the parent or another person)**
  The child is considered to be at risk of being a victim of sexual abuse considering the imposed and abusive behaviours, of sexual nature, involving a physical contact or not, by the parent or another person living with the child, towards a minor other than the child. This situation may

be recent or not. It is only considered if there has never been an intervention to correct the situation.

- ◊ **Abus sexuels envers des majeurs de la part du parent ou d'une autre personne (Sexual abuse against an adult by the parent or another person)**
  The child is considered to be at risk of being a victim of sexual abuse considering the imposed and abusive behaviours, of sexual nature, involving a physical contact or not, by the parent or another person living with the child, towards an adult. This situation may be recent or not. It is only considered if there has never been an intervention to correct the situation.

- ◊ **Climat non approprié entretenu par le parent au plan sexuel ou d'une autre personne (Inappropriate environment maintained by a parent or another person)**
  The child is considered to be at risk of being a victim of sexual abuse considering the ambiguous and intrusive environment, on a sexual level, maintained by a parent or another person (exposure to explicit material, inappropriate sexual comments, lack of respect for the child's intimacy, the parent's tolerance of the sexual deviance of the child).

- ◊ **Risque d'exploitation sexuelle (risk of sexual exploitation)**
  The child is considered to be at risk of being a victim of sexual abuse in relation to an issue of sexual exploitation. The risk must be serious and imminent. It differs from the presence of behavioral disorders that may be associated with the issue, with the presence of specific indicators leading to serious concerns for the emergence of a situation of sexual exploitation.

## 38 E)1 ABUS PHYSIQUES (Physical Abuse)

- ◊ **Sévices corporels de la part du parent ou d'une autre personne (Corporal punishment by a parent or another person)**
  The child is considered a victim of physical abuse if the parent(s) or another person is intentionally subjecting the child to gestures (stricking, burning, hitting, shaking, whipping, making the child ingest something, etc.), that are inflicting injuries, lesions or physical trauma. Ex: use of a belt or any blunt object.

- ◊ **Méthodes éducatives déraisonnables de la part du parent ou d'une autre personne (Inappropriate means of discipline by a parent or another person)**
  The child is considered a victim of physical abuse if the parent or another person subjects the child to physical or corporal punishment (food, sleep, and physical care deprivation, of accommodation, and other conditions essential to his physical well-being, etc). The unreasonable methods of upbringing are given with the intention to educate him, but threaten his physical or psychological integrity which are essential to his physical integrity, without inflicting an injury.

- ◊ **Autres formes d'abus physiques de la part du parent ou d'une autre personne (Other forms of physical abuse by a parent or another parent)**
  The child is considered a victim of physical abuse if the parent, or another person, threatens his physical integrity by using other forms of physical mistreatment (i.e. Münchhausen Syndrome by Proxy).

◊ **Blessures inexpliquées (Unexplained injuries)**
The child is considered a victim of physical abuse if suspicious or unexplained injuries are observed, and evidently appear to be the result of excessive, immoderate or unreasonable means towards him.

## 38 E)2 RISQUE D'ABUS PHYSIQUES (Risk of Physical Abuse)

◊ **Menaces de la part du parent ou une autre personne (Threats by the parent or another person)**
The child is considered at risk of becoming a victim of physical abuse due to threats uttered by the parent or another person. This situation disturbs his psychological integrity but is not considered a serious threat to his physical integrity; as acting on the threat is not anticipated.

◊ **Exposition à la violence familiale de la part du parent ou une autre personne (Exposure to family violence by a parent or another person)**
The child is considered at risk of becoming a victim of physical abuse due to exposure to family violence demonstrated by one (or both) parent(s), or another person, towards a sibling or a third party residing in the home environment. Although he is not the subject of the verbal and/or physical violence, this constitutes a threat to his physical integrity as he could reasonably become a victim of this violence.

◊ **Exposition à la violence conjugale de la part du parent ou une autre personne (Exposure to conjugal violence by a parent or another person)**
The child is considered at risk of becoming a victim of physical abuse due to exposure to the verbal and/or physical violence between the partners in his living environment.

◊ **Antécédents de violence non résolue chez le parent ou une autre personne (History of unresolved violence by the parent or another person)**
The child is considered at risk of becoming a victim of physical abuse due to a history of violence, criminal or not, by the parent or another person, towards one or all of his children, which was the subject or not of an intervention to correct the situation.

◊ **Autres comportements à risque de la part du parent ou une autre personne (At risk behaviour by a parent or another person)**
The child is considered at risk of becoming a victim of physical abuse due to the parent's or another person's behaviour, which is directly threatening the child's life. In this case, it is not the neglect of ordinary preventive measures such as wearing a helmet while riding a bike, skiing or the seat belt in the car. Instead, the behaviour could be such as administering strong medication or dangerous driving of a motor vehicle with limited faculties in the company of the child.

## 38 F) TROUBLES DE COMPORTEMENT SÉRIEUX (Serious Behavioural Disturbance)

◊ **Problème de toxicomanie (substance abuse problems)**
The child undermines his physical or psychological integrity by regularly and excessively consuming alcohol, drugs, medication or other psychotropic drugs.

- **Problème de jeu excessif (gambling problems)**
  The child undermines his physical or psychological integrity due to a problem with excessive gambling. This problem would manifest itself in a continuous or periodic loss of control or by the progressive amounts played and the frequency of the plays.

- **Problème de fugue (runaway)**
  The child undermines his physical or psychological integrity by running away from his regular residence, and his educational supervision by responsible adults towards him.

- **Problème de fréquentations à risque (risky association)**
  The child undermines his physical or psychological integrity by associating with people, minors or adults, whose previous behaviours, present lifestyle or established reputation leads to believe that the influence that they have over him is negative. This influence can generate or increase the child's behavioural problems.

- **Problème de comportements sexuels inappropriés (inappropriate sexual behaviour)**
  The child undermines his physical or psychological integrity by adopting behaviours which present a risk on a sexual level. It includes having unprotected sexual relations or a sexual deviance.

- **Problème de comportement suicidaire (suicidal behaviour)**
  The child undermines his physical or psychological integrity by demonstrating suicidal gestures (actual gestures or not to commit suicide, that may be minimally threatening or very serious) or verbalizing suicidal ideations or threatening to commit suicide.

- **Problème de refus des soins pour sa santé mentale (refusal for mental health care)**
  The child aged 14 or more, undermines his physical or psychological integrity, by refusing interventions aiming to correct a mental health problem.

- **Problème de refus des soins pour sa santé physique (refusal for physical health care)**
  The child aged 14 or more, undermines his physical or psychological integrity, by refusing interventions aiming to correct a physical health problem.

- **Problème d'autres comportements inappropriés pour l'enfant (other inappropriate behaviour for the child)**
  The child undermines his physical or psychological integrity by adopting dangerous behaviours, such as knowingly placing himself in contact with a serious contagious disease, driving a vehicle under the influence, playing Russian roulette, walking on the railings of a bridge or demonstrating cruelty against animals.

- **Problème de vol (theft)**
  The child undermines the physical or psychological integrity of others through stealing. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

- **Problème de vandalisme (vandalism)**
  The child undermines the physical or psychological integrity of others by vandalizing objects in order to damage or to destroy them intentionally. Since this behaviour is considered a criminal

offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

◊ **Problème de pyromanie (arson)**
The child undermines the physical or psychological integrity of others by starting a fire intentionally, in an inappropriate location and without concern for danger, with the purpose of pathological self-satisfaction. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

◊ **Problème de violence verbale (verbal violence)**
The child undermines the physical or psychological integrity of others by being verbally threatening towards people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

◊ **Problème de violence physique (Physical violence)**
The child undermines the physical or psychological integrity of others by being physically threatening towards people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

◊ **Problème de violence sexuelle (sexual violence)**
The child undermines the physical or psychological integrity of others by exhibiting inappropriate gestures of sexual nature towards people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

◊ **Problème de commerce de drogue (drug dealing)**
The child undermines the physical or psychological integrity of others by drug dealing with people around him. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

◊ **Problème d'autres comportements inappropriés pour autrui (other inappropriate behaviours towards others)**
The child undermines the physical or psychological integrity of others by adopting dangerous behaviours such as driving under the influence, playing dangerously with a weapon, having unprotected sexual intercourse knowing he has an STI, etc. Since this behaviour is considered a criminal offence, the application of the Youth Criminal Justice Act (YCJA) for a child over the age of 12 should be preferred.

## Section 38.1

### 38.1 A) FUGUE (Runaway)

- **De son propre foyer :** The child leaves his family home without permission.
- **De sa famille d'accueil :** The child leaves his foster home without permission.

- **Du centre de réadaptation :** The child leaves his rehabilitation centre without permission.
- **Du centre hospitalier :** The child leaves the hospital without permission.

## 38.1 C) DÉLAISSEMENT DE L'ENFANT PLACÉ (Abandonment while being placed)

Refers to the absence of involvement or an insufficient involvement by the parents in the placement of their child, if this placement lasts more than one year. The evaluation of this situation should preferably be dealt with in subsection a) of section 38 (absence of the parents).

# CONFIDENTIALITÉ :

## APPLICATION DES ARTICLES 35.4 ET 36 DE LA LOI SUR LA PROTECTION DE LA JEUNESSE

**Vous agissez en vertu de l'article 32 ou 33 de la LPJ et souhaitez avoir accès à un renseignement personnel ou consulter un dossier (art. 35.4 et 36 LPJ)**

Avez-vous obtenu le consentement de la personne concernée ou de son parent, si elle est âgée de moins de 14 ans, pour obtenir le renseignement personnel souhaité ?

**Non**

Le renseignement personnel souhaité est-il détenu par un établissement, un organisme* ou un professionnel autre qu'un avocat ou un notaire ?

**Oui**

Le renseignement personnel souhaité permet-il de révéler ou de confirmer l'existence d'une situation en lien avec le motif de compromission allégué par le DPJ et dont la connaissance pourrait permettre, selon le cas :

- de retenir le signalement pour évaluation ;
- de décider si la sécurité ou le développement de l'enfant est compromis ou le demeure ;
- de décider de l'orientation de l'enfant.

Si tel n'est pas le cas, le renseignement personnel souhaité permet-il de confirmer ou d'infirmer l'existence d'une situation en lien avec des faits nouveaux survenus depuis la décision portant sur la compromission et dont la connaissance pourrait permettre de réviser la situation de l'enfant ?

**Oui**

Vous pouvez exiger de recevoir le renseignement personnel souhaité.

**Non**

Vous pouvez demander de recevoir le renseignement personnel souhaité auprès des organismes publics et privés concernés, sans toutefois les contraindre à vous le transmettre.

**Oui**

Vous pouvez exiger de recevoir le renseignement personnel souhaité.

**Non**

Si le renseignement souhaité se trouve dans un jugement ou un acte de procédure en matière familiale, vous pouvez obtenir copie de ce document auprès du greffe de la Cour supérieure.

Malgré les renseignements reçus, vous souhaitez consulter le dossier de :

**L'enfant** : Vous pouvez pénétrer, à toute heure raisonnable, ou en tout temps dans un cas d'urgence, dans une installation maintenue par un établissement ou dans un lieu tenu par un organisme ou dans lequel un professionnel pratique sa profession afin de prendre connaissance sur place du dossier de cet enfant et d'en tirer copie**.
***Cette consultation doit être nécessaire pour assurer la protection d'un enfant dont le signalement a été retenu.***

**Du parent ou d'une personne mise en cause par le signalement** : Vous pouvez, **avec l'autorisation du tribunal**, prendre connaissance sur place, dans une installation maintenue par un établissement ou dans un lieu tenu par un organisme ou dans lequel un professionnel pratique sa profession, du dossier d'un parent ou d'une autre personne mise en cause par un signalement. ***Cette consultation doit être nécessaire pour assurer la protection d'un enfant dont le signalement a été retenu.***

**À retenir** : Dans tous les cas où un renseignement personnel vous est communiqué, vous pouvez exiger d'une personne qui a la connaissance d'un renseignement ou d'un dossier visé par le présent article les explications nécessaires à la compréhension de ce renseignement ou de ceux que ce dossier contient.

* Organisme : « tout organisme scolaire, tout organisme du milieu social et tout milieu de garde ainsi que tout autre groupement de personnes ou de biens, quelle qu'en soit la forme juridique, qui sont reconnus, dans un cas ou l'autre, pour fournir des services aux enfants et à leur famille conformément aux règles de l'art ou aux normes établies, d'aide aux enfants et à leurs parents, d'hébergement, de défense des droits, de loisir, de sport ou dont la mission est la protection des intérêts des enfants ou l'amélioration de leurs conditions de vie » (art. 1 LPJ).

** Cette façon de faire devrait demeurer exceptionnelle. Une demande par écrit d'un formulaire demeure toujours à privilégier, lorsque les circonstances le permettent.

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22-838-09W

Votre gouvernement

Québec

# CONFIDENTIALITY – SECTION 35.4 and 36 of the YPA
**(In effect since 2023-04-26)**

Pursuant to amendments to the YPA coming into force as of April 26, 2023, new progress note types (suivi d'activité) have been introduced in PIJ with regards to confidentiality and exercising the DYP's powers of enquiry.

| | |
|---|---|
| **Obtention renseignement 35.4** | Lorsque le directeur ou toute personne qui agit en vertu des articles 32 ou 33, se voit communiquer des renseignements concernant l'enfant, l'un de ses parents ou une autre personne mis en cause par un signalement lorsqu'un tel renseignement permet de confirmer ou d'infirmer l'existence d'une situation en lien avec des faits nouveaux survenus depuis la décision portant sur la compromission et dont la connaissance pourrait permettre de réviser la situation de l'enfant. Fiche 1.1 Confidentialité art 35.4 - Publications.msss.gouv.qc.ca<br><br>*Where the director or any person acting under section 32 or 33 is given information to communicate concerning the child, one of the parents or another person implicated in a report where such information confirms or denies the existence of a situation in connection with new facts that have occurred since the decision on the compromise and knowledge of which could make it possible to review the child's situation.* |
| **Prendre connaissance doss.35.4** | Lorsque directeur ou toute personne qui agit en vertu des articles 32 ou 33, pénètre dans une installation maintenue par un établissement ou dans un lieu tenu par un organisme ou dans lequel un professionnel pratique sa profession afin de prendre connaissance sur place du dossier de l'enfant et d'en tirer une copie s'il l'estime nécessaire pour assurer la protection d'un enfant, ou du dossier des parents ou d'une autre personne mis en cause après avoir obtenu l'autorisation du tribunal. Fiche 1.1 art 35.4 Confidentialité - Publications.msss.gouv.qc.ca<br><br>*Where the director or any person acting under section 32 or 33 enters a facility maintained by an institution or a place maintained by an organization or in which a professional practices his profession in order to examine the child's record on the premises and to make a copy thereof if he considers it necessary to ensure the protection of a child, or the record of the parents or other respondent after obtaining authorization from the court.* |
| **Obtention doc.greffe C.Sup. 36** | Lorsque directeur ou toute personne qui agit en vertu des articles 32 ou 33, obtient, auprès du greffe de la Cour supérieure, copie d'un jugement ou d'un acte de procédure en matière familiale qui concerne un enfant faisant l'objet d'un signalement. Fiche 1.2 Confidentialité art 36 - Publications.msss.gouv.qc.ca<br><br>*Where the director or any person acting under section 32 or 33 obtains from the office of the Superior Court a copy of a judgment or a pleading in a family matter that concerns a child who is the subject of a report.* |

*Note that the above "suivi d'activités" replace the following types:*

- Demande de renseignement 35.4
- Connaissance du dossier art. 36

**Obtention doc. Greffe C. Sup 36 / Obtaining document from Superior Court section 36**
This entry should be used if you "obtain from the office of the Superior Court a copy of a judgment or a pleading in a family matter that concerns a child who is the subject of a report", as per section 36 of the YPA.

**Obtention renseignement 35.4 / Obtaining information Section 35.4**
Information obtained by the worker according to section 35.4 of the YPA, in order to request information pertinent to the current allegations reported to the DYP. **New:** now we can obtain information not only from institutions from within the MSSS, but alos from organizations, or professionals, when it is pertinent to our signalement.

**Prendre connaissance doss. 35.4 / Reviewing file Section 35.4**
This entry is used when reviewing/consulting the file obtained through section 35.4

# DYP Intake form

**Date:_____ Time:_____**

**Declarant:_____ Role/Professional Title:_____**

**Professional Address:_____**

**Work number:_____ Cell Number:_____**

| First name of child/ren | Last name of child/ren | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Cultural Background:_____ Citizenship:_____**

**Date arrived in Canada:_____ Languages Spoken:_____**

**Translator required: _____School:_____**

**CLSC:_____ CLSC referral made:_____**

**Other Professionals involved (name, contact information):_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**
**_____**

**Custody arrangement (if parents separated/divorce): Superior Court or Informal (circle one)**

**Name of Parent 1:_____ Date of Birth:_____**

**Address:_____**

**Home number:_____ Work number:_____ Cell number:_____**

**Home email:_____ Work email address:_____**

**Name of Parent 2:_____ Date of Birth:_____**

**Address (if different from parent 1):_____**

**Home number:_____ Work number:_____ Cell number:_____**

**Home email:_____ Work email: _____**

**If parents are separated/divorced:**

**Name of Parent 1's partner:_____ Date of Birth:_____**

**Address:_____**

**Home number:_____ Work number:_____ Cell number:_____**

**Home email:_____ Work email address:_____**

**If the partner has children:**

| First name of child/ren | Last name of child/ren | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Name of Parent 2's partner:_____ Date of Birth:_____**

**Address (if different from parent 1):_____**

**Home number:_____ Work number:_____ Cell number:_____**

**Home email:_____ Work email: _____**

**If the partner has children:**

| First name of child/ren | Last name of child/ren | Date of Birth |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allegations (38A, 38B1i), ii), iii), 38B2, 38C1, 38D1, 38D2, 38E1, 38E2, 38F):**

**Details:_____**

# Child Protection Law

## The When and How-To of Reporting Maltreatment Concerns

**Eleni Parigoris, MSW, PSW**
Department of Social Services
Montreal Children's Hospital
McGill University Health Centre

Centre universitaire de santé McGill
McGill University Health Centre

# Learning Objectives

- Understand the Youth Protection Act in Quebec
- Understand how to access and navigate the Youth Protection System

# Table of Contents

- What is the Director of Youth Protection?
- The Youth Protection Act.
- The Structure of DYP.
  - Branches of DYP
  - Roles and Responsibilities of Healthcare Professionals within these Branches
- How to Signal to Youth Protection.

# Understanding Youth Protection

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# Director of Youth Protection (DYP)

- The DYP was established in 1977.
- The primary responsibility of the director of youth protection is to enforce the Youth Protection Act, which applies to children whose **security and development** may be compromised or considered to be in danger.
- There are 19 youth protection directors in Quebec.

# Who to Call

**Bas-Saint-Laurent**
1 800 463-9009
418 723-1255

**Saguenay–Lac-Saint-Jean**
1 800 463-9188
418 543-3006

**Capitale-Nationale**
1 800 463-4834
418 661-0951

**Mauricie–Centre-du-Québec**
1 800 567-8510
819 378-5481

**Estrie**
1 800 463-1029
819 566-4121

**Montréal**
French-speaking
514 896-3100

English-speaking (Batshaw)
514 935-6196
514 989-3885

**Outaouais**
1 800 567-6810
819 771-6060

**Abitibi-Témiscamingue**
1 800 567-8405
819 825-0002

**Côte-Nord**
1 800 463-8547
418 589-9927

**Nord-du-Québec**
Eastern portion, Chapais and Chibougamau
See Saguenay–Lac-Saint-Jean

Western portion
See Abitibi-Témiscamingue

**Gaspésie–Îles-de-la-Madeleine**
1 800 463-0629
418 368-1803

**Chaudière-Appalaches**
1 800 461-9321

**Laval**
1 888 975-4084
450 975-4150
450 975-4000

**Lanaudière**
1 800 686-1414
450 756-4558

**Laurentides**
1 800 361-8885
450 431-8885

**Montérégie**
1 800 361-5310
514 721-1811

**Nunavik**
Baie d'Ungava
819 964-2005

Baie d'Hudson
1 877 535-2345
819 988-2191 (day)
819 989-2267 (night)

**Terres-Cries-de-la-Baie-James**
Chisasibi
1 800 409-6884
819 855-2844 (day)

Waswanipi
1 800 409-6884
819 753-2324 (day)

Conseil de la Nation Atikamekw
1 866 472-3533

# Common Terminology/Phrases

- **DYP/DPJ** – Director of Youth Protection/Directeur de la Protection de la Jeunesse.
- **Batshaw** – English and Jewish DYP on the island of Montreal.
- **Signal/Signalement** – to report an incident to DYP.
- **Retained** – a report (signalement) to youth protection was *accepted* and will undergo further *evaluation.*

# Youth Protection Act (YPA)

- “Under the Charter of human rights and freedoms and the Civil Code of Québec, every child has a right to the protection, security and attention that his parents or the persons acting in their stead are able to give to him” (1977, c. 20; 2022, c. 11, s. 1).

- The YPA is a legal document which guides the DYP, and outlines the roles and responsibilities of the DYP, and citizens of Quebec in ensuring the protection and security of children up until the age of 18.

# The YPA – Article 38

- 38a) Abandonment
  - A situation in which a **child's parents are deceased or fail to provide for the child's care, maintenance or education** and those responsibilities are not assumed by another person in accordance with the child's needs
- 38b) Neglect
  - a situation in which the child's parents or the person having custody of the child **do not meet the child's basic needs**,
  - Includes concerns of child's (i) "basic needs", (ii) access to healthcare, and (iii) education.
- 38c) Psychological ill-treatment
  - A situation in which a child is **seriously or repeatedly subjected to behaviour** on the part of the child's parents or another person **that could cause harm** to the child, and the child's parents fail to take the necessary steps to put an end to the situation

# The YPA – Article 38

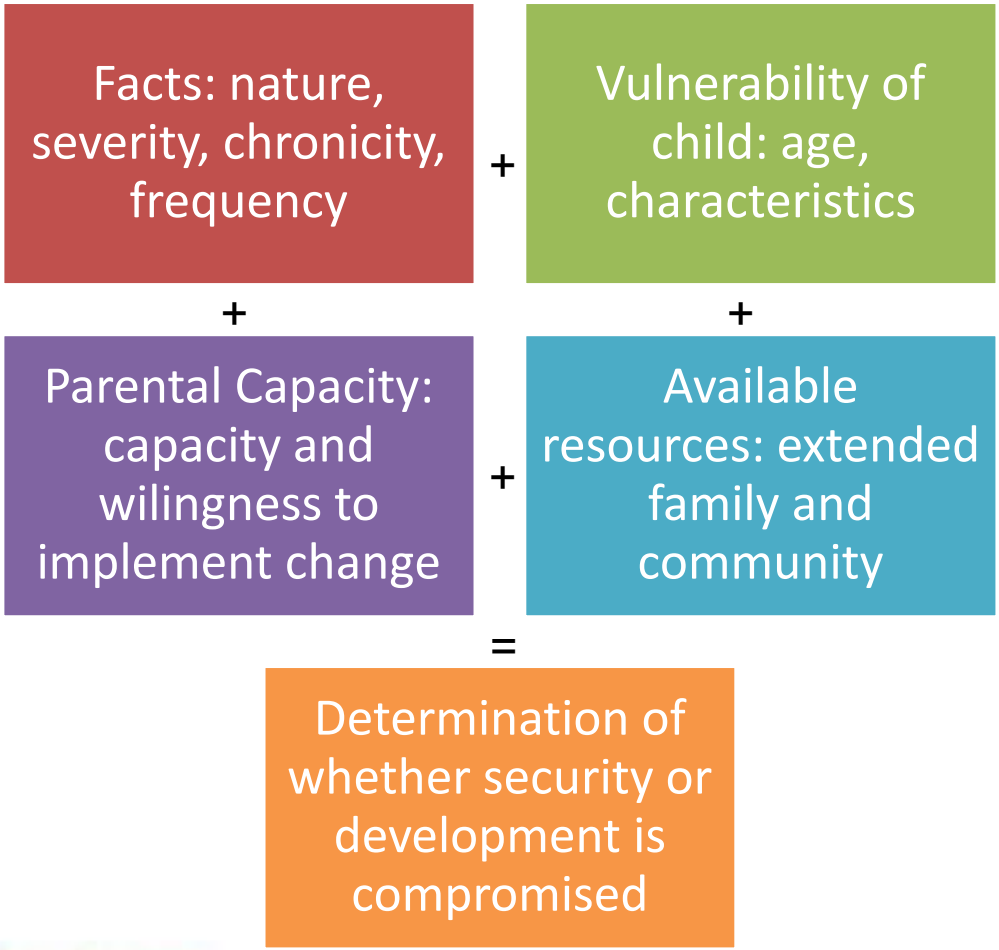
- 38d) Sexual abuse
  - A situation in which the child is subjected to **gestures of a sexual nature** by the child's parents or another person, **with or without physical contact**, including any form of sexual exploitation, and the child's parents fail to take the necessary steps to put an end to the situation
- 38e) Physical abuse
  - A situation in which the child is the **victim of bodily injury** or is subjected to **unreasonable methods of upbringing** by his parents or another person, and the child's parents fail to take the necessary steps to put an end to the situation
- 38f) Serious behavioral disturbances
  - A situation in which a **child behaves in such a way as to repeatedly or seriously undermine the child's or others' physical or psychological integrity**, and the child's parents fail to take the necessary steps to put an end to the situation or, if the child is 14 or over, the child objects to such steps.

# The Structure of the DYP




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# Factors Considered by DYP



# RTS (Receiving and Transmitting of a Signalment)

- RTS is the front-line service of the DYP.
- RTS connects callers with the appropriate departments within the DYP, and receives reports of potential child abuse (signalement).
- RTS workers, in collaboration with their supervisors, determine whether a report warrants further intervention through the DYP. This depends if the reported concerns fall under the need for social intervention under art. 38 in the YPA.

- As healthcare professionals, majority of our communication with the DYP is through RTS.
- You do not require consent from parents, guardians, or a child over the age of 14 to communicate with RTS.

# EO (Evaluation)

- Once a report to youth protection has been **retained**, the file is coded, and assigned to an **EO worker** in order to evaluate/investigate the situation further.
- In this stage, the role/responsibility of the EO worker include:
  - To determine whether the facts reported to RTS are founded or not founded.
  - To determine whether the security and/or development of the child remains compromised.
  - Exercise legal responsibility to ensure the child is not at risk.

- When a file is in the **evaluation stage**, healthcare professionals (and other individuals) are **legally required to collaborate** with the EO worker to facilitate in the evaluation.
- If you are uncertain if the file is under evaluation, you can ask the person on the phone to validate this.
- You can also ask that the EO worker to send you a copy of their **delegation letter.**

# EO (Orientation)

- If it is determined in the evaluation stage that the facts reported to RTS are founded, and the security and development of the child remains compromised, the DYP file remains open, and transitions to **Orientation.**
- In some situations, the file may be transferred to a designated orientation worker but can also remain with the initial EO worker.
- In this stage, the role/responsibility of the EO worker include:
  - To determine an intervention plan to address the concerns found in the evaluation, such as an agreement of short-term intervention, an agreement on voluntary measures, or a referral to youth court.

- When a file is in the **orientation stage**, healthcare professionals (and other individuals) require written consent from the parents, guardians, or child above the age of 14 to communicate with the assigned EO worker.

# AM (Application of Measures)

- Once the intervention plan is finalized, and the course of action includes **voluntary measures** or a **court order**, the DYP file is transferred to an AM worker, whose role is to ensure that the intervention plan is being followed.
- In this stage, the role/responsibility of the AM worker include:
  - To collaborate with the child and family for a duration of generally 6 months to 1 year.
  - To ensure the measures determined in orientation are being followed.
  - Ensure the child and family are being connected to the appropriate resources, and the child and family are engaging in these resources
  - Determine at the end of the intervention whether the security and development of the child is still compromised.

- When a file is in the **application of measures stage**, healthcare professionals (and other individuals) require written consent from the parents, guardians, or child above the age of 14 to communicate with the assigned AM worker.

# Additional Branches in DYP

## VT (terrain verification)

- A service that helps RTS assess further if a report should be retained.
- An assigned worker will take steps to “verify” concerns, including calling collaterals, or going to a child’s home, school, etc.

## YOS (Youth Offenders Service)

- A designated service that work under the law of the Youth Criminal Justice Act.
- Collaborate with the courts for children 12-17 who are accused of a criminal offense.

## SES

- The emergency service for evening and weekend emergency intervention.
- Will become involved if immediate intervention is needed during off-hours.

# Making a Signalement to the DYP

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# Obligations and Responsibilities

- According to art. 39 and 39.1 of the YPA, “Professionals who work with children, employees of institutions in the health and social services network, teachers, people working in a daycare and police officers”, when performing their duties, **must report** any concerns under the YPA (Quebec, 2018).

# Information Needed to Signal at DYP

- Child's legal name.
- Child's date of birth.
- Child's primary address.
- Parents legal name and updated phone number.
- Parents primary address (if it defers from the child's address).

# Non-essential Information (that may be helpful)

- Child's school.
- Parent's date of birth.
- Declarant legal name.
- Declarant contact information.

- It is important to note that **all declarants** have a right to report a situation anonymously to youth protection.
- However, it is helpful to the DYP to have the declarant contact information, as they can communicate with the declarant for further information and inform the declarant of the DYP's final decision of whether the report to the DYP was retained or not retained.

# Making the Signalement

- Once identification of the child, family, and declarant are finalized, the RTS worker will allow you to share your concerns of the child you are signaling.
- While providing this information, make sure you are concise, while also ensuring you are not missing any pertinent information. Sometimes, writing down your points may be helpful in jogging your memory.
- During your reporting, the RTS worker may ask you additional questions to either clarify or expand the information you are currently providing.
- Make sure to **only** share what you know. If the RTS worker asks you a question you do not know the answer to, it is better to respond, “I don’t know”.

# Multi-Sectoral Entente

- Collaboration of DYP, police/detectives, and crown prosecutions in cases of (1) physical abuse, (2) sexual abuse, and (3) severe neglect.
- Entente is activated **by DYP**.
- Allows for seamless communication between all parties, and limits needs for consent.
- Why can this entente only be activated for these three situations?

# Some Tips

- Allow 30-60 minutes for the report
  - Sometimes put on hold or get call back
- Explain clearly why you are worried – potential harm to the child
  - Do not interview, but if disclosure made, report and document "verbatim"
- Avoid medical jargon!!
  - e.g. Subdural hemorrhages = bleeding around the brain, tibia = shin bone etc.
- Handling medical uncertainty
  - Most likely/most probable/concern for...
- Avoiding bias...
- Information is stored for 2 years

# References


Quebec. (2018). *Duty to report - reporting a situation to the director of Youth Protection (DYP)*. Gouvernement du Québec. Retrieved March 12, 2023, from https://www.quebec.ca/en/family-and-support-for-individuals/childhood/services-youth-difficulty-families/youth-protection/reporting-a-situation-to-the-director-of-youth-protection/duty-to-report

Quebec Government. (1979). Youth Protection Act, Revised in 1995. https://www.legisquebec.gouv.qc.ca/en/document/cs/p-34.1

COMMUNIQUÉ
AUX INTERVENANT(ES), INFIRMIER (ES) ET MÉDECINS AUPRÈS DES VICTIMES D'AGRESSIONS SEXUELLES

## Sujet : Lame de réserve pour l'analyse d'ADN

Cette lame doit être conservée au centre désigné **dans un endroit dédié et verrouillé** (armoire ou réfrigérateur).

ATTENTION : NE JAMAIS REMETTRE LA LAME DE RÉSERVE POUR L'ANALYSE D'ADN DANS LES TROUSSES MÉDICOLÉGALES ET MÉDICOSOCIALES.

Cette lame peut servir à identifier le profil génétique de l'agresseur dans les cas où :

- la victime revient sur sa décision de porter plainte et la trousse médicolégale a été détruite

- la victime décide de porter plainte et seule la trousse médicosociale a été utilisée (dans un délai de 5 jours ou moins suite à l'agression sexuelle)

Les personnes intervenants auprès des victimes d'agression sexuelle doivent informer la victime qu'une lame de réserve est conservée et que cette lame pourrait être utilisée ultérieurement si cela s'avérait nécessaire.

Bien mentionner à la victime que **cette lame ne peut être utilisée qu'avec son consentement écrit.** Veuillez remettre à la victime le document intitulé : Information à l'intention des victimes d'agression sexuelle concernant la lame de réserve pour l'analyse d'ADN.

Lorsque la victime décide de porter plainte dans les cas précis mentionnés précédemment et désire qu'une analyse d'ADN soit effectuée sur la lame, **elle doit remplir et signer le document intitulé « Formulaire de consentement et de remise aux policiers de la lame de réserve pour l'analyse d'ADN».** L'intervenant(e) et le policier qui en prend possession doivent aussi remplir et signer ce formulaire. La copie blanche doit être conservée au dossier de la victime. Les autres copies du formulaire ainsi que la lame sont transmis au policier.

Les formulaires de consentement contenant le nouveau titre en français et en anglais, devront être commandés à la même adresse où sont assemblées les trousses médicolégales et médicosociales soit :

Les Ateliers MIRIA-DOR
Établissement de détention-Sherbrooke
1055 rue Talbot
Sherbrooke (Québec)
Tél : (819) 820-3100
Téléc : (819) 820-3964

Pour toutes autres informations, vous pouvez communiquer avec moi aux coordonnées suivantes :

Martine Bazinet
Spécialiste en biologie judiciaire
Laboratoire de sciences judiciaires et de médecine légale
Tel : (514) 873-3301 poste 61484
Courriel : martine.bazinet@msp.gouv.qc.ca

Date : 9 décembre 2013

# INFORMATION À L'INTENTION DES VICTIMES D'AGRESSION SEXUELLE CONCERNANT **LA LAME DE RÉSERVE POUR L'ANALYSE D'ADN**

Une nouvelle lame fait partie de la trousse médicolégale et médicosociale depuis 2008. Cette lame s'intitule « lame de réserve pour l'analyse d'ADN » et a pour but de permettre des tests d'ADN ultérieurs si cela s'avérait nécessaire.

Cette lame pourrait servir à identifier le profil génétique de l'agresseur dans les cas où :

- Vous revenez sur votre décision de porter plainte et la trousse médicolégale a été détruite
- Vous décidez de porter plainte et seule la trousse médicosociale a été utilisée (dans un délai de 5 jours ou moins suite à l'agression sexuelle)

La lame de réserve pour l'analyse d'ADN sera conservée un certain temps au centre désigné dans un endroit dédié et verrouillé.

**Cette lame ne peut être utilisée qu'avec votre consentement écrit.**

Si vous décidez de porter plainte et d'utiliser cette lame, vous devez remplir et signer le document intitulé « Formulaire de consentement et de remise aux policiers de la lame de réserve pour l'analyse d'ADN »

révision : mars 2014

Sent from my iPhone

# List of hand outs for the SA course

Step to Direct intervention (algorithm from centre conseil des centres designes)

Triage Algorithm for the Management of Sexual Abuse Victims in the Pediatric ED 16th october 2023

SA verification checklist 2025

Slide for Age and behavior reaction and disorder after SA

Sexual Abuse Tip Sheet Do and Don't

ASQ questionnaire

Sexual Assault Pamphlet EngFr

SA Interview flow cheat sheet

SA documentation sheet PDF

DYP Quebec yellow information French and English

F1-F12 Trousse sheet photocopies

Script how to confidentiality etc…

Theory SA Evaluation

SERVICE-CONSEIL
aux centres désignés pour l'intervention médicosociale auprès des victimes d'agression sexuelle

# Manuel d'autoformation

## Formation provinciale

sur l'intervention médicosociale en centres désignés auprès des victimes d'agression sexuelle

*Formation intérimaire basée sur la formation provinciale de 2017*

Document produit par :

Le **Service-conseil aux centres désignés pour l’intervention médicosociale auprès des victimes d’agression sexuelle**

Ce document s’adresse aux intervenantes et intervenants du réseau québécois des centres désignés pour l’intervention médicosociale auprès des victimes d’agression sexuelle qui suivent la *Formation provinciale - sur l'intervention médicosociale en centres désignés auprès des victimes d’agression sexuelle*.

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# Plan de la formation

**Introduction**

**0.1.** Les centres désignés et l'intervention médicosociale : définition, objectifs et fonctionnement

**0.2.** La répartition des rôles dans l'équipe médicosociale

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**1.** Premier contact et premières consignes

**Étape 2 : Orientation de l'intervention**

**2.1.** Le Guide d'intervention médicosociale

**2.2.** Les outils d'intervention : trousses médicolégale et médicosociale

**2.2.1.** La composition des trousses

**2.2.2.** Exercice : Choisir le bon outil

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**Étape 4 : Examens médical et médicolégal**

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**4.1.4.** Les vêtements

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**4.3.1.** Ordre de prélèvement des échantillons médicolégaux et médicaux

**4.4.** Le rôle des formulaires de la trousse dans l'examen médical (p. 5, 6, 7, 8)

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**6.1.** Information et soutien, signalement au DPJ, dénonciation à la police et références

**6.2.** Remplir les formulaires, sceller et transférer la trousse (p. 10, 11, 12)

**Étape 7 : Suivi médical**

**Étape 8 : Suivi psychosocial**

**Module d'approfondissement**

**9.** Le Laboratoire de sciences judiciaires et de médecine légale

**9.1.** Le LSJML – Section Biologie

**9.2.** Le LSJML – Section Toxicologie

**10.** L'intervention médicosociale en centres désignés auprès des victimes mineures d'agression sexuelle

**10.1.** Les particularités de l'intervention médicosociale en centres désignés auprès des victimes mineures d'agression sexuelle

**10.2.** Examen médical - Intervention médicosociale auprès des victimes mineures

**10.3.** ITSS et le suivi

**0.1.** Les centres désignés et l'intervention médicosociale : définition, objectifs et fonctionnement

NOTES :

**L'intervention médicosociale divisée en 8 étapes :**

Étape 1 : Accueil et soutien émotionnel

Étape 2 : Orientation de l'intervention

Étape 3 : Histoire médicosociale

Étape 4 : Examens médical et médicolégal

Étape 5 : Soins et traitements

Étape 6 : La fin de l'intervention médicosociale initiale

Étape 7 : Suivi médical

Étape 8 : Suivi psychosocial

## **0.2.** La répartition des rôles dans l'équipe médicosociale

**Tableau 1 : Qui peut faire quoi lors de l'intervention médicolégale.**

| | Intervenant·e· psychosocial·e | Infirmier·ère | Infirmier·ère au rôle élargi et praticien·ne spécialisé·e (IPS) | Médecin, pédiatre |
|---|---|---|---|---|
| Étape 1 : Accueil et soutien émotionnel | **X** | **X** | **X** | **X** |
| Étape 2 : Orientation de l'intervention | **X** | **X** | **X** | **X** |
| Étape 3 : Histoire médicosociale | **X** | **X** | **X** | **X** |
| Étape 4 : Examens médical et médicolégal | * | * | **X** | **X** |
| Étape 5 : Soins et traitements | * | **X** | **X** | **X** |
| Étape 6 : La fin de l'intervention médicosociale initiale | **X** | **X** | **X** | **X** |
| Étape 7 : Suivi médical | * | **X** | **X** | **X** |
| Étape 8 : Suivi psychosocial | **X** | **X** | **X** | **X** |
| * Ces membres de l'équipe médicosociale peuvent néanmoins être présent·e·s lors de ces étapes pour rassurer la victime et collaborer avec le médecin ou l'infirmier·ère. | | | | |

## Activité de recherche après la formation

**« Mon centre désigné »**

Qui est ma répondante ou mon répondant?

Qui sont nos partenaires pour l’intervention médicosociale et pour le suivi?

Quels sont nos protocoles pour la répartition des rôles entre les membres de l’équipe médicosociale?

Quels sont nos protocoles de conservation et de destruction des trousses?

## Étape 1 : Accueil et soutien émotionnel

NOTES :

### 1. Premier contact et premières consignes

#### Premières consignes

- Pour préserver les preuves dans la mesure du possible :
  - Ne pas se laver
  - Ne pas aller à la toilette
  - Ne pas manger
  - Ne pas se rincer la bouche ni se brosser les dents

- Si la victime appelle avant :
  - Ne pas jeter ni laver les vêtements portés pendant l'agression. Les apporter au centre désigné.
  - Se rendre sans tarder au centre désigné le plus près.
  - À l'arrivée au triage du centre désigné, dire, sans avoir à donner de détails, que l'on a été victime d'agression sexuelle. Préciser qui nous a orienté vers le centre désigné.

- Au centre désigné:
  - Faire les prélèvements de sang et d'urine rapidement s'il y a intoxication ou qu'on suspecte une soumission chimique (c'est-à-dire que l'agression a été facilitée par des substances).

- Les premières consignes peuvent varier en fonction du contexte (p. ex., selon le délai depuis l'agression sexuelle et les prélèvements pertinents). On va parler de ça à la prochaine étape!

## Étape 2 : Orientation de l'intervention

### **2.1.** Le Guide d'intervention médicosociale

NOTES :

### Exercice : Le Guide d'intervention médicosociale

Pour cette activité, ouvrez la version électronique du Guide d'intervention médicosociale dans votre navigateur Web et utilisez Ctrl F pour ouvrir une boîte de recherche.

1. Imaginons que vous ayez besoin de connaître les facteurs de risque de transmission du VIH parce que la victime insiste pour suivre un traitement préventif contre une éventuelle infection.
    - Quel terme de recherche utiliseriez-vous dans le guide électronique?
    - Avez-vous trouvé l'information dont vous aviez besoin?
    - Où l'avez-vous trouvée?
2. Il serait possible de récupérer de l'ADN sur plusieurs sites du corps de la victime. Vous ne savez pas où faire le prélèvement pour la lame de réserve.
    - Quel terme de recherche utiliseriez-vous pour trouver cette information dans le guide électronique?
    - Avez-vous trouvé l'information dont vous aviez besoin?
    - Où l'avez-vous trouvée?

## **2.2.** Les outils d'intervention : trousses médicolégale et médicosociale

### Tableau synthèse TML vs TMS

| La trousse médicolégale peut être utilisée si **TOUTES** les conditions suivantes sont respectées : | La trousse médicosociale peut être utilisée si **UNE OU PLUSIEURS** des conditions suivantes sont respectées : |
|---|---|
| → L'agression sexuelle remonte à 5 jours ou moins. | → L'agression sexuelle remonte à plus de 5 jours. |
| → Il y a une possibilité de trouver du matériel biologique de l'agresseur. | → Aucun prélèvement médicolégal n'est possible. |
| → La victime consent à l'examen médicolégal. | → La victime consent à l'intervention médicosociale. |
| **ET** | **OU** |
| → La victime veut dénoncer l'agression à la police ou est susceptible de le faire. | → La victime n'a pas l'intention de faire de dénonciation à la police. |

### **2.2.1.** La composition des trousses

| Trousse médicolégale | Trousse médicosociale |
|---|---|
| Formulaires 1-12 | Formulaires 1-9, 11-12 |
| Prélèvements médicolégaux | ---------- |
| Lame de réserve (dans un délai de 5 jours) | Lame de réserve (dans un délai de 5 jours) |

**Les formulaires**

NOTES :

**Les prélèvements médicolégaux**

NOTES :

**La lame de réserve**

NOTES :

## Aide-mémoire – Choix du prélèvement pour la lame de réserve

*Acte unique :*

| Acte commis | Délai | Lame de réserve |
|---|---|---|
| Pénétration vaginale | 5 jours | Frottis vaginal |
| Éjaculation sur la peau | 2 jours ou moins | Frottis cutané |
| Pénétration anale | 2 jours ou moins | Frottis anal |
| Pénétration orale | 1 jour ou moins | Frottis buccal |

Dans le cas d'actes multiples, favoriser le prélèvement avec le plus long délai ou l'endroit où la victime sait qu'il y a eu éjaculation si cela respecte les délais maximaux recommandés.

Si les actes sont incertains, il est recommandé de faire le frottis vaginal.

## Schéma décisionnel

**1** Selon le récit de la personne victime, les **actes subis** lors de l'agression sexuelle et les délais maximaux de prélèvement, il est possible de récolter des preuves sur le corps ou les vêtements de la personne victime.

| Temps écoulé depuis AS | 24 heures ou moins | 48 heures ou moins | 5 jours ou moins | 6 jours ou plus |
|---|---|---|---|---|
| **Circonstances possibles** | • Pénétration orale<br>• Sang, sperme ou salive sur la peau ou les cheveux<br>• Pénétration anale<br>• Pénétration vaginale<br>• Intoxication ou perte de mémoire<br>• Vêtement ou objets pertinents | • Sang, sperme ou salive sur la peau ou les cheveux<br>• Pénétration anale<br>• Pénétration vaginale<br>• Intoxication ou perte de mémoire<br>• Vêtement ou objets pertinents | • Pénétration vaginale<br>• Intoxication ou perte de mémoire<br>• Vêtement ou objets pertinents | • Vêtements ou objets pertinents |

**2** La personne victime souhaite dénoncer l'agression sexuelle au service de police ou est susceptible de le faire ultérieurement.

- OUI → **3**
- NON → **TROUSSE MÉDICOSOCIALE**

**3** La personne victime consent à un examen médicolégal (examen médical comprenant des prélèvements médicolégaux).

- OUI → **TROUSSE MÉDICOLÉGALE**
- NON → **TROUSSE MÉDICOSOCIALE**

## Tableau des délais pour les prélèvements médicolégaux

| Site | Prélèvements | Délai maximal |
|---|---|---|
| Buccal<br>si pénétration | 2A & 2B | 24 heures |
| Anal<br>si pénétration | 2E & 2F | 48 heures |
| Cutané<br>si salive, sperme ou sang de l'agresseur | 2CI & 2CII<br>Cou, seins, vulve, pénis, région périnéale, cheveux, poils pubiens, sous les ongles, autres. | 48 heures |
| Vagin et col utérin<br>si pénétration | 1B, 1C & 1D | 5 jours |
| Sanguin<br>si intoxication et ADN | 1E | 5 jours |
| Urinaire<br>si intoxication | 2G | 5 jours |
| Objets/corps étrangers<br>pouvant contenir des substances biologiques de l'agresseur | 2D<br>Incluant les produits sanitaires | Aucun délai |
| Vêtements<br>incluant les couches | 3A, 3B, 3C, 3D & 3E | Aucun délai |

### **2.2.2.** Exercice : Choisir le bon outil

**Pour chacun des cas suivants, indiquez la trousse appropriée.**

1. Une femme agressée sexuellement (pénétration vaginale) par son mari depuis plusieurs mois; la dernière agression a eu lieu il y a 2 jours. Elle a porté plainte à la police.

   Médicolégale ◯ Médicosociale ◯

2. Un jeune homme a perdu conscience lors d'une soirée dans un bar et s'est réveillé le lendemain avec des bleus et des douleurs à l'anus. Il croit avoir été drogué. Il se présente au centre désigné la journée même, mais ne sait pas s'il veut porter plainte.

   Médicolégale ◯ Médicosociale ◯

3. Une adolescente qu'un camarade de classe a agrippée et attouchée par-dessus ses vêtements hier. Elle a porté plainte à la police.

   Médicolégale ◯ Médicosociale ◯

4. Une femme rapporte que son patron l'a pénétrée vaginalement, après la fermeture du magasin; elle s'est débattue et a des douleurs à plusieurs endroits. Elle est certaine de ne pas vouloir porter plainte à cause d'une mauvaise expérience passée avec la police.

   Médicolégale ◯ Médicosociale ◯

5. Une femme rapporte s'être endormie chez un ami et s'être réveillée pendant la nuit alors qu'il la pénétrait vaginalement. Elle l'a repoussé et il a arrêté; elle a remarqué qu'il portait un condom quand il s'est retiré. Elle a pris une douche avant de venir au centre désigné et elle ne sait pas si elle veut porter plainte.

   Médicolégale ◯ Médicosociale ◯

6. Une jeune femme rapporte qu'un homme rencontré sur Internet l'a forcée à lui faire une fellation et a éjaculé dans son visage. Elle se présente au centre désigné 3 jours plus tard et n'est pas certaine de vouloir porter plainte.

   Médicolégale ◯ Médicosociale ◯

7. Un garçon de 12 ans a révélé à sa mère qu'il avait vécu un abus sexuel lors d'un événement sportif il y a plus d'une semaine. Sa mère a constaté une tache (de sperme?) sur son chandail de sport. Elle l'a apporté au centre désigné. La mère et le garçon souhaitent porter plainte.

   Médicolégale ◯ Médicosociale ◯

## Étape 3 : Histoire médicosociale

### **3.1.** L'entrevue avec la victime

**Aide-mémoire – les 4 C**[1]

- ***Calm*** *(calmer)* : Adopter une attitude calme, un ton bas, une posture et des expressions rassurantes.
- ***Contain*** *(contenir)* : Limiter les éléments pouvant générer ou réveiller des traumatismes.
- ***Care*** *(prendre soin)* : *Pratiquer des auto-soins et faire preuve d'auto-compassion tout en prenant soin des autres.*
- ***Cope*** *(s'adapter)* : Encourager les stratégies d'adaptation, les relations positives et les interventions qui soutiennent la résilience.

NOTES :

[1] Source: L. Kimberg et M. Wheeler, « Trauma and Trauma-Informed Care », dans M. R. Gerber (dir.), *Trauma-Informed Healthcare Approaches: A Guide for Primary Care*, Springer, 2019, p. 25-56.

**3.2.** Le consentement (p. 1)




NOTES :

**Consentement à l'intervention médicosociale – circonstances particulières**

- Intoxication contre sa volonté ou état d'ébriété avancé
  - Prélever 1E (Sang) et 2G (Urine) le plus rapidement possible pour que l'analyse toxicologique se fasse dans les meilleures conditions possibles.
  - Attendre le réveil de la victime pour discuter des examens médical et médicolégal.
- Blessures graves : coma, vie en danger, etc.
  - Puisque cette situation peut durer pendant une période prolongée, ce qui risque d'entraîner la détérioration des preuves, l'examen médical et les prélèvements médicolégaux peuvent être faits sans le consentement de la victime.
  - Les prélèvements médicolégaux seront conservés jusqu'à ce que la victime puisse décider quelles démarches elle veut entreprendre ou, dans certains cas, un parent ou tuteur pourra consentir à la remise de la trousse médicolégale aux policiers.

- Mineur : 13 ans ou moins
    - Un des parents ou le tuteur de l'enfant doit signer le consentement.
    - Si ces derniers refusent, le Directeur de la protection de la jeunesse peut autoriser l'examen et les prélèvements.
- Mineur : 14 à 18 ans
    - Le consentement à l'examen et aux prélèvements est donné par la victime elle-même.
    - Les parents ne peuvent pas se prévaloir de leur autorité parentale pour en décider autrement.
- Déficience intellectuelle
    - Si l'équipe médicosociale considère que la victime est apte à consentir, son consentement à l'examen médical et aux prélèvements médicolégaux est valide.
    - Si la victime est inapte à donner son consentement, l'examen médical et les prélèvements médicolégaux peuvent être autorisés par un tuteur ou par le Curateur public.

(Pour plus d'information sur le consentement à l'examen médical et aux prélèvements médicolégaux, consulter le Guide d'intervention médicosociale, Étape 2, pages 9 à 12.)

**3.3.** L'histoire médicosociale et la description de l'agression sexuelle (p. 2, 3, 4, 5)





NOTES :





NOTES :

**3.4.** Choisir les prélèvements à faire (p. 9)



## EXERCICE

*Cet exercice est conçu pour vous entraîner à utiliser les pages 3 et 9 concernant les échantillons à prélever en fonction du récit de la victime. Lisez les vignettes suivantes et remplissez la page 3, puis la page 9 du mieux que vous pouvez. Les solutions vous seront fournies lorsque vous reprendrez la vidéo.*

**Scénario 1.** Une femme rapporte s'être endormie chez un ami et s'être réveillée pendant la nuit alors qu'il la pénétrait vaginalement. Elle l'a repoussé et il a arrêté. Elle a pris une douche avant de venir au centre désigné dans un délai de 24 heures.


AGRESSION SEXUELLE

Examen médicolégal

3



AGRESSION SEXUELLE

Examen médicolégal

+ NE FAIRE QUE LES PRÉLÈVEMENTS NÉCESSAIRES

**Scénario 2.** Une jeune femme rapporte qu’un homme rencontré sur Internet l’a forcée à lui faire une fellation et a éjaculé dans son visage. Elle se présente au centre désigné 24 heures plus tard.


AGRESSION SEXUELLE

Examen médicolégal

3



AGRESSION SEXUELLE

Examen médico-légal

✦ NE FAIRE QUE LES PRÉLÈVEMENTS NÉCESSAIRES

**Scénario 3.** Un jeune homme a perdu conscience lors d'une soirée dans un bar et s'est réveillé le lendemain avec des bleus, mal à la gorge et des douleurs à l'anus. Il se présente au centre désigné la journée même.


AGRESSION SEXUELLE

Examen médicolégal



AGRESSION SEXUELLE

Examen médicolégal

DATE DE L'EXAMEN

✦ NE FAIRE QUE LES PRÉLÈVEMENTS NÉCESSAIRES

| Site | Circonstances | Prélèvements pour la recherche du contre-indigné | Prélèvements AVANT ou non pour la Laboratoire de recherches judiciaires |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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## Étape 4 : Examens médical et médicolégal

**4.1.** Le contenu de la trousse médicolégale – Comment faire les prélèvements
- **4.1.1.** La mise en place
- **4.1.2.** La trousse de base
- **4.1.3.** Le matériel complémentaire
- **4.1.4.** Les vêtements

NOTES :

**4.2.** L'examen médical

NOTES :

## **4.3.** Les prélèvements médicaux et médicolégaux et autres tests

*Mise à jour des pratiques de dépistage et de traitement prophylactiques dans les contextes d'agression sexuelle au Québec (2021)*

### *Au sujet du Guide d'intervention médicosociale*

La dernière version du Guide d'intervention médicosociale a été publiée en 2010 et inclut des sections sur l'examen médical, les soins et les traitements. Une nouvelle version du Guide est en cours de révision et sa publication concordera avec l'introduction des nouveaux outils d'intervention médicosociale. Le présent document vise à offrir une mise à jour dans la période intérimaire.

### *ITSS et agression sexuelle*

La prévalence des ITSS à la suite d'une agression sexuelle est basse au Québec. Les infections à chlamydia ou à gonorrhée détectées chez les victimes le sont en général au premier rendez-vous au centre désigné, peu de temps après l'agression sexuelle; elles sont donc, dans la majorité des cas, le fait d'infections asymptomatiques déjà présentes avant l'agression. L'agression sexuelle étant la plupart du temps un acte unique, les risques de transmission sont moindres. De plus, au Québec, comme ailleurs au Canada et aux États-Unis, on ne rapporte que de très rares cas de VIH, de syphilis ou d'hépatite B à la suite d'une agression sexuelle.

### *Dépistage*

On effectue des **tests de base** lorsque la victime se présente au centre désigné dans les heures ou jours suivant l'agression sexuelle : gonorrhée, chlamydia, trichomonas; sérologies VIH, syphilis, hépatite B; test de grossesse.

Par contre, les tests plus concluants pour une infection qui aurait été transmise lors de l'agression sexuelle seront faits dans les délais optimaux pour chacune des ITSS. Dans le cas de la chlamydia et de la gonorrhée, ces tests pourraient être effectués ensemble à 14 jours. Le test de grossesse pourra aussi être répété à ce moment. Les sérologies peuvent être répétées en même temps à 3 mois.

Le tableau suivant indique les tests recommandés et les délais optimaux de dépistage.

| | Test de dépistage recommandé | Délai optimal pour dépistage |
|---|---|---|
| **Gonorrhée** | TAAN/PCR | 14 jours |
| **Chlamydia** | TAAN/PCR | 14 jours |
| **Trichomonas** | Selon le labo. Test antigène possible | En général 14 jours |
| **VIH** | Sérologie | 4 semaines (99 % si le laboratoire utilise un test de 4e génération).<br>3 mois (100 %) |
| **VDRL** | Sérologie | 3 mois |
| **Hépatite B** | Sérologie | 3 mois |
| **Grossesse** | Sanguin ou urinaire (en fonction du type de tests) | Sanguin : 5 jours<br>Urinaire : 14 jours |

Pour les prélèvements ITSS au niveau vaginal, **on ne recommande pas les auto-prélèvements**. S'il y avait un résultat positif, le prélèvement pourrait être contesté en Cour, même si en général les tests ITSS constituent rarement une preuve admissible, sauf chez les enfants.

**4.3.1.** Ordre de prélèvement des échantillons médicolégaux et médicaux

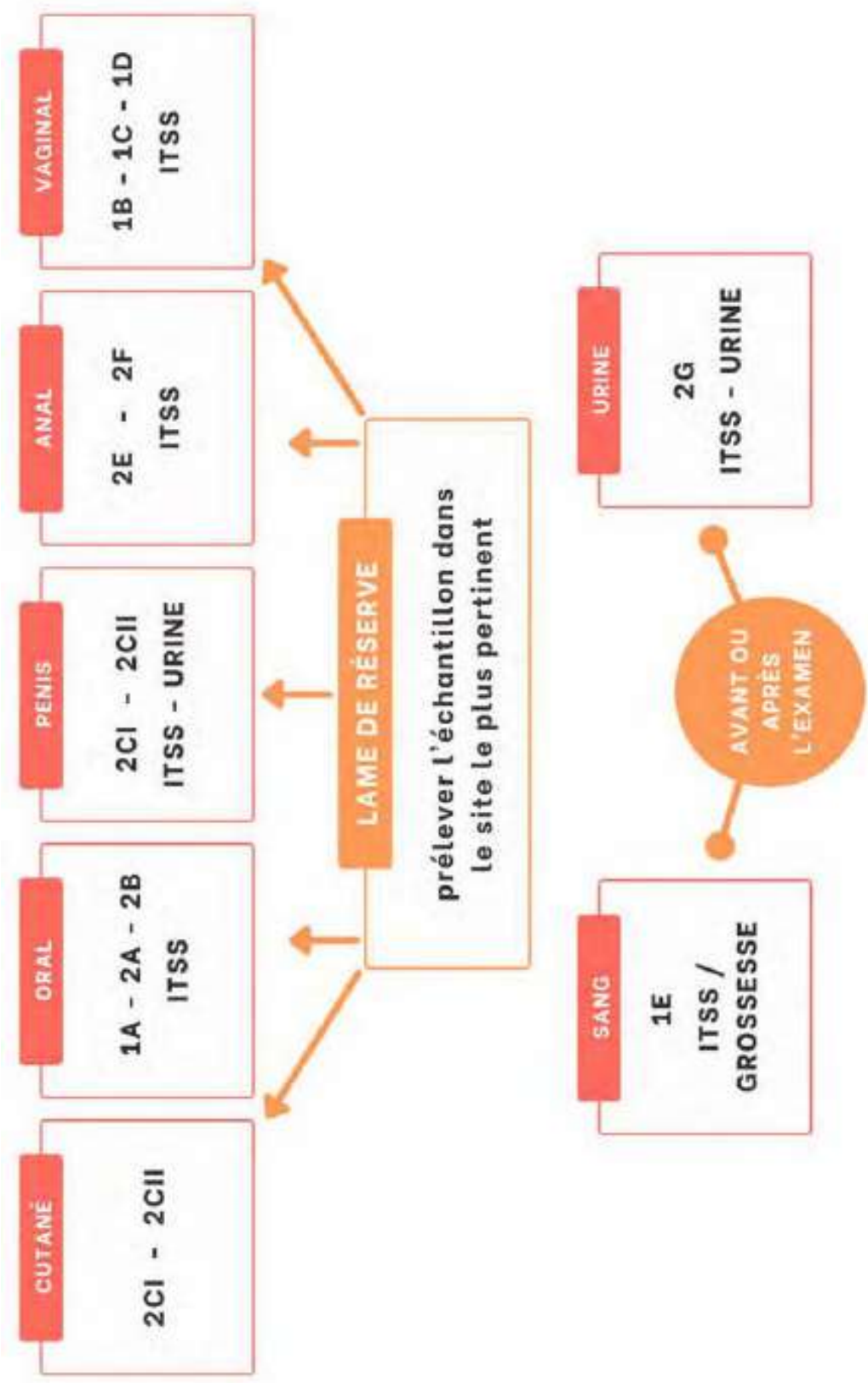


**Tableau : Ordre de prélèvement des échantillons médicolégaux et médicaux**

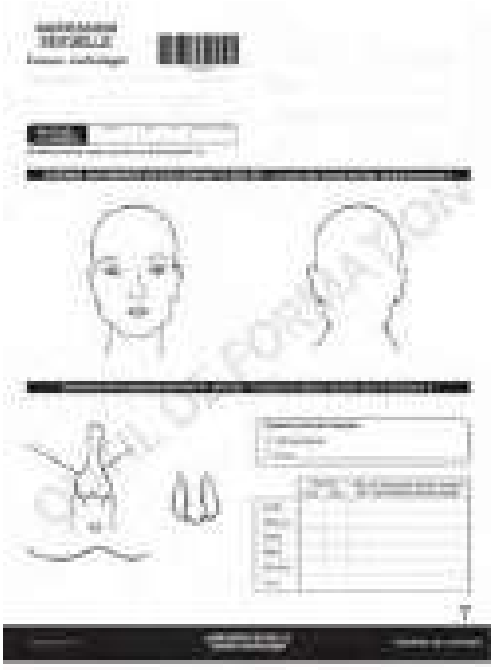


**4.4.** Le rôle des formulaires de la trousse dans l'examen médical (p. 5, 6, 7, 8)





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## Étape 5 : Soins et traitements

### **5.1.** Les soins et traitements

*Mise à jour des pratiques de dépistage et de traitement prophylactiques dans les contextes d'agression sexuelle au Québec (2021)*

#### Traitements prophylactiques des ITSS

Afin de prendre une décision éclairée par rapport à la prophylaxie post-exposition, le médecin considérera :

- les éléments obtenus à l'examen physique,
- les caractéristiques de l'agression sexuelle,
- les facteurs de risque d'ITSS chez la victime et l'agresseur,
- les probabilités que la victime se présente à sa visite de suivi.

**La prophylaxie ITSS post-exposition est rarement recommandée, encore moins chez les enfants.**

Pour les adultes, il peut être approprié d'offrir une prophylaxie dans des situations où il y a eu pénétration vaginale, orale ou anale, en considérant les facteurs ci-haut et si :

- l'on sait que l'agresseur est infecté;
- il est impossible d'effectuer des prélèvements PCR pour analyse de laboratoire;
- on craint que la victime ne se présentera pas à un rendez-vous de suivi après avoir reçu un résultat positif;
- la victime en fait la demande, même si elle comprend bien les indications, risques et bénéfices.

**Pour le VIH, les facteurs de risque chez l'agresseur sont plus élevés s'il s'agit :**

- d'un homme ayant des relations sexuelles avec des hommes (HARSAH);
- d'un usager de drogues par voie intraveineuse;
- d'un détenu ou d'un ex-détenu;
- d'un homme ayant des relations sexuelles avec de multiples partenaires;
- d'un porteur du VIH ou de l'hépatite B ou C, ou d'une personne ayant eu un contact sexuel ou avec le sang de ce porteur;
- d'un individu issu d'une communauté où l'hépatite B est endémique;
- d'un individu issu d'une communauté où la prévalence de certaines ITSS (NG-CT) est plus importante, incluant certaines populations autochtones;
- d'un voyageur ayant eu des contacts sexuels ou ayant été en contact avec du sang dans des régions où l'hépatite B ou le VIH sont endémiques;
- d'un agresseur inconnu.

## Traitements prophylactiques : grossesse et ITSS

| | **Médication recommandée** | **Délai pour recevoir la prophylaxie** | **Autres considérations** |
|---|---|---|---|
| **Gonorrhée** | Ceftriaxone 250 mg IM, en dose unique<br>**OU**<br>Céfixime 800 mg, po, dose unique<br>**Et**<br>Azithromycine 2 g, po, dose unique | Aucun délai maximal | Pour la gonorrhée, si exposition pharyngée, le premier choix est la ceftriaxone.<br>Tenir compte de l'acceptabilité d'une injection IM.<br>Pour la chlamydia, tenir compte de l'adhérence au traitement dans le cas de la doxycycline.<br>On privilégie la doxycycline pour l'exposition rectale.<br>Voir les recommandations : https ://www.inesss.qc.ca/fileadmin/doc/INESSS/Outils/Guides_ITSS/Guide_ITSS-Chlamydia_gonorrhoeae.pdf |
| **Chlamydia** | Doxycycline 100 mg PO, BID x 7 jours<br>**OU**<br>Azithromycine 1 g po | | |
| **Traitement d'un présumé contact avec la gonorrhée ou la chlamydia** | **1er choix** :<br>Ceftriaxone 250 mg IM, en dose unique<br>**ET**<br>Doxycycline 100 mg PO, BID x 7 jours<br>**2e choix** :<br>Ceftriaxone 250 mg IM, en dose unique<br>**Ou**<br>Céfixime 800 mg, po, dose unique<br>**ET**<br>Azithromycine 2 g, po, dose unique | | Tenir compte de l'acceptabilité d'une injection IM.<br>On privilégie la ceftriaxone pour l'exposition pharyngée.<br>Tenir compte de l'adhérence au traitement dans le cas de la doxycycline.<br>On privilégie la doxycycline pour l'exposition rectale.<br>Voir les recommandations : https ://www.inesss.qc.ca/fileadmin/doc/INESSS/Outils/Guides_ITSS/Guide_ITSS-Chlamydia_gonorrhoeae.pdf |

| | | | |
|---|---|---|---|
| **VIH** | Emtricitabine 200 mg + Tenofovir 300 mg (Truvada)<br>PO, DIE x 28 jours<br>**ET**<br>Raltegravir 400 mg (Isentress)<br>PO, BID x 28 jours | Optimal : Moins de 24 heures après l'exposition<br>Maximal : 72 heures après l'exposition | L'ensemble des études indique que la transmission du VIH survient très rarement à la suite d'une agression sexuelle. La prophylaxie post-exposition (PPE) contre le VIH n'est pas recommandée en général chez les victimes d'agression sexuelle au Québec.<br>Elle peut être considérée dans certaines circonstances particulières. **Consulter aussi l'annexe 1 du présent document pour un résumé des éléments à prendre en considération dans l'évaluation de la victime et la prise de décision.**<br>Se référer au *Guide pour la prophylaxie et le suivi après une exposition au VIH, au VHB et au VHC* : https://publications.msss.gouv.qc.ca/msss/fichiers/2018/18-338-01W.pdf<br>Pour les doses chez les enfants, voir Figure 4. |
| **Syphilis** | Aucun traitement prophylactique n'est approuvé pour la syphilis. | | |

| | | | |
|---|---|---|---|
| **Hépatite B** | Immunoglobulines anti-hépatite B<br>0,06 ml/kg; IM, en dose unique | Optimal :<br>< 48 heures<br>Maximal : 14 jours | L'outil interactif « Aide à la décision pour la post-exposition à l'hépatite B » peut être utilisé pour la marche à suivre dans un cas particulier : http://www.msss.gouv.qc.ca/aide-decision/etape.php?situation=Hepatite-B<br><br>On peut administrer le vaccin et les immunoglobulines en même temps ou selon l'algorithme du Protocole d'immunisation du Québec (PIQ).<br><br>Les victimes nées après 1985 ou qui ont immigré au Québec après 1994 ont majoritairement été vaccinées. |
| | Vaccin (Recombivax HB ou Engerix-B)<br>19 ans et moins : 0,5 ml IM<br>20 ans et plus : 1 ml IM | Optimal :<br>< 48 heures<br>Maximal : 14 jours | |
| **Hépatite C** | Aucun traitement prophylactique n'est disponible pour l'hépatite C. | | |
| **Grossesse** | Levonorgestrel 1,5 mg (Plan B)<br>1 dose STAT | Le plus rapidement possible jusqu'à 5 jours après l'agression sexuelle | C'est le contraceptif d'urgence de premier choix si le poids est de < 75 kg, l'IMC < 25 et le délai est de 1 à 3 jours après l'agression sexuelle. |
| | Ulipristal 30 mg (Ella)<br>1 dose STAT | Le plus rapidement possible jusqu'à 5 jours après l'agression sexuelle | Il peut être utilisé :<br>1) s'il y a allergie au lévonorgestrel ou si le poids est > 75kg ou l'IMC > 25;<br>2) si le délai est de 4-5 jours après l'agression sexuelle. |

## Insomnie et anxiété

Certaines victimes peuvent présenter une anxiété importante, surtout s'il y avait déjà une anxiété préalable. Des victimes ayant déjà un sommeil perturbé peuvent craindre des insomnies ou présenter des insomnies qui persistent au-delà de quelques jours.

Pour l'anxiété ou l'insomnie, il faut d'abord privilégier des soins non pharmacologiques avec le soutien d'un·e intervenant·e.
Sinon, le lorazepam (1 mg) peut être prescrit pour diminuer la tension ou l'insomnie. L'alprazolam (0,5 mg) ou le clonazepam (0,5 mg) peuvent être indiqués lorsque des éléments de panique ou d'anxiété extrême dominent.
Une prescription régulière (3 ou 4 fois par jour), pour quelques jours, est associée à moins de dépendance psychologique qu'une posologie « au besoin ».

## **5.2.** L'IVAC




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### Pour en savoir plus

Pour avoir en savoir plus sur l'IVAC, pour trouver les formulaires et pour plus d'information, rendez-vous sur le site www.ivac.qc.ca et téléchargez le *Guide d'utilisation des formulaires médicaux de la Direction générale de l'IVAC.*

## Étape 6 : La fin de l'intervention médicosociale initiale

### **6.1.** Information et soutien, signalement au DPJ, dénonciation à la police et références

La dernière étape de l'intervention médicosociale initiale doit être adaptée aux circonstances et aux besoins exprimés par la personne victime. Voici une liste de tout ce que cette étape peut comprendre.

→ Offrir à la personne victime le **soutien émotionnel** nécessaire :

- ☐ Vérifier l'état psychologique de la victime en prévision de sa sortie du centre;
- ☐ Discuter du réseau de soutien de la victime;
- ☐ Rassurer la victime en lui disant qu'elle n'est pas responsable de l'agression sexuelle.

→ Vérifier qu'elle a tous ses **documents importants** :

- ☐ Tout outil qui fournit un résumé de l'intervention pour la victime;
- ☐ Demande de prestations à l'IVAC à remplir;
- ☐ Attestation médicale (IVAC ou CNESST);
- ☐ Autres documents à l'appui d'une demande de prophylaxie VIH;
- ☐ Ordonnances à présenter dans une pharmacie;
- ☐ Billet de médecin pour le travail/l'école;
- ☐ Ressources d'aide offertes dans sa région.

→ Voir à sa **sécurité** et renforcer son sentiment de sécurité :

- ☐ Plan de sécurité
- ☐ Préparer un départ sécuritaire du centre désigné
- ☐ Trouver un hébergement (au besoin)

→ Assurer l'accès aux **suivis** :

- ☐ médical;
- ☐ psychosocial;
- ☐ médicolégal.

→ Remettre des **documents de référence** sur :

- ☐ la problématique de l'agression sexuelle;
- ☐ les démarches judiciaires possibles;
- ☐ la santé et les aspects médicaux liés à l'agression.

→ Soutenir la personne victime dans sa **dénonciation au service de police**

→ Remplir votre obligation légale de **signalement** pour :

- ☐ les personnes de moins de 18 ans;
- ☐ les personnes majeures vulnérables.

**Aide-mémoire – signalement au DPJ**

- Le plus de renseignements possibles sur l'enfant :
  - Son nom;
  - Sa date de naissance;
  - Son adresse;
  - Son numéro de téléphone;
  - Le nom de ses parents.

Les autres faits connus qui peuvent aider le DPJ à évaluer le signalement :

- La ou les personnes avec qui l'enfant habite. L'école ou le milieu de garde fréquenté par l'enfant.
- Est-ce que la situation concerne d'autres enfants? Le cas échéant, quelles informations a-t-on sur ces enfants (p. ex., leur nom, leur âge)?

On rapporte les faits que l'on connaît, soit :

- Ce que l'enfant ou ses parents ont dévoilé au sujet de l'agression sexuelle;
- Les faits entourant l'agression sexuelle :
  - Le moment de l'agression, s'il s'agit d'agressions répétées et si l'enfant est présentement en danger;
  - L'identité de l'agresseur suspecté et son âge et si l'enfant est encore en contact avec cet individu;
  - La police a-t-elle été avisée?
- Les conséquences observées (physiques, psychologiques, comportementales) ou rapportées par l'enfant ou ses parents;
- L'engagement des parents face à la situation;
- Les ressources déjà impliquées auprès de la famille.

**6.2.** Remplir les formulaires, sceller et transférer la trousse (p. 10, 11, 12)





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## Étape 7 : Suivi médical

| On adapte le calendrier en fonction des besoins de la victime, des vaccins, etc. | |
|---|---|
| Première relance : **2 à 3 semaines** | Deuxième relance : **3 mois** |
| → État émotionnel<br>→ Évaluation pour anxiété, insomnie (soutien psychosocial ou médication si indiqué)<br>→ Prélèvements ITSS : gonorrhée, chlamydia, autres<br>→ État des blessures<br>→ Symptômes particuliers<br>→ Retour des menstruations et test de grossesse si indiqué | → État émotionnel<br>→ Symptômes particuliers<br>→ Sérologie pour VIH, hépatite B, syphilis |

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## Activité de recherche après la formation

**« Mon centre désigné »**

Comment le suivi médical est-il organisé dans mon centre désigné?

Qui la victime doit-elle contacter si elle présente des complications ou des symptômes entre deux rendez-vous de suivi?

## Étape 8 : Suivi psychosocial

### Exercice : se mettre à la place de son client.

*Essayez de répondre au type de questions que vous pourriez poser à la victime dans le cadre d'un suivi psychosocial.*

Comment faites-vous face à des situations traumatiques ou stressantes?

Avez-vous des stratégies d'adaptation « négatives » et/ou « positives »?

Qualifieriez-vous certaines émotions de bonnes ou de mauvaises? Pourquoi?

Sur quel soutien personnel/communautaire/institutionnel pouvez-vous compter lorsque vous avez besoin d'aide?

**9.** Le Laboratoire de sciences judiciaires et de médecine légale

**9.1.** Le LSJML – Section Biologie

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**9.2.** Le LSJML – Section Toxicologie

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**10.** L'intervention médicosociale en centres désignés auprès des victimes mineures d'agression sexuelle

**10.1.** Les particularités de l'intervention médicosociale en centres désignés auprès des victimes mineures d'agression sexuelle

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**10.2.** Examen médical - Intervention médicosociale auprès des victimes mineures

NOTES :

**10.3.** ITSS et le suivi

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## ANNEXE A – Aide à la décision pour la prophylaxie post-exposition au VIH

***Évaluation des victimes à la suite d'une exposition potentielle au VIH***

L'ensemble des études indique que la **transmission du VIH survient très rarement** à la suite d'une agression sexuelle. **La prophylaxie post-exposition (PPE) contre le VIH n'est pas recommandée en général chez les victimes d'agression sexuelle au Québec**.

L'évaluation d'une victime potentiellement exposée au VIH doit se faire le plus rapidement possible, car **si une prophylaxie post-exposition (PPE) doit être prescrite, la médication antirétrovirale doit commencer dans les 72 heures qui suivent l'agression et idéalement en moins de 24 heures**. Le clinicien doit évaluer les avantages, pour la victime à risque, de suivre ce traitement. Il doit également évaluer la volonté de la victime de prendre ces médicaments. Les risques et bénéfices de la médication doivent être abordés avec la victime afin que celle-ci accepte ou refuse la prophylaxie de manière éclairée. La décision doit être prise au cas par cas, en considérant les risques et les bénéfices et de préférence, particulièrement pour les enfants, après consultation avec un médecin spécialiste en maladies infectieuses.

**Circonstances où la prophylaxie VIH n'est pas recommandée :**

- Si la victime exposée est déjà infectée par le VIH.
- Si le statut infectieux de l'agresseur est connu et qu'il n'est pas infecté par le VIH.
- Si le délai depuis l'exposition est supérieur à 72 heures.
- Si la victime a été exposée à répétition au même agresseur depuis plus de 72 heures.
- Si le type de contact sexuel est considéré comme comportant un risque faible ou nul (voir Figure 1).

**Circonstances où la prophylaxie VIH est recommandée :**

- Si le statut infectieux de l'agresseur est connu et qu'il est infecté par le VIH,
  ET qu'il y a eu pénétration anale ou vaginale, insertive ou réceptive.

**Circonstances où la prophylaxie VIH peut être considérée :**

- Si le statut infectieux de l'agresseur pour l'infection par le VIH est inconnu.
  - Dans ce cas, la décision devra être fondée sur :
    - le risque associé à la transmission selon le type de contact sexuel (voir Figure 1);
    - l'épidémiologie de l'infection au VIH dans la population concernée (voir Figure 2);
    - les facteurs de risque de l'agresseur.
- Si l'examen physique révèle des lésions génitales ou anales importantes et qu'il y a des facteurs de risque chez l'agresseur.
- Si la victime présente une anxiété importante quant à la possibilité de transmission du VIH, une perception du risque excessive par rapport au risque réel, même après avoir reçu les informations appropriées sur le risque de transmission (voir Figure 3).

***Trousses de départ***

Les centres désignés devraient avoir une trousse de départ pour la prophylaxie du VIH avec les médicaments nécessaires pour quelques jours. En effet, il est recommandé, si un traitement prophylactique est prescrit, que **des médicaments soient remis pour 3 jours à la victime** et que celle-ci soit alors revue le troisième jour afin d'évaluer la pertinence de poursuivre la médication. La victime sera dans un état émotionnel plus favorable pour évaluer les risques, comprendre les enjeux, intégrer l'information et prendre une décision éclairée quant à la poursuite ou non de la prophylaxie. De plus, cela permet à la victime de remettre sa prescription à la pharmacie, qui pourrait ne pas avoir la médication en stock, pour éviter le risque que le traitement soit interrompu.

*Coût de la prophylaxie VIH*

Le coût du traitement complet peut varier entre 900 $ et 1500 $.

Si la victime est éligible pour l'IVAC (voir module 5.2 IVAC)

Une entente existe entre la Direction de l'indemnisation des victimes d'actes criminels (IVAC) et l'Ordre des pharmaciens du Québec. Celle-ci permet le paiement entier direct à la pharmacie par l'IVAC, ce qui implique que la victime n'aura pas à payer pour remplir la prescription.

La victime doit joindre une pièce justificative à sa prescription pour que la facture puisse être payée par l'IVAC. Une attestation médicale IVAC ou CNESST constitue une pièce justificative suffisante qui doit être émise en même temps que la prescription par le médecin.

Si la victime n'est pas éligible pour l'IVAC

La prescription ne sera pas couverte par l'IVAC. Il faut évaluer si la victime est présentement assurée avec une assurance privée ou le régime public d'assurance médicaments de la RAMQ ou si elle y est admissible et s'assurer qu'elle comprend et est en mesure de payer les coûts de franchise et de coassurance, le cas échéant. D'autres programmes pourraient aider à rembourser certains frais, dont les programmes d'indemnisation des victimes des autres provinces si l'agression a eu lieu au Canada.

**Figure 1 : Indication de la PPE anti-VIH à la suite d'un contact sexuel[2]**

| Exposition | Statut VIH de la source | Traitement de la personne exposée | | |
|---|---|---|---|---|
| | | Recommandé | Non recommandé | À envisager†† |
| Anale insertive/ réceptive | Négatif | | X† | |
| | Positif | X* | | |
| | Inconnu | | | X‡ |
| Vagin-pénis réceptive/ insertive | Négatif | | X† | |
| | Positif | X* | | |
| | Inconnu | | | X‡ |
| Orale réceptive avec éjaculation | Négatif | | X** | |
| | Positif | | | X* ‡‡ |
| | Inconnu | | | X§ |
| Orale réceptive sans éjaculation | Négatif | | X | |
| | Positif | | X | |
| | Inconnu | | X | |
| Orale insertive avec/ sans éjaculation | Négatif | | X | |
| | Positif | | X | |
| | Inconnu | | X | |
| Annilingus | Négatif | | X | |
| | Positif | | X | |
| | Inconnu | | X | |
| Cunnilingus | Négatif | | X | |
| | Positif | | X | |
| | Inconnu | | X | |
| Partage d'objets sexuels§§ | Négatif | | X† | |
| | Positif | X* | | |
| | Inconnu | | | X§ |

* La PPE anti-VIH n'est pas indiquée lorsque la personne vivant avec le VIH prend un traitement antirétroviral comme prescrit et que sa charge virale, mesurée par des analyses consécutives de laboratoire tous les quatre à six mois, se maintient à moins de 200 copies par millilitre de sang. Dans ces conditions, il n'y a pas de preuves de transmission.

† La PPE est recommandée si la source fait partie d'un groupe à risque et a présenté des symptômes de primo-infection au cours des trois derniers mois.

‡ La PPE est recommandée si la source fait partie d'un groupe à risque.

§ La PPE peut être envisagée si la source fait partie d'un groupe à risque.

** La PPE peut être envisagée si la source fait partie d'un groupe à risque et a présenté des symptômes de primo-infection au cours des trois derniers mois.

†† Lorsque la PPE anti-VIH est envisagée, elle doit être administrée après évaluation des avantages et des inconvénients.

‡‡ La PPE peut être envisagée. La prescription des antirétroviraux est optionnelle et doit être basée sur une décision prise en commun par la personne exposée et le médecin.

§§ Contact d'un objet sexuel avec les sécrétions génitales d'un partenaire (personne source), puis pénétration de cet objet dans le vagin ou l'anus de l'autre partenaire (personne contact).

[2] Tiré du *Guide pour la prophylaxie et le suivi après une exposition au VIH, au VHB et au VHC*, Gouvernement du Québec, janvier 2019.

**Figure 2 : Prévalence du VIH, du VHC et du VHB dans différents groupes de la population québécoise[3]**

| Population | | Année des données | Prévalence (%) | Incidence (par 100 personnes-années) |
|---|---|---|---|---|
| UDI[7] | VIH | 2003-2014 | 19,7 %, Montréal<br>15,4 %, milieu urbain<br>7,6 %, milieu semi-urbain | 1,5* |
| | VHC | 2003-2014 | 62,2 %, milieu urbain<br>52,3 %, milieu semi-urbain | 22,1** |
| HARSAH[8] | VIH | 2008-2009 | 12,5 % | 1,3 |
| Personnes incarcérées (UDI et non UDI amalgamés)[9] | VIH | 2014 | 1,9 %, hommes<br>0,8 %, femmes | |
| | VHC | 2014 | 11,9 %, hommes<br>19,6 %, femmes | |
| Personnes originaires des Caraïbes anglophones ou d'Afrique subsaharienne[10] | VIH | 2013-2014 | 0,8 %, Caraïbes<br>1,7 %, Afrique | |
| | VHB | 2014 | 5 - 7 %, Caraïbes<br>≥ 5 %, Afrique | |
| | VHC | 2014 | 1,5 - 3,5 %, Caraïbes<br>1,5 ≥ 3,5 %, Afrique | |
| Personnes originaires d'Haïti[11] | VIH | 2010 | < 1 % | |
| Jeunes de la rue[12] | VIH | 2011-2012 | 1,1 % | |
| | VHC | 2011-2012 | 13,9 % | |

* Années 1995-2014
** Années 1997-2014

[3] Tiré du *Guide pour la prophylaxie et le suivi après une exposition au VIH, au VHB et au VHC*, Gouvernement du Québec, janvier 2019.

**Figure 3 : Risque de transmission associé à une exposition sexuelle, source dont l'infection par le VIH-1 a été confirmée[4]**

| Type d'exposition | Niveau de risque* |
|---|---|
| Relation orale insertive | 0,005 % |
| Relation orale réceptive | 0,01 % |
| Relation vaginale insertive | 0,05 - 0,1 % |
| Relation anale insertive | 0,06 - 0,16 % |
| Relation vaginale réceptive | 0,08 - 0,19 % |
| Relation anale réceptive | 0,5 - 3,38 % |

* Il n'y a aucune preuve de transmission de l'infection par le VIH pendant les relations sexuelles orales, vaginales ou anales sans condom lorsque la personne vivant avec le VIH prend un traitement antirétroviral comme prescrit et que sa charge virale, mesurée par des analyses consécutives de laboratoire tous les quatre à six mois, se maintient à moins de 200 copies par millilitre de sang. Dans ce contexte, le risque de transmission est négligeable[1].

[4] Tiré du *Guide pour la prophylaxie et le suivi après une exposition au VIH, au VHB et au VHC*, Gouvernement du Québec, janvier 2019.

**Figure 4 : Régimes de prophylaxie VIH pour les enfants**[5]

| Médicament | Formulation | Dose | Maximum |
|---|---|---|---|
| **Zidovudine (AZT)** | 10 mg/ml | 4-9 kg :<br>12 mg/kg/dose BID<br>9-30 kg :<br>9 mg/kg/dose BID<br>≥ 30kg :<br>300 mg BID | 300 mg (30 ml) BID |
| **Lamivudine (3TC)** | 10 mg/ml | 4 mg/kg/dose BID | 150 mg (15 ml) BID |
| **Lopinavir (LPV)/ ritonavir (RTV) (Kaletra[MD])** | 80 mg LPV-<br>20 mg RTV/ml | < 15 kg :<br>12 mg LPV/kg/dose<br>15-40 kg :<br>10 mg LPV/kg/dose<br>>40 kg :<br>400 mg LPV BID | 400 mg (5 ml) BID |

**Note**

**Pédiatrie :** Si < 12 ans, < 40 kg ou incapable d'avaler des comprimés, prescrire, en suspension liquide : **zidovudine (AZT) + lamivudine (3TC) + Kaletra[MD] (LPV/RTV), 10 mg/kg/dose (max. 400 mg lopinavir/100 mg ritonavir), 5 ml BID.**

- En cas d'intolérance à cette combinaison, communiquer avec le médecin de garde en maladies infectieuses au Centre hospitalier universitaire Sainte-Justine (514 345-4931) pour discuter d'un traitement alternatif.
- Si > 12 ans ou > 40 kg, prescrire le régime pour l'adulte (emtricitabine/ténofovir disoproxil fumarate [Truvada[MD]]1 co die et raltégravir [Isentress[MD]] 400 mg BID).

[5] Tiré du *Guide pour la prophylaxie et le suivi après une exposition au VIH, au VHB et au VHC*, Gouvernement du Québec, janvier 2019.

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[X] HME MCH [ ] HGM MGH [ ] HRV RVH
[ ] HNM MNH [ ] ITM MCI [ ] CL LC

*FMU-9714*

**DÉPARTEMENT DE L'URGENCE PÉDIATRIQUE**
**Ordonnance suite à une exposition non professionnelle aux virus transmis par le sang**

PEDIATRIC EMERGENCY DEPARTMENT
Non Occupational Blood Borne Pathogen Exposure Prescription

**ALLERGIES** : _____

**Poids** / Weight (kg): _____ **Taille** / Height (cm): _____ **Surface corporelle /** BSA ($m^2$): _____

| **Initiales du prescripteur pour chaque ordonnance** Prescriber's initials for each order | **ORDONNANCE DU PRESCRIPTEUR** / PRESCRIBER'S ORDERS | **Initiales de l'infirmier(ère) notées** Nurse's initials noted |
|---|---|---|
| | Prior to initiating treatment:<br>HIV serology (HIV Ab/Ag screen), STAT HBsAb and HBsAg serology, HCV serology, ALT/AST/bilirubin, creatinine, CBC, urine beta-HCG test<br>Prescriber to send outpatient consult the Congenital Infections Clinic (CIC) | |
| | **If applicable (see protocol):**<br>☐ Hepatitis B vaccine 0.5 mL IM once<br>(Engerix B™ 10 mcg/0.5 mL OR Recombivax HB™ 5 mcg/0.5 mL)<br>☐ Hepatitis B immunoglobulin 0.06 mL/kg = _____ IM x once (available via blood bank)<br>Immunoglobulin preferably given within 48 hours after contact and up to 7 days<br>Administer Hepatitis B immunoglobulin at another IM site than hepatitis B vaccine. | |
| | **Child weighing 25 kg or more:**<br>☐ Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg (Biktarvy®)<br>1 tab PO once daily **x 28 days**<br>*If patient cannot swallow the tablet whole, it can be dispersed in 15 mL water before administration* | |
| | **Child weighing less than 25 kg:**<br>Zidovudine syrup (10 mg/mL):<br>4 kg to less than 9 kg ☐ 12 mg/kg/dose = _____ mg PO BID x **28 days**<br>9 kg to less than 25 kg ☐ 9 mg/kg/dose = _____ mg PO BID x **28 days**<br>**AND** lamivudine suspension (10 mg/mL)<br>1 to less than 3 months : ☐ 4 mg/kg/dose = _____ PO BID x **28 days**<br>3 months old and older : ☐ 5 mg/kg/dose = _____ PO BID x **28 days**<br>**AND** dolutegravir dispersible tablets (5 mg/tablet)<br>3 kg to less than 6 kg ☐ 5 mg PO once daily x **28 days**<br>6 kg to less than 10 kg ☐ 15 mg PO once daily x **28 days**<br>10 kg to less than 14 kg ☐ 20 mg PO once daily x **28 days**<br>14 kg to less than 20 kg ☐ 25 mg PO once daily x **28 days**<br>20 kg to less than 25 kg ☐ 30 mg PO once daily x **28 days**<br>* Dispersible tablets may be swallowed whole or dispersed in 10 mL of water *<br>*N.B : Dispersible tablets and tablets are not bioequivalent and therefore not substitutable on a mg to mg basis* | |

| | **Nom en lettres moulées** *Name in print* | **Signature** | **N° Permis** *License No.* | **Heure /** *Time* 00:00 | **Date** AAYY/MM/JD |
|---|---|---|---|---|---|
| **Prescripteur** *Prescriber* | | | | | |

| | **Nom en lettres moulées et/ou Numéro de permis** *Name in print and/or License Number* | **Initiale** *Initial* | **Heure /** *Time* 00:00 | **Date** AAYY/MM/JD |
|---|---|---|---|---|
| **Infirmier(ère)** *Nurse* | | | | |
| **Pharmacien(ne)** *Pharmacist* | | | | |

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☐ HNM MNH ☐ ITM MCI ☐ CL LC

*FMU-9724*

**DÉPARTEMENT DE L'URGENCE PÉDIATRIQUE**
**Ordonnances pour un patient pédiatrique suite à une agression sexuelle**

**ALLERGIES** _____

Poids _____kg Taille _____ cm Indice de masse corporelle _____

| Initiales du prescripteur pour chaque ordonnance | ORDONNANCE DU PRESCRIPTEUR | Initiales de l'infirmier(ère) notées |
|---|---|---|

## INFECTION SEXUELLEMENT TRANSMISSIBLES (IST)
## Traitement en cas de suspicion d'exposition à *N. gonorrhoea* or *C. trachomatis*

| **Traitement recommandé si l'un des cas suivants est présent:** | **Lors du choix de traitement prendre en compte les éléments suivants :** |
|---|---|
| • Signes et symptômes d'infection chez le patient<br>• Agresseur considéré comme contagieux<br>• Contact buccal, rectal ou vaginal<br>• Risque de mauvaise observance du suivi médical<br>• Impossibilité de réaliser un prélèvement<br>• Demande de prophylaxie par le patient ou son ou de la personne prodiguant des soins | • L'acceptabilité de l'injection intramusculaire<br>• La préférence pour la ceftriaxone lors d'exposition buccal<br>• La préférence pour la doxycycline lors d'exposition rectal<br>• Risque de mauvaise observance liés au traitement par la doxycycline<br>• La contreindication de la doxycycline pendant la grossesse |

### Adolescents pesant 45 kg ou plus

**Premier choix:**

☐ CefTRIAXone 500 mg IM en dose unique **ET** Doxycycline 100 mg PO BID pour 7 jours

**Deuxième choix:**

☐ CefTRIAXone 500 mg IM en dose unique **ET** Azithromycin 1 g PO en dose unique

**OU**

☐ Cefixime 800 mg PO en dose unique **ET** Azithromycin 2 g PO en dose unique

### Adolescents pesant moins de 45kg

**Premier choix:**

☐ CefTRIAXone 500 mg IM en dose unique **ET** Doxycycline 5 mg/kg/jour PO BID pour 7 jours (maximum 100 mg PO BID)

**Deuxième choix:**

☐ CefTRIAXone 500 mg IM en dose unique **ET** Azithromycin 1 g PO en dose unique

**OU**

☐ Cefixime 800 mg PO en dose unique **ET** Azithromycin 1 g PO en dose unique

### Enfants prépubères

En raison de la prévalence exceptionnellement faible des IST dans cette population, un traitement empirique n'est pas recommandé par de nombreuses sources, notamment la Société canadienne de pédiatrie.
Il est recommandé d'effectuer un dépistage des IST selon les indications et d'assurer un suivi approprié.

**Suite à Page 2**

| | **Nom en lettres moulées** Name in print letters | **Signature** | **N° Permis** License No. | **Heure /** Time **00:00** | **Date** **AA**YY/**M**M/**J**D |
|---|---|---|---|---|---|
| **Prescripteur** *Prescriber* | | | | | |

| | **Nom en lettres moulées et/ou numéro de permis** Name in print and/or license number | **Initiales** Initials | **Heure /** Time **00:00** | **Date** **AA**YY/**M**M/**J**D |
|---|---|---|---|---|
| **Infirmier(ère)** Nurse | | | | |
| **Pharmacien(ne)** Pharmacist | | | | |

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☐ HNM MNH ☐ ITM MCI ☐ CL LC

* F M U – 9 7 2 4 *

**PEDIATRIC EMERGENCY DEPARTMENT**
**Orders For a Pediatric Patient**
**After a Sexual Assault**

**ALLERGIES** _____

Weight _____kg Height _____ cm BMI _____

| Prescriber's initials for each order | PRESCRIBER'S ORDERS | Nurse's initials noted |
|---|---|---|
| | **SEXUALLY TRANSMITTED INFECTIONS (STI)**<br>**Treatment for suspected contact with *N. gonorrhoea* or *C. trachomatis*** | |
| | **Treatment is recommended if any of:**<br>• Signs and symptoms of infection in the patient<br>• Aggressor is considered infectious<br>• Oral, rectal or vaginal contact<br>• Possible non-adherence with medical follow-up<br>• Impossible sample collection<br>• Patient or caretaker request prophylaxis<br>**When selecting treatment choice consider:**<br>• IM injection acceptability<br>• Ceftriaxone is preferred for oral exposure<br>• Doxycycline is preferred for rectal exposure<br>• Compliance issue with doxycycline regimen<br>• Doxycycline is contraindicated during pregnancy | |
| | **Adolescents weighing 45 kg or more** | |
| | **First choice:**<br>☐ CefTRIAXone 500 mg IM once **AND** Doxycycline 100 mg PO BID for 7 days | |
| | **Second choice:**<br>☐ CefTRIAXone 500 mg IM once **AND** Azithromycin 1 g PO once<br>**OR**<br>☐ Cefixime 800 mg PO once **AND** Azithromycin 2 g PO once | |
| | **Adolescents weighing less than 45kg** | |
| | **First choice:**<br>☐ CefTRIAXone 500 mg IM once **AND** Doxycycline 5mg/kg/day PO BID for 7 days (maximum 100 mg PO BID) | |
| | **Second choice:**<br>☐ CefTRIAXone 500 mg IM once **AND** Azithromycin 1 g PO once<br>**OR**<br>☐ Cefixime 800 mg PO once **AND** Azithromycin 1 g PO once | |
| | **Prepubertal children** | |
| | Due to the exceptionally low prevalence of STIs in this population, empiric treatment is not recommended by many sources, including the Canadian Pediatric Society.<br>The recommendation is to perform STI testing as indicated and assure appropriate follow-up. | |
| | **Continued on Page 2** | |

| | Nom en lettres moulées<br>Name in print letters | Signature | N° Permis<br>License No. | Heure / Time<br>00:00 | Date<br>AAYY/MM/JD |
|---|---|---|---|---|---|
| **Prescripteur**<br>*Prescriber* | | | | | |

| | Nom en lettres moulées et/ou numéro de permis<br>Name in print and/or license number | Initiales<br>Initials | Heure / Time<br>00:00 | Date<br>AAYY/MM/JD |
|---|---|---|---|---|
| **Infirmier(ère)**<br>Nurse | | | | |
| **Pharmacien(ne)**<br>Pharmacist | | | | |

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***FMU-9724***

**DÉPARTEMENT DE L'URGENCE PÉDIATRIQUE**
**Ordonnances pour un patient pédiatrique suite à une agression sexuelle**

**ALLERGIES** _____

Poids _____kg Taille _____ cm Indice de masse corporelle _____

| Initiales du prescripteur pour chaque ordonnance | ORDONNANCE DU PRESCRIPTEUR | Initiales de l'infirmier(ère) notées |
|---|---|---|
| | **CONTRACEPTION D'URGENCE** | |
| | **Moins de 72 heures après le dernier rapport sexuel non protégé ET un indice de masse corporelle inférieur à 30 kg/m²**<br>☐ Levonorgestrel (Plan B®) 1.5 mg PO en dose unique<br><br>**Entre 72 heures et 120 heures après le dernier rapport sexuel non protégé OU un indice de masse corporel égal à ou supérieur à 30 kg/m²**<br>☐ Ulipristal (Ella®) 30 mg PO en dose unique | |
| | **IMMUNISATION D'URGENCE POUR L'HÉPATITE B** | |
| | Consulter : « l'aide à la décision pour la post-exposition à l'hépatite B du Protocole d'Immunisation du Québec (PIQ) »<br>**Si la vaccination contre l'hépatite B et l'administration d'immunoglobulines sont recommandées, inscrivez les ordonnances dans l'ordonnance pré-imprimée : « Prescription pour une exposition non professionnelle à des agents pathogènes transmissible par le sang »** | |
| | **PROPHYLAXIE D'URGENCE CONTRE LE VIRUS DE L'IMMUNODÉFICIENCE HUMAINE (VIH)** | |
| | Il est possible de consulter le service des maladies infectieuses avant de prescrire une prophylaxie contre le HIV; veuillez également consulter le "Protocole de l'Hôpital de Montréal pour enfants concernant l'approche et la prise en charge des patients ayant subi une exposition non professionnnelle au virus de l'immunodéficience humaine (VIH) et à d'autres virus transmissibles par le sang" | |
| | **EXAMENS DE LABORATOIRE (à prescrire dans OACIS)** | |
| | Comme l'indique le contexte clinique: | |
| | *Chlamydia trachomatis* and *Neisseria gonorrhoea* – PCR<br>☐ Gorge, ☐ Rectal, ☐ Vaginal, ☐ Urétrale, ☐ Urine | |
| | Culture générale ☐ Rectal, ☐ Vaginal<br>☐ *Trichomonas vaginalis* AG ☐ *Trichomonas* PREP (masculin) | |
| | Gonadotrophine chorionique humaine bêta (HCG)<br>☐ Qualitative Urine, ☐ Quantitative Sérum | |
| | ☐ Syphilis dépistage (EIA), ☐ VIH Ac et Ag (dépistage)<br>☐ Hépatite B (Anticorps de surface) ☐ Hépatite B (Antigène de surface)<br>☐ Hépatite C (Anti-VHC) Ac totaux ☐ Dépistage de drogue Urine<br>☐ Dépistage de drogue Sérum (Non prescrit dans OACIS, utiliser la requête du centre anti-poison) | |
| | ☐ Autre : _____ | |

| | Nom en lettres moulées | Signature | N° Permis | Heure 00:00 | Date AAAA/MM/JJ |
|---|---|---|---|---|---|
| **Prescripteur** | | | | | |

| | Nom en lettres moulées et/ou numéro de permis<br>Name in print and/or license number | Initiales | Heure 00:00 | Date AAAA/MM/JJ |
|---|---|---|---|---|
| **Infirmier(ère)** | | | | |
| **Pharmacien(ne)** | | | | |

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***FMU-9724***

**PEDIATRIC EMERGENCY DEPARTMENT**
**Orders For a Pediatric Patient**
**After a Sexual Assault**

**ALLERGIES** _____

Weight _____kg Height _____ cm BMI _____

| Prescriber's initials for each order | ORDONNANCE DU PRESCRIPTEUR | Nurse's initials noted |
|---|---|---|
| | **EMERGENCY CONTRACEPTION** | |
| | **Less than 72 hours after last unprotected sexual contact AND body mass index less than 30 kg/m$^2$**<br>☐ Levonorgestrel (Plan B®) 1.5 mg PO as a single dose<br><br>**Between 72 hours and 120 hours after last unprotected sexual contact OR body mass index equal to or greater than 30 kg/m$^2$**<br>☐ Ulipristal (Ella®) 30 mg PO as a single dose | |
| | **EMERGENCY IMMUNIZATION HEPATITIS B** | |
| | Consult : « l'aide à la décision pour la post-exposition à l'hépatite B du Protocole d'Immunisation du Québec (PIQ) »<br>**If Hepatitis B Immunization and Immunoglobulin administration are recommended enter orders in the pre-printed order: "Non occupational blood borne pathogen exposure prescription"** | |
| | **EMERGENCY HUMAN IMMUNODEFICIENCY VIRUS (HIV) PROPHYLAXIS** | |
| | Infectious Disease may be consulted prior to ordering any HIV prophylaxis and see "The Montreal Children's Hospital protocol for the approach to and management of patients with non-occupational exposure to Human immunodeficiency virus (HIV) and Other Blood Borne Viruses". | |
| | **LABORATORY INVESTIGATIONS (order in OACIS)** | |
| | As indicated by the clinical context: | |
| | *Chlamydia trachomatis* and *Neisseria gonorrhoea* – PCR<br>☐ Throat, ☐ Rectal, ☐ Vaginal, ☐ Urethral, ☐ Urine | |
| | General culture ☐ Rectal, ☐ Vaginal<br>☐ *Trichomonas vaginalis* AG ☐ *Trichomonas* PREP (male) | |
| | Beta human Chorionic Gonadotropin (HCG)<br>☐ Qualitative Urinary, ☐ Quantitative Serum | |
| | ☐ Syphilis screen (EIA), ☐ HIV Ab/Ag screen<br>☐ Hepatitis B surface Antibody, ☐ Hepatitis B surface Antigen,<br>☐ Hepatitis C Antibody ☐ Drugs screen Urine<br>☐ Drugs screen Serum (Not ordered in OACIS, use poison control paper requisition) | |
| | ☐ Other: _____ | |

| | Name in print letters | Signature | License No. | Time 00:00 | Date YYYY/MM/DD |
|---|---|---|---|---|---|
| **Prescriber** | | | | | |

| | Nom en lettres moulées et/ou numéro de permis<br>Name in print and/or license number | Initials | Time 00:00 | Date YYYY/MM/DD |
|---|---|---|---|---|
| **Nurse** | | | | |
| **Pharmacist** | | | | |

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# PEDIATRIC-CLINICAL PROTOCOL – MUHC

**(PROTOCOLE CLINIQUE - CUSM)**

☒ Medication included ☐ No Medication included

☒ MCH ☐ MGH ☐ RVH ☐ MNH ☐ MCI ☐ LACHINE

**THIS IS NOT A MEDICAL ORDER**

| | |
|---|---|
| **Title:** | Guidelines for the approach to and management of patients with non-occupational exposure to Human Immunodeficiency Virus (HIV) and other blood borne viruses at the Montreal Children's Hospital |
| **This document is attached to:** | Non occupational blood borne pathogen exposure prescription Pre-Printed Order<br>Orders for a pediatric patient after a sexual aggression Pre-Printed Order<br>Administration of a Medication or Vaccine Via the intramuscular (IM) Route to a Neonatal or Pediatric Patient – Clinical Procedure (MSI Expertise Santé)<br>MUHC clinical protocol: Prevention of mother to child HIV transmission<br>MUHC clinical protocol: Management of expressed breastmilk errors |

## 1. PURPOSE

This protocol addresses the approach and management of patients with non-occupational exposure to (HIV) and/or other blood borne viruses such as Hepatitis B virus (HBV), and Hepatitis C virus (HCV).

## 2. PROFESSIONALS

Pediatric Emergency nurses, Pediatric Emergency physician, Infectious Disease physician on call, Congenital Infection Clinic (CIC) physicians, Adolescent Medicine physicians, pharmacists, licensed practical nurses (LPNs), who have read the protocol and who understand their roles and responsibilities.

## 3. PATIENT POPULATION

All pediatric patients exposed to and at risk for blood borne viral infections (NOBBVI) via any of the following routes:

- Needles and other sharp objects contaminated with another person's blood and/or body fluids,
- Mucosal (including sexual) contact with body fluids and/or blood of another person,
- Splash injuries that involve the eyes or mucosae with another person's blood and/or body fluids,
- Bite injuries where there is a break in the skin of the person who was bitten.

## Exclusion Criteria

This protocol does not address occupational exposure to blood borne viruses, management of exposure to other sexually transmitted infections (STIs), accidental human milk ingestion, or mother-to-child transmission (MTCHT) of blood borne viruses.

- Health Care Workers exposed to occupational exposures to blood borne viruses are referred to the Royal Victoria Hospital Emergency Department (ED). The Chronic Viral Illness Service and (Prevention and Health Promotion Service (formerly: Occupational Health) will manage the case.
- For patients exposed to human milk where HIV and HBV infections could be concerns, please consult the McGill University Health Centre's (MUHC) Clinical protocol: Management of expressed breast milk errors.
- In the case of possible perinatal Mother-to-Child HIV Transmission (MTCHT), refer to the MUHC Protocol for the Prevention of MTCHT, and page the Infectious Diseases (ID) physician on call.

## 4. ELEMENTS OF CLINICAL ACTIVITY

Professionals are responsible to know the limits and extent of their practice as related to the particular protocol.

***Procedure:***

## General Principles

Non-occupational Human Immunodeficiency Virus (HIV) and other blood borne viral infection exposures (NOBBVI) are not uncommon in the community. It involves injuries sustained via: contaminated needles and other sharp objects, mucosal contact with blood and/or body fluids of another person, splash injuries that involve the eyes or mucosae with blood and/or body fluids of another person, bite injuries where there is a break in the skin of the person who was bitten.

The risks of transmission **per exposure event** are known in the case of HBV (non-immune individuals), HCV, as well as HIV in an occupational setting, and have been reported at approximately 30%, 3%, and 0.3%, respectively. The risk is much lower in a non-occupational or community setting. While there have been reports of HIV, HBV, and HCV transmissions in injection drug use (IDU) and sexual contact, there has never been any report in the literature of specifically HIV transmission via accidental exposure to a contaminated needle in a community setting. As opposed to HBV, HIV does not survive long enough in the outside environment due to a variety of factors (e.g. temperature, humidity).

### LABORATORY TESTING:

Any patient being evaluated in the context of a non-occupational exposure to (HIV) and/or other blood borne viruses such as Hepatitis B virus (HBV), and Hepatitis C virus (HCV) should have bloodwork drawn to assess their baseline infectious and immune status.

Baseline bloodwork and investigations that is recommended for cases of non-occupational blood borne virus exposure includes the following:

- HIV serology: HIV Antigen (Ag)/Antibody (Ab) screen
- HCV Ab
- Hepatitis B surface antibody (HBsAb) – **send as a STAT order to the Central Lab**
- Hepatitis B surface antigen (HBsAg)
- Urine beta-hCG (if there is a risk of pregnancy)
- Other tests for STIs (e.g., chlamydia, gonorrhea, syphilis) are indicated in the context of SA
- If non-occupational post-exposure prophylaxis (nPEP) is considered, also draw these:
    - Complete Blood count (CBC)
    - Creatinine

- Liver enzymes: Alanine aminotransferase (ALT), Aspartate transaminase (AST), bilirubin

**FOLLOW-UP**

Evaluation of a patient with a non-occupational exposure to Human Immunodeficiency Virus (HIV) and other blood borne viruses, with or without the **dispensation of nPEP against HIV, must automatically trigger an outpatient Congenital Infections Clinic (CIC) consult (via fax to -24494) by the ED.**

A member of the CIC team will contact the patient by telephone within 72 hours after leaving the ED to:

- Ensure that nPEP is being taken adequately and encourage adherence to nPEP.
- Review potential adverse effects of nPEP and manage accordingly.
- Review if any contraindications to nPEP exist (namely SEVERE hepatic and/or renal dysfunction as evidenced in the ED baseline bloodwork (see Table 5 below).
- Review the HBV immune status of the patient (based on the STAT HBV serology drawn in ED).
- Arrange for HBV vaccine with or without Hepatitis B immunoglobulin (HBIG) if the patient is HBV-non-immune on testing (see below section on HBV and Table 5), if not done in the ED: this will be done through a visit to the Medical Day Hospital (MDH) within 4 days of the exposure.
- Arrange follow-up in CIC.
- Ensure the patient is followed by Adolescent Medicine/Sexual Abuse Clinic if indicated.

**If nPEP is not offered to the patient in the context of an exposure, a CIC consult is still needed for follow up of these patients**.

If the concern for exposure occurred in a context of sexual abuse/assault, a consultation with the MCH Sexual Abuse Clinic or MCH Adolescent Medicine clinic is indicated in addition to the CIC consultation.

## Concerning HIV:

Post-exposure prophylaxis (PEP) is offered to health care workers and others who suffer a percutaneous injury or significant mucosal contact with blood and/or body fluids in a health care setting from a source with a known or unknown HIV infection status. Multiple studies have shown a significant decrease in the risk of HIV transmission if PEP is taken by the patient as soon as possible (less than 72 hours (about 3 days) after the injury/contact) and given for 28 days.

The following is a table based on data that have been adapted from the Quebec Ministère de Santé et Services sociaux (MSSS) and the US Centers for Disease Control and Prevention (CDC) outlining the risk of transmission of HIV per exposure event. It can be used as a tool to inform both the health care provider and the patients and/or their caretakers concerning non-occupational post-exposure HIV prophylaxis (nPEP) decisions:

**Table 1. Estimated Probability of Acquiring HIV from an Infected Source**

**(Risks are Per-Act and include all ages except perinatal transmission and continuous human milk ingestion)***

| Type of Exposure (in the absence of effective antiretroviral therapy in source patient) | Risk per 10,000 exposures | Percent (%) risk per exposure |
|---|---|---|
| **Parenteral** | | |
| Blood transfusion | 9,250 | 92.5 |
| Needle-sharing during Injection Drug Use (IDU) | 63 | 0.63 |
| Percutaneous (**Occupational** Needle-Stick) | 23-30 | 0.23-0.30 |
| **Perinatal** | | |
| Maternal HIV PCR viral load (VL) detectable at delivery, baby not given PEP, and breastfed | 1,300-4,500 | 13-45 |
| Maternal HIV PCR viral load (VL) not detectable at delivery, baby given PEP, and not breastfed | Less than 200 | Less than 2 |
| **Sexual** | | |
| Unprotected receptive anal intercourse | 50-138 | 0.5-1.38 |
| Unprotected insertive anal intercourse | 6.5-11 | 0.065-0.11 |
| Unprotected receptive penile-vaginal intercourse | 8-10 | 0.08-0.1 |
| Unprotected insertive penile-vaginal intercourse | 4-5 | 0.04-0.05 |
| Receptive oral intercourse | 1 | 0.01 |
| Insertive oral intercourse | Less than 0.5 | Less than 0.005 |
| Woman to woman | Negligible | Negligible |
| **Human milk ingestion** | | |
| Once | Less than 0.5 | Less than 0.005 |
| Per year of breastfeeding | ~900 | 9 |
| **Other^** | | |
| Spitting | Negligible | Negligible |
| Throwing body fluids (including semen or saliva) | Negligible | Negligible |
| Sharing sex toys | Negligible | Negligible |
| Biting | Negligible | Negligible |

* Factors that may increase the risk of HIV transmission include presence of other sexually transmitted infections primarily in the source person, acute and late-stage HIV infection, and high viral load, all in the source person. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and pre-exposure prophylaxis. Some of these factors are accounted for in the estimates presented in the table.

^ HIV transmission through these exposure routes is technically possible but unlikely and not well documented.

**CONSIDERATION OF nPEP :**

**Non-sexual contact exposure:**

In general, Non-occupational Post-Exposure Prophylaxis (**nPEP) is not given** to patients presenting for care after suffering a non-occupational **needle-stick or other sharp object injury, a single ingestion of human milk, or for any of the "other" types of exposures listed in the above table in a community setting** due to the very low risk of HIV transmission.

Factors that may influence the decision to administer nPEP should be discussed between the treating (e.g. ED) physician, the Infectious Diseases (ID) physician on call, along with patients and their parents/caretakers. These factors include:

- A **significant sharp object injury** (e.g. large bore needle, visible fresh blood on the object, a significant injury where active bleeding is visible on the injured patient).
- A sharp object **injury in a high-risk setting** (e.g. near a supervised IDU facility).
- A sharp object injury where the **source is known to be HIV-infected.**
- Oral consumption of a **large** quantity of someone else's blood or semen.
- In cases of sexual assault (SA) where the event is considered high risk and/or if the assailant is from a high-risk group (see table 2).
- Extreme parental anxiety is not an indication to give nPEP. In these cases, education from the medical team is warranted.

**Sexual contact exposure:**

Consideration of post-exposure prophylaxis for HIV following a sexual assault should be considered on a case-by-case basis according to risk as assessed with the tools below.

nPEP is to be considered only if the patient seeks medical care within 72 hours the sexual assault

- If the assault happened 72 hours and more prior to the patient seeking medical care, the situation does not warrant nPEP. Rather this warrants a comprehensive investigation into HIV infection and other STIs, and this is the responsibility of the MCH Sexual Abuse Clinic and/or the MCH Adolescent Medicine service.

A patient or family's decision to pursue (or not) other aspects of SA care, including a Sexual Assault Evidence Kit, should not factor into the consideration of offering nPEP if indicated based on the other elements outlined here.

In the case of sexual contact/assault, the risk of HIV transmission to the victim increases with:

- the nature of the contact (see tables 1 above and 2 below)
- the presence of injury to the victim or genital lesions in the assailant
- contact of blood/body contact (ejaculation onto mucous membranes)
- sexual contact that is repetitive over time
- assailant from a high-risk group

**High-risk groups (for transmission of HIV) during sexual contact (SA or other) are:**

- HIV infected with known detectable viral load
- HIV infected and unknown if detectable viral load

- Signs or symptoms of mucosal injury (bleeding, lacerations, tears, other STIs, genital lesions, etc)
- Known or suspected intravenous-drug use
- Men who have sex with men
- Partner (SA or not) with unknown HIV infection status is from an HIV-endemic area of the world include Sub-Saharan Africa, Asia (Indian subcontinent and Thailand), Eastern Europe, Caribbean and Latin America.

**Table 2. Nature of the sexual contact and need for nPEP (adapted from the Quebec MSSS)**

| Exposure | Source HIV status | nPEP | | |
|---|---|---|---|---|
| | | No | Yes | Consider* |
| **Unprotected receptive anal intercourse** | Negative | X | | |
| | Positive | | X | |
| | Unknown | | | X |
| **Unprotected insertive anal intercourse** | Negative | X | | |
| | Positive | | X | |
| | Unknown | | | X |
| **Penile-vaginal intercourse (receptive or insertive)** | Negative | X | | |
| | Positive | | X | |
| | Unknown | | | X |
| **Receptive oral intercourse (with ejaculation)** | Negative | X | | |
| | Positive | | | X |
| | Unknown | X | | |
| **Receptive oral intercourse (without ejaculation)** | Negative | X | | |
| | Positive | X | | |
| | Unknown | X | | |
| **Insertive oral intercourse (with or without ejaculation)** | Negative | X | | |
| | Positive | X | | |
| | Unknown | X | | |
| **Woman to woman sexual contact** | Negative | X | | |
| | Positive | X | | |
| | Unknown | X | | |

**MEDICATIONS***:*

If nPEP is decided upon, the recommended options are:

**Table 3. Patient 4 weeks of age or older and weighing less than 25 kg:**

- **Zidovudine** (10 mg/mL) syrup:
  - 4 kg to less than 9 kg: 12 mg/kg/dose (maximum dose: 300 mg) PO BID X 28 days,
  - 9 kg to less than 25 kg: 9 mg/kg/dose (maximum dose: 300 mg) PO BID X 28 days
- **AND Lamivudine** (10 mg/mL) syrup:
  - 1 month to less than 3 months old: 4 mg/kg/dose (maximum dose: 150 mg) PO BID X 28 days
  - 3 months old and older: 5 mg/kg/dose (maximum dose: 150 mg) PO BID x 28 days
- **AND Dolutegravir** (5 mg) dispersible tablets (doses as below):

| **Pediatric weight** | **Dolutegravir dispersible tablets dose*** | **Number of Dolutegravir dispersible tablets*** |
|---|---|---|
| 3 kg to less than 6 kg | 5 mg PO once daily X 28 days | 1 |
| 6 kg to less than 10 kg | 15 mg PO once daily X 28 days | 3 |
| 10 kg to less than 14 kg | 20 mg PO once daily X 28 days | 4 |
| 14 kg to less than 20 kg | 25 mg PO once daily X 28 days | 5 |
| 20 kg to less than 25 kg | 30 mg PO once daily X 28 days | 6 |
| ***Drug interactions troubleshooting and Contraindications** | Dolutegravir is contraindicated if the patient is on dofelitide.<br>Dose needs to be given BID in the presence of interacting medications (patient will be called within 72 hours after discharge). The medication include: fosphenytoin/phenytoin, oxcarbazepine, carbamazepine, rifampin, phenobarbital, St John's wort. | |
| ***Administration** | Dolutegravir may be swallowed whole or dispersed in 10 mL of water and mix until no clumps appear. Drink the whole amount of liquid within 30 minutes. Rinse cup with extra water and give it to child to drink.<br>Dispersible and regular tablets are NOT interchangeable.<br>Take at least 2 hours before or 6 hours after cation-containing antacids or laxatives, calcium or iron-containing medications. | |
| **Altered kidney or liver function** | Lamivudine and zidovudine may require adjustment in severe kidney impairment<br>Dolutegravir is not recommended in severe liver impairment | |

*In the extremely rare event that the patient is a neonate, refer to the MUHC Protocol for the Prevention of MTCHT, section on high-risk exposure, and **page the Infectious Diseases (ID) physician on call.**

**Table 4. Patient weighing 25 kg or more:**

| o **Bictegravir 50 mg/emtricitabine 200 mg/tenofovir alafenamide 25 mg(Biktarvy™)** 1 tablet PO once daily X 28 days | |
|---|---|
| **Drug interactions troubleshooting and Contraindications** | Contraindicated in patients with **known** severe hepatic impairment (Child Pugh class C) and/or renal impairment. Call ID on call for guidance if such is the case.<br>Contraindicated with the concomitant use of rifampin, dofelitide and St. John's Wort (may have to stop or replace St. John's Wort if necessary).<br>Other drug interactions include carbamazepine, fosphenytoin/phenytoin, oxcarbazepine, and phenobarbital among others. |
| **Administration** | **Swallow whole. Or if the patient cannot swallow the pill, Biktarvy™ can be dissolved in 15 mL of water (within 10-15 minutes).**<br>If taken without food: Take at least 2 hours before or 6 hours after cation-containing antacids or laxatives, calcium or iron-containing medications.<br>If taken with food: cation-containing antacids or laxatives, calcium or iron-containing medications can be administered with Biktarvy™ |

**The above drug regimens can be taken with or without food and are safe during pregnancy.**

Whatever the drug regimen, the MCH Pharmacy will supply, and the ED will provide the full 28-day course to the patient. The first dose should be administered in the ED. Patient education material must be given to the patient. Example of resources (see Annex 2):

- HIV post-exposure prophylaxis: Bitarvy (ENGLISH)
- Prophylaxie post-exposition au VIH - Biktarvy (FRANÇAIS)

The provision of the entire supply of 28-day course of nPEP medication at the initial visit has been reported to increase the likelihood of adherence by removing barriers to filling the prescription at a pharmacy or need to return for multiple follow-up visits. This management approach is particularly important in the context of sexual assault which is often associated with trauma.

Anytime a nPEP is prescribed, the ED should contact the pharmacist (main Pharmacy hours weekdays 8:00-22:00, weekends and statutory holidays 8:00-16:00, and at all other times: on-call pharmacist).

The pharmacist will need to:

- check if there are any interactions or contraindications with the nPEP. Since there is a potential for interactions with some medications as well as natural products and the pharmacist will not have access to the patient's file, the ED will be the most appropriate intermediate to discuss the current medication and natural products that the patient is currently taking. This can be done by either filling out a medication reconciliation in the clinical information system (Oacis) or faxing an annotated Dossier Santé Québec (DSQ) list (including natural products and over the counter medication) to the pharmacy. In the exceptional case

that the patient does not have a DSQ file, and a medication reconciliation cannot be done, a list of medications written on a communication note and faxed to the pharmacy will be acceptable.

- send an e-mail within 24 hours to the Congenital Infections Clinic (CIC) group via ssss.gouv.qc.ca e-mail accounts (Christos Karatzios, Marie-Astrid Lefebvre, Gillian Morantz). This does not preclude the ED from faxing a consult to the CIC clinic (fax - 24494).

- supply the 28 days of nPEP. During opening hours, the pharmacy will supply all doses. When the pharmacy is closed, the ED will page the pharmacist on-call. If the patient is 25 kg or more, the pharmacist will validate the prescription from home and the nurse will be able to take a prepackaged 28-doses pack from the automated cabinet and provide it to the patient. If the patient is less than 25 kg the on-call pharmacist will need to come to the hospital to prepare and supply the full 28 day course to the ED.

## Concerning HBV

Most individuals born in Quebec are vaccinated against HBV from infancy or childhood and are therefore immune. However, up to 15% of fully vaccinated people are non-responders to HBV vaccination and thus not immune (**HBsAb level less than 10 international units/L**).

If the patient has **documentation** (in vaccine booklet or Registre de vaccination du Québec) **of having received a full series of HBV vaccine**, there is nothing further to do aside from drawing the HBsAb and HBsAg (mark STAT for the Central Lab).

If the patient's HBV vaccine status is **incomplete or uncertain/unknown** then:

- Offering **vaccination** against HBV is warranted in the ED. HBV vaccination is most effective if given within 48 hours after exposure but can be given up until 7 days after exposure.
- **HBIG** administration is only recommended in the ED if the patient or his/her family **know the patient is not fully vaccinated and/or not immune**. HBIG is most effective if given within 48 hours after exposure but can be given up until 7 days after exposure.

**MEDICATIONS/MEDICAL INTERVENTIONS***:*

**Table 5. Active and passive immunization against HBV**

| | | |
|---|---|---|
| **Dosing of HBV vaccine (Engerix B™ pediatric 10 mcg/0.5 mL OR Recombivax HB™ 0.5 mcg/0.5 mL) for patients less than 20 years old** | 0.5 mL IM X 1 | Preferably given within 48 hours after contact/injury and up to 7 days. The rest of the series will be completed in the MCH Congenital Infections Clinic (CIC). |
| **Dosing of HBIG** | 0.06 mL/kg IM X 1 (minimum 0.5 mL) | Preferably given within 48 hours after contact/injury and up to 7 days. |

- Offering medications active against HBV specifically as HBV PEP is not recommended.

**An outpatient CIC consult is still needed for follow up of these patients.**

## Concerning HCV:

There is no HCV vaccine available, and there is no HCV PEP regimen that is recommended.

- Drawing **baseline HCV testing (HCV serology)** is recommended in the ED.

**An outpatient CIC consult is still needed for follow up of these patients**

**Recommended baseline bloodwork in the ED:**
The following table summarizes the bloodwork that needs to be performed in the ED on patients with a potential exposure to bloodborne viruses:

**Table 6: Recommended blood work and investigations in the ED**

| Pathogen | Test(s) |
|---|---|
| **HIV** | o HIV serology (HIV Ab/Ag screen)<br>o ALT + AST + bilirubin ("Liver enzymes") – if nPEP is offered<br>o Creatinine – if nPEP is offered<br>o Urine Beta-HCG pregnancy test (if risk of pregnancy) |
| **HBV** | o STAT HBV serology (HBsAb + HBsAg)<br>o "Liver enzymes"<br>o Urine Beta-HCG pregnancy test (in cases of sexual assault, and risk of pregnancy) |
| **HCV** | o HCV serology<br>o "Liver enzymes"<br>o Urine Beta-HCG pregnancy test (in cases of sexual assault, and risk of pregnancy) |

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## 7. APPROVAL PROCESS

***Institutional and professional approval***

| Committees | Date approved [yyyy-mm-dd] |
|---|---|
| ☐ Adult Clinical Practice Review Committee (CPRC) (if applicable) | |
| ☒ Pediatric Clinical Practice Review Committee (CPRC) (if applicable) | 2026-04-26 |
| ☐ Adult Pharmacy and Therapeutics (P&T) (if applicable) | |
| ☒ Pediatric Pharmacy and Therapeutics (Peds P&T) (if applicable) | 2026-06-08 |
| ☐ Multidisciplinary Council (MDC) (if applicable) | |

## 8. REVIEW DATE

To be updated in maximum of 4 years or sooner if presence of new evidence or need for practice change.

## 9. REFERENCES


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| **Version History**<br>(for Administrative use only) | | | |
|---|---|---|---|
| **Version** | **Description** | **Author/responsable** | **Date** |
| No 1 | Creation | Dr. Christos Karatzios, Paediatric Infectious Diseases, Director of the MCH HIV/Congenital Infections Clinic<br>Irène Gernet, Pharmacist<br>Denise Kurdika RN, Advanced Practice Nurse Pediatric Emergency<br>Dr. Amanda Lord, Child Maltreatment Paediatrics<br>Dr. Jennifer Turnbull, MCH Paediatric Emergency Medicine | 22-01-2026 |
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# Annex 1: Summary of Health Care Worker Responsibilities:

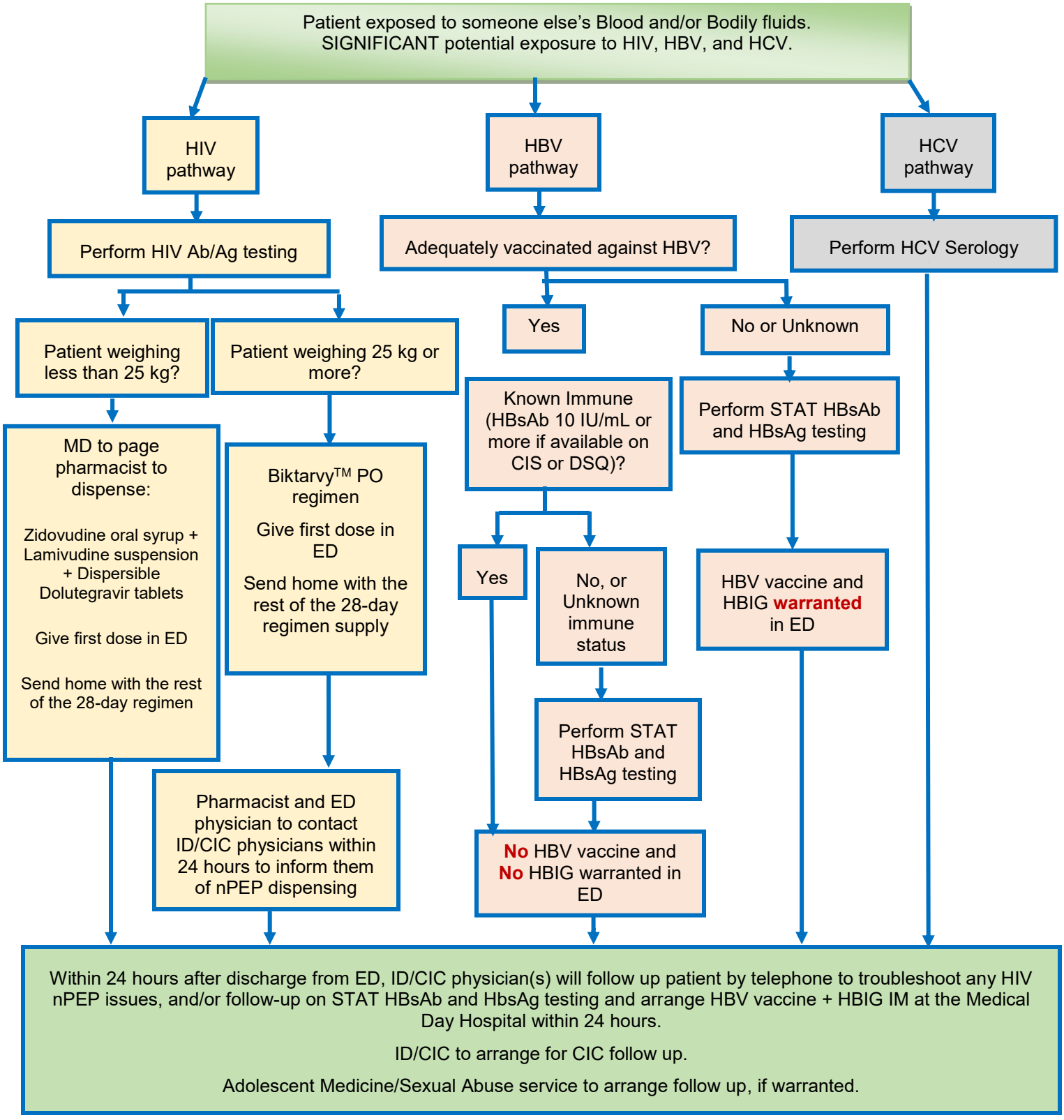
**Table 7. Responsibilities of key stakeholders in managing patients exposed to bloodborne pathogens in a community setting**

| Health care worker | Responsibilities |
|---|---|
| **ED nurse** | o Draw baseline bloodwork and perform pregnancy testing as prescribed. If indicated, administer HBV vaccine with or without HBIG to patient<br>o Review all medication, over-the-counter medication and health products taken by the patient and transmits this information to the MCH pharmacist<br>o Fax nPEP prescription to the MCH pharmacy<br>o Receive nPEP from the pharmacy or the ED “Night Cupboard’’<br>o Review with patient and/or patient’s caretaker(s) nPEP administration.<br>o Administer first dose of nPEP to the patient as per protocol.<br>o Provide the rest of the 28-day course nPEP to the patient and/or their caretaker(s). |
| **ED physician** | o Manage medical aspects of the patient's visit.<br>o Assess risk of bloodborne virus exposure (see Table 1 and 2).<br>o If indicated, decide on the type of nPEP (see Tables 3 and 4).<br>o Use MCH NOBBVI PPO to order nPEP<br>o Page the Pharmacist on call if the pharmacy is closed.<br>o Ensure patient receives first dose of nPEP in ED and has the full 28- day course supplied.<br>o Assess HBV vaccination status via history.<br>o Write a consultation to ID (Congenital Infections Clinic) and send it via fax to 514-412-4494.<br>o If indicated, write a consultation to Adolescent Medicine/Sexual Abuse Clinic. |

| | |
|---|---|
| **Pharmacy** | o Once called by the ED, receives the list of medication already taken by the patient. Pharmacist will assess if there are any interactions or contraindications then validate the prescription and supply the 28-day supply kit during opening hours.<br>o If the pharmacy is **closed**, the pharmacist on call will be paged to validate the prescription from home (list of medication will be provided by ED and sent by fax to the pharmacy with the prescription. If the patient weighs 25 kg or more, the prepackaged kit will be taken from the automated cabinet by the nurse. If the patient weighs less than 25 kg, the pharmacist will come in and prepare the 28-day supply.<br>o Contact the CIC physicians via group e-mail within 24 hours after supplying any form of nPEP.<br>o Ensure that the ED automated cabinet is stocked with at least 2 courses of nPEP for patients weighing more than 25 kg (Table 4). |
| **ID physician on-call** | o Help the ED physician with assessment of risk of bloodborne virus exposure, if needed.<br>o In the case of a KNOWN severe hepatic and/or renal dysfunction in the patient, contact the CIC physicians for a change to the recommended nPEP above in Tables 3 and 4. |
| **CIC physician** | o Receive the faxed consult request from the ED physician and the e-mail from the pharmacist to follow up patient on nPEP within 72 hours via telephone.<br>o Follow up by telephone all patients who are on nPEP within 72 hours and follow steps listed prior (see end of section “Concerning HIV”).<br>o Assess HBV immune status as evidenced by HBsAb drawn in ED. If non-immune (HBsAb less than 10 International Units/L), and vaccine and HBIG were not given in ED: arrange vaccination with HBV vaccine and HBIG in the Medical Day Hospital ideally within 7 days after risk contact.<br>o Ensure adequate CIC follow-up. |
| **Adolescent Medicine** | o Ensure adequate follow-up with Adolescent Medicine Clinic, when warranted. |

## Summary Algorithm for the Approach to and Management of Patients with Non-Occupational Exposure to HIV and Other Bloodborne Viruses in the ED

**(See body of protocol for details about nPEP)**



# PRÉVENTION VIH

GUIDE THÉRAPEUTIQUE VIH / VHC

## PROPHYLAXIE POST-EXPOSITION AU VIH (PPE)

# BIKTARVY[MD]




(Bictégravir/Emtricitabine/Ténofovir AF)

Comprimés à 50/200/25 mg

La **prophylaxie post-exposition**, ou **PPE**, est une méthode de prévention de la transmission du virus de l'immunodéficience humaine (VIH) reposant sur l'utilisation rapide de médicaments antirétroviraux suite à une exposition avec un risque important de contracter le VIH.

## Comment ce médicament agit-il ?

Biktarvy[MD] résulte de l'association de trois médicaments: le bictégravir, l'emtricitabine et le ténofovir AF. Ils font parties de deux classes de médicaments : les inhibiteurs de la transcriptase inverse et les inhibiteurs de l'intégrase. Ces médicaments inhibent des enzymes dont le VIH a besoin pour se multiplier dans l'organisme.

Biktarvy[MD] est utilisé en thérapie le plus rapidement possible après une exposition au VIH afin d'empêcher le virus de se propager dans l'organisme et d'éviter ainsi une infection.

## Comment prendre ce médicament ?

Biktarvy[MD] ⟶ 1 comprimé **1 fois** par jour, soit toutes les 24 heures.

Biktarvy[MD] peut être pris **avec ou sans nourriture**.

Il est important de prendre Biktarvy[MD] de façon régulière, à la même heure chaque jour, et de respecter l'horaire établi le plus fidèlement possible.

N'arrêtez jamais votre traitement sans d'abord en parler à votre médecin.

À noter que si vous êtes porteur de l'hépatite B, il faut d'abord en discuter avec votre médecin pour effectuer un suivi approprié. L'arrêt de Biktarvy[MD] pourrait réactiver ou réveiller le virus de l'hépatite B ce qui pourrait endommager votre foie et nécessiter une hospitalisation.

## J'ai oublié de prendre une dose !



Prenez la dose oubliée dès que possible et ensuite poursuivez votre traitement selon l'horaire habituel.

**S'il reste moins de 6 heures avant votre prochaine dose :**

Laissez tomber la dose manquée et continuez selon l'horaire prévu.

**Ne doublez pas la dose.**

## Quels sont les effets indésirables de ce médicament ?

Biktarvy[MD] est généralement bien toléré. Il se peut que vous ressentiez, au début de votre traitement, certains malaises tels que nausées, maux de tête et fatigue.

Ces effets indésirables tendent à disparaître après les premières semaines. Les maux de tête peuvent être soulagés par la prise d'acétaminophène (Tylenol[MD]).

Des effets gastro-intestinaux (digestifs) tels que des nausées/vomissements, des douleurs abdominales et de la diarrhée pourraient survenir. Afin de diminuer ces effets, vous pouvez prendre Biktarvy[MD] avec de la nourriture.

Si des effets indésirables se manifestent et persistent, consultez votre pharmacien, votre médecin, une infirmière ou une diététiste afin de trouver des solutions visant à les gérer.

## Grossesse

Si vous êtes enceinte, si vous désirez l'être ou si vous allaitez, avisez-en votre médecin avant de prendre Biktarvy[MD].

## Est-ce que je peux prendre Biktarvy[MD] avec mes autres médicaments ?

Les médicaments suivants sont contre-indiqués ou à éviter et ne doivent pas être pris avec Biktarvy[MD]:

- Dofétilide pour traiter des troubles cardiaques.
- Rifampicine ou rifabutine pour traiter certaines infections bactériennes comme la tuberculose.
- Carbamazépine, oxcarbazépine, phénytoïne ou phénobarbital pour prévenir les convulsions.
- Enzalutamide pour traiter le cancer de la prostate.
- Produits naturels contenant du millepertuis (Hypericum perforatum) pour traiter la dépression.

Vous devez en discuter avec votre médecin avant de les prendre. Une solution de rechange, des ajustements de doses ou un suivi pourront être suggérés si nécessaire.

Les médicaments contenant des cations polyvalents (antiacides, laxatifs, sucralfate), les vitamines et les suppléments de calcium ou de fer peuvent diminuer l'absorption de Biktarvy[MD]. Ils peuvent être pris au moins 2 heures avant ou au moins 2 heures après Biktarvy[MD] ou prenez-les en même temps que Biktarvy[MD] avec de la nourriture.

D'autres médicaments ou produits pourraient aussi interagir avec Biktarvy[MD]. Consultez votre médecin ou votre pharmacien avant de prendre un nouveau médicament sur ordonnance, un médicament en vente libre, un produit naturel ou même une drogue à usage récréatif.

## Est-ce que je peux prendre de l'alcool avec Biktarvy[MD]?

Évitez la consommation excessive ou régulière de boissons alcoolisées (bière, vin et spiritueux) qui peut augmenter le risque d'hépatite (inflammation du foie) ou interagir avec certains de vos médicaments.

Évitez également de sauter une dose de médicament parce que vous désirez prendre une boisson alcoolisée. À moins d'avis contraire de votre médecin, une consommation raisonnable et occasionnelle d'alcool ne devrait pas nuire à votre traitement.

## Afin d'éviter la transmission de l'infection dans les trois mois suivant l'exposition

- Éviter tout rapport sexuel ou utiliser des condoms;
- Éviter la grossesse, s'abstenir d'allaiter, de donner du sang, du plasma, des organes, des tissus ou du sperme.

Et en tout temps : évitez de partager des seringues.

## Mode de conservation

Conservez les comprimés de Biktarvy[MD] en flacon à une température inférieure à 30˚C (86˚F) et en plaquette alvéolée entre 15 et 30˚C (59 et 86˚F).

Gardez ce médicament dans un contenant qui ferme bien. Tenez hors de portée et hors de vue des enfants.

## Conseils généraux

Soyez fidèle à vos rendez-vous avec le médecin et l'équipe soignante afin qu'ils puissent suivre étroitement votre état de santé.

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# HIV PREVENTION

HIV / HCV MEDICATION GUIDE

## HIV POST-EXPOSURE PROPHYLAXIA (PEP)

# BIKTARVY®




(Bictegravir/Emtricitabine/Tenofovir AF)

Tablets at 50/200/25 mg

**Post-exposure prophylaxis**, or **PEP**, is a method of preventing human immunodeficiency virus (HIV) transmission based on the rapid use of antiretroviral medications following exposure to a significant risk of contracting HIV.

## How this medication works ?

Biktarvy® is a combination of three antiretroviral drugs: bictegravir, emtricitabine and tenofovir AF. They belong to two classes of drugs: reverse transcriptase inhibitors and integrase inhibitors. These drugs inhibit enzymes that HIV needs to multiply in the body.

Biktarvy® is used in treatment as soon as possible after exposure to HIV to prevent the virus from spreading in the body and thus avoiding infection.

## How to take this medication ?

Biktarvy® ⟶ 1 tablet **once** a day, i.e. every 24 hours

Biktarvy® can be taken **with or without food**.

It is important to take Biktarvy® regularly, at the same time each day, and to stick to the established schedule as closely as possible.

Never stop your treatment without first talking to your doctor.

Note that if you are a carrier of hepatitis B, you must first discuss it with your doctor to carry out an appropriate follow-up. Stopping Biktarvy® could reactivate or awaken the hepatitis B virus which could damage your liver and require hospitalization.

## I forgot to take a dose !



Take the missed dose as soon as possible and then continue your treatment according to the usual schedule.

**If it is less than 6 hours until your next dose :**

Skip the missed dose and continue as scheduled.

**Do not double up dose.**

## What are the side effects of this medication ?

Biktarvy® is generally well tolerated. At the start of your treatment, you may experience certain discomforts such as nausea, headaches and fatigue.

These side effects tend to disappear after the first few weeks. Headaches can be relieved by taking acetaminophen (Tylenol®).

Gastrointestinal (digestive) effects such as nausea/vomiting, abdominal pain and diarrhea may occur. To lessen these effects, you can take Biktarvy® with food.

If side effects occur and persist, talk to your pharmacist, doctor, nurse or dietitian about ways to manage them.

## Pregnancy

If you are pregnant, planning to become pregnant, or breastfeeding, tell your doctor before taking Biktarvy®.

## Can I take Biktarvy® with my other medications?

The following medications are contraindicated or should be avoided and should not be taken with Biktarvy®:

- Dofetilide to treat heart problems.
- Carbamazepine, oxcarbazepine, phenytoin or phenobarbital to prevent seizures.
- Rifampicin or rifabutin to treat certain bacterial infections such as tuberculosis.
- Enzalutamide to treat prostate cancer.
- Natural products containing St. John's wort (Hypericum perforatum) to treat depression.

You should talk to your doctor before taking them. Alternative solutions, dose adjustments or follow-up may be suggested if necessary.

Medicines containing multivalent cations (antacids, laxatives, sucralfate), vitamins, and calcium or iron supplements may decrease the absorption of Biktarvy®. They can be taken at least 2 hours before or at least 2 hours after Biktarvy® or taken at the same time as Biktarvy® **with food**.

Other medications or products may also interact with Biktarvy®. Consult your doctor or pharmacist before taking any new prescription medication, over-the-counter medication, natural product, or even recreational drug.

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## Can I drink alcohol with Biktarvy®?

Avoid excessive or regular consumption of alcoholic beverages (beer, wine and spirits) which may increase the risk of hepatitis (inflammation of the liver) or interact with some of your medication.

However, avoid skipping a dose of medication because you want o have an alcoholic drink. Unless your doctor tells you otherwise, reasonable and occasional alcohol consumption should not interfere with your treatment

## In order to avoid transmission of infection within 3 months of exposure

- Avoid sexual intercourse or using condoms;
- Avoid pregnancy, refrain from breastfeeding and donating blood, plasma, organs, tissues or semen.

And at all times : avoid sharing syringes.

## Storage

Store Biktarvy® tablets in a bottle below 30˚C (86˚F) and in a blister pack between 15 and 30˚C (59 and 86˚F).

Keep this medication in a tightly closed container. Keep out of reach and out of sight of children.

## General advice

Be faithful to your appointments with the doctor and care team; they will be able to closely monitor your state of health.

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## DIRECTIONS DE LA PROTECTION DE LA JEUNESSE
(Services RTS et d'Urgence-sociale – Autres régions du Québec)

**MARCH 2020**

| | Régions | Durant les heures de travail | En dehors des heures de travail |
|---|---|---|---|
| 01 | Bas Saint-Laurent | 418 723-1255<br>1 800 463-9009 | 1 800 463-9009 |
| 02 | Saguenay-Lac-Saint-Jean | 418 543-3006<br>1 800 463-9188 | 1 800 463-9188 |
| 03 | Québec | 418 661-6951<br>1 800 463-4834 | 418 661-3700<br>1 800 463-4834 |
| 04 | Mauricie et Centre-du-Québec | 819 375-6886<br>1 800 567-8520 | 819 375-6886<br>1 800 567-8520 |
| 05 | Estrie | 819 566-4121<br>1 800 463-1029 | 1 800 463-1029 |
| 06 | Montréal (fax :514-896-3190)<br>accueildpj@cjm-ime.qc.ca | 514 896-3100<br>Direct : 514-896-3184/85 | 514 896-3100 |
| 06 | Batshaw | 514 935-6196 | 514 935-6196 |
| 07 | Outaouais (fax :819-771-7263) | 819 776-6060<br>1 800 567-6810 | 1 800 567-6810 |
| 08 | Abitibi-Témiscamingue | 819 732-3244<br>1 800 567-6405 | 819 732-5858<br>1 800 567-6405 |
| 09 | Côte-Nord | 1 800 463-8547 | 1 800 463-8547 |
| 10 | Gaspésie/Îles-de-la-Madeleine | 1 800 463-4225 or<br>418-368-1803 | 1 800 463-0629 |
| 11 | Chaudière-Appalaches | 418 837-9331<br>1 800 461-9331 | 418 837-9331<br>1 800 461-9331 |
| 12 | Laval | 450 975-4000 | 450 975-4000<br>Fax : 450-975-3862 |
| 13 | Lanaudière | 450 752-6644<br>1 800 665-1414 | 1 800 665-1414<br>Fax :450-759-5343 |
| 14 | Laurentides | 450 431-6885<br>1 800 361-8665 | 1 800 361-8665 |
| 15 | Montérégie<br>Email :<br>signalements.dpj.cissme16@ssss.gouv.qc.ca<br>Fax : 450-447-8222<br>Khanawake<br>450-632-6880 | 450 679-0831<br>514 721-1811<br>1 800 361-5310 | 450 679-0831<br>514 721-1811<br>1 800 361-5310 |
| 16 | Ungava Kuujjuaq | 819 964-2905 | 819 964-2919<br>PAGER :819-964-0050<br>#92(leave message) |
| 17 | Baie d'Hudson Inuvik | 819 988-2191 | 819 988-2957<br>Fax : 819-988-2304 |
| 18 | Baie James- Mistissini Chisasibi Waswanipi | 819 855-2844<br>819 753-2324 | 1 800 409-6884<br>Fax : 819-855-3045<br>(baie james) |
| 19 | Cree Territories | 1-800-409-6884 | |

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| Picard | La Pocatière | Bas du Fleuve | 47 |
| Piedmont | Saint-Jérôme | Laurentides-Lan. | 50 |
| Pierreville | Nicolet | Centre du Québec | 51 |
| Pike River | Cowansville | Richelieu | 45 |
| Pikogan | Amos | Abitibi-Témisc. | 46 |
| Pincourt | Île Perrot | Richelieu | 45 |
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| Pohenegamook | Cabano | Bas du Fleuve | 47 |
| Pointe-à-la-Croix | Amqui | Bas du Fleuve | 47 |
| Pointe-à-la-Croix | Bonaventure | Gaspésie | 49 |
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| Pointe-du-Moulin | Île Perrot | Richelieu | 45 |
| Pointe Fortune | Île Perrot | Richelieu | 45 |
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| Ponsonby | Hull | Outaouais | 52 |
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| Rivière-Patapédia | Amqui | Bas du Fleuve | 47 |
| Rivière-Pentecôte | Sept-Iles | Côte Nord | 48 |
| Rivière-St-Jean | Havre Saint-Pierre | Côte Nord | 48 |
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| Sacré-Coeur-de-Jésus | St-Joseph | Québec | 52 |
| Sacré-Coeur-de-Marie | Thetford Mines | Québec | 53 |
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| Sawyerville | Sherbrooke | Estrie | 49 |
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| Scott-Jonction | St-Joseph | Québec | 52 |
| Senneterre | Senneterre | Abitibi-Témisc. | 46 |
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| St-Adrien-d'Irlande | Thetford Mines | Québec | 53 |
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| St-Agricole | Saint-Jérôme | Laurentides-Lan. | 50 |
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| St-Aimé-du-Lac-des-Îles | Mont-Laurier | Laurentides-Lan. | 50 |
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| St-Albert-de-Warwick | Bois-Francs | Centre du Québec | 51 |
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| St-Alexandre (paroisse/village) | St-Jean | Richelieu | 45 |
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| St-André d'Argenteuil | Saint-Jérôme | Laurentides-Lan. | 50 |
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| St-Ange-Gardien | Cowansville | Richelieu | 45 |
| St-Anicet (Cazaville) | Valleyfield | Richelieu | 45 |
| St-Anselme | Lévis | Québec | 52 |
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| St-Antoine-Daniel | Thetford Mines | Québec | 53 |
| St-Antoine-de-la-Baie-du-Febvre | Nicolet | Centre du Québec | 51 |
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| St-Arsène | Rivière-du-Loup | Bas du Fleuve | 47 |
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| St-Athanase | St-Jean | Richelieu | 45 |
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| St-Augustin-de-Desmaures | Portneuf | Québec | 52 |
| St-Augustin-de-Woburn | Lac Mégantic | Estrie | 48 |
| St-Barnabé | Louiseville | Centre du Québec | 51 |
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| St-Barthélémy | Joliette | Laurentides-Lan. | 50 |
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| St-Benoît-du-Lac | Cowansville | Richelieu | 45 |
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| St-Bernard-de-Lacolle | St-Jean | Richelieu | 45 |
| St-Blaise | St-Jean | Richelieu | 45 |
| St-Bonaventure | Drummondville | Centre du Québec | 51 |
| St-Boniface-de-Shawinigan | Mauricie | Centre du Québec | 51 |
| St-Bruno | Alma | Saguenay | 53 |
| St-Bruno | La Pocatière | Bas du Fleuve | 47 |
| St-Bruno-de-Guigues | Ville-Marie | Abitibi-Témisc. | 47 |
| St-Bruno-de-Montarville | Longueuil | Richelieu | 45 |
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| St-Cajetan d'Armagh | Lévis | Québec | 52 |
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| St-Charles-de-Lachenaie | Repentigny | Laurentides-Lan. | 50 |
| St-Charles-de-Mandeville | Joliette | Laurentides-Lan. | 50 |
| St-Charles-des-Grondines | Portneuf | Québec | 52 |
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| St-Christophe-d'Arthabaska | Bois-Francs | Centre du Québec | 51 |
| St-Chrysostome | Valleyfield | Richelieu | 45 |
| St-Claude | Sherbrooke | Estrie | 49 |
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| St-Cléophas | Amqui | Bas du Fleuve | 47 |
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| St-Clet | Valleyfield | Richelieu | 45 |
| St-Coeur-de-Marie | Alma | Saguenay | 53 |
| St-Colomban | Saint-Jérôme | Laurentides-Lan. | 50 |
| St-Côme | Joliette | Laurentides-Lan. | 50 |
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| St-Cuthbert | Joliette | Laurentides-Lan. | 50 |
| St-Cyprien | Rivière-du-Loup | Bas du Fleuve | 47 |
| St-Cyprien | St-Jean | Richelieu | 45 |
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| St-Dominique | St-Hyacinthe | Richelieu | 45 |
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| St-Edmond | Amqui | Bas du Fleuve | 47 |
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| St-Eugène | Dolbeau | Saguenay | 53 |
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| St-Gérard | Amos | Abitibi-Témisc. | 46 |
| St-Gérard | Sherbrooke | Estrie | 49 |
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| St-Hyacinthe | St-Hyacinthe | Richelieu | 45 |
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| Ste-Marguerite | Lévis | Québec | 52 |
| Ste-Marguerite-de-Gallix | Sept-Îles | Côte Nord | 48 |
| Ste-Marguerite-du-Lac-Masson | Saint-Jérôme | Laurentides-Lan. | 50 |

| Municipalities | Branches | S.S.C. | Page |
|---|---|---|---|
| Ste-Marie | St-Joseph | Québec | 52 |
| Ste-Marie-de-Blandford | Nicolet | Centre du Québec | 51 |
| Ste-Marie-de-Monnoir | St-Jean | Richelieu | 45 |
| Ste-Marie-Madeleine | St-Hyacinthe | Richelieu | 45 |
| Ste-Marie-Salomée | Joliette | Laurentides-Lan. | 50 |
| Ste-Marthe | Ste-Anne-des-Monts | Gaspésie | 49 |
| Ste-Marthe (Beauvoir) | Île Perrot | Richelieu | 45 |
| Ste-Marthe (village) | Île Perrot | Richelieu | 45 |
| Ste-Marthe-de-Thetford Mines | Thetford Mines | Québec | 53 |
| Ste-Marthe-duCap-de-la-Madeleine | Trois-Rivières | Centre du Québec | 51 |
| Ste-Marthe-sur-le-Lac | Ste-Thérèse | Laurentides-Lan. | 50 |
| Ste-Martine | Châteauguay | Richelieu | 44 |
| Ste-Martine-de-Courcelles | Thetford Mines | Québec | 53 |
| Ste-Mélanie | Joliette | Laurentides-Lan. | 50 |
| Ste-Monique | Alma | Saguenay | 53 |
| Ste-Monique | Nicolet | Centre du Québec | 51 |
| Ste-Monique | Saint-Jérôme | Laurentides-Lan. | 50 |
| Ste-Odile | Rimouski | Bas du Fleuve | 47 |
| Ste-Paule | Matane | Bas du Fleuve | 47 |
| Ste-Perpétue | Nicolet | Centre du Québec | 51 |
| Ste-Philoméne-de-Fortierville | Bois-Francs | Centre du Québec | 51 |
| Ste-Praxède | Thetford Mines | Québec | 53 |
| Ste-Prudentienne(vill./paroisse) | Granby | Richelieu | 45 |
| Ste-Rita | Trois-Pistoles | Bas du Fleuve | 47 |
| Ste-Rosalie | St-Hyacinthe | Richelieu | 45 |
| Ste-Rose-de-Watford | St-Joseph | Québec | 52 |
| Ste-Rose-du-Nord | Chicoutimi | Saguenay | 53 |
| Ste-Sabine | Cowansville | Richelieu | 45 |
| Ste-Sabine | St-Joseph | Québec | 52 |
| Ste-Scholastique | Saint-Jérôme | Laurentides-Lan. | 50 |
| Ste-Séraphine | Bois-Francs | Centre du Québec | 51 |
| Ste-Sophie | Bois-Francs | Centre du Québec | 51 |
| Ste-Sophie | Saint-Jérôme | Laurentides-Lan. | 50 |
| Ste-Sophie-de-Lévrard | Nicolet | Centre du Québec | 51 |
| Ste-Thécle | Mauricie | Centre du Québec | 51 |
| Ste-Théodosie-Calixa-Lavallée | Longueuil | Richelieu | 45 |
| Ste-Thérèse | Chandler | Gaspésie | 49 |
| Ste-Thérèse | Ste-Thérèse | Laurentides-Lan. | 50 |
| Ste-Thérèse (partie ouest) | Ste-Thérèse | Laurentides-Lan. | 50 |
| Ste-Thérèse-de-Gatineau | Maniwaki | Outaouais | 52 |
| Ste-Thérèse-de-Lisieux | Québec | Québec | 52 |
| Ste-Thérèse-du-Colombier | Forestville | Côte Nord | 48 |
| Ste-Thérèse-ouest (Boisbriand) | Ste-Thérèse | Laurentides-Lan. | 50 |
| Ste-Ursule | Louiseville | Centre du Québec | 51 |
| Ste-Victoire-d'Arthabaska | Bois-Francs | Centre du Québec | 51 |
| Ste-Victoire-de-Sorel | Sorel | Richelieu | 45 |
| Stoke | Sherbrooke | Estrie | 49 |
| Stoneham | Québec | Québec | 52 |
| Stornoway | Lac Mégantic | Estrie | 48 |
| Stratford | Lac Mégantic | Estrie | 48 |
| Sts-Anges | St-Joseph | Québec | 52 |
| Sts-Martyrs | Thetford Mines | Québec | 53 |
| Stukeley-Sud | Magog | Estrie | 49 |
| Stukeley Sud (paroisse/village) | Granby | Richelieu | 45 |
| Suffolk & Addington | Hull | Outaouais | 52 |
| Sullivan | Val d'Or | Abitibi-Témisc. | 46 |
| Sutton (ville et canton) | Cowansville | Richelieu | 45 |

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| Taschereau | La Sarre | Abitibi-Témisc. | 46 |
| Tee Lake | Témiscamingue Sud | Abitibi-Témisc. | 46 |
| Témiscamingue | Témiscamingue Sud | Abitibi-Témisc. | 46 |
| Templeton | Hull | Outaouais | 52 |
| Terrasse Vaudreil | Île Perrot | Richelieu | 45 |
| Terrebonne | Repentigny | Laurentides-Lan. | 50 |
| Tête-à-la-Baleine | Havre Saint-Pierre | Côte Nord | 48 |
| Tewkesbury | Québec | Québec | 52 |
| Thetford Mines | Thetford Mines | Québec | 53 |
| Thorne | Campbell's Bay | Outaouais | 51 |
| Tingwick | Bois-Francs | Centre du Québec | 51 |
| Touraine | Hull | Outaouais | 52 |
| Tracy | Sorel | Richelieu | 45 |
| Très-Saint-Rédempteur | Île Perrot | Richelieu | 45 |
| Très-Saint-Sacrement | Valleyfield | Richelieu | 45 |
| Tring-Jonction | St-Joseph | Québec | 52 |
| Trinité-des-Monts | Rimouski | Bas du Fleuve | 47 |
| Trois-Lacs | Asbestos | Estrie | 48 |
| Trois-Pistoles | Trois-Pistoles | Bas du Fleuve | 47 |
| Trois-Rivières | Trois-Rivières | Centre du Québec | 51 |
| Trois-Rivières-Ouest | Trois-Rivières | Centre du Québec | 51 |
| Turgeon | Mont-Laurier | Laurentides-Lan. | 50 |
| Ulverton | Drummondville | Centre du Québec | 51 |
| Upton | St-Hyacinthe | Richelieu | 45 |
| Val-Alain | Lévis | Québec | 52 |
| Val-Barrette | Mont-Laurier | Laurentides-Lan. | 50 |
| Val-Bélair | Québec | Québec | 52 |
| Val-Brillant | Amqui | Bas du Fleuve | 47 |
| Val-d'Espoir | Chandler | Gaspésie | 49 |
| Val-d'Or | Val d'Or | Abitibi-Témisc. | 46 |
| Val-David | Saint-Jérôme | Laurentides-Lan. | 50 |
| Val-des-Lacs | Saint-Jérôme | Laurentides-Lan. | 50 |
| Val-Jalbert | Roberval | Saguenay | 53 |
| Val-Morin | Saint-Jérôme | Laurentides-Lan. | 50 |
| Val-Paradis | La Sarre | Abitibi-Témisc. | 46 |
| Val-Racine | Lac Mégantic | Estrie | 48 |
| Val-Senneville | Val d'Or | Abitibi-Témisc. | 46 |
| Val-St-Gilles | La Sarre | Abitibi-Témisc. | 46 |
| Val-St-Michel | Québec | Québec | 52 |
| Valcourt (village et canton) | Granby | Richelieu | 45 |
| Valcourt (Ville et Canton) | Sherbrooke | Estrie | 49 |
| Vallée-Jonction | St-Joseph | Québec | 52 |
| Valleyfield | Valleyfield | Richelieu | 45 |
| Varennes | Longueuil | Richelieu | 45 |
| Vassan | Val d'Or | Abitibi-Témisc. | 46 |
| Vaudreil-sur-le-Lac | Île Perrot | Richelieu | 45 |
| Vaudreuil | Île Perrot | Richelieu | 45 |
| Vendée | Saint-Jérôme | Laurentides-Lan. | 50 |
| Venise-en-Québec | Cowansville | Richelieu | 45 |
| Verchères | Longueuil | Richelieu | 45 |
| Victoriaville | Bois-Francs | Centre du Québec | 51 |
| Village Huron | Québec | Québec | 52 |
| Ville-Marie | Ville-Marie | Abitibi-Témisc. | 47 |
| Ville Vanier | Québec | Québec | 52 |
| Villebois | La Sarre | Abitibi-Témisc. | 46 |
| Villemontel | Amos | Abitibi-Témisc. | 46 |

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|---|---|---|---|
| Villeneuve | Québec | Québec | 52 |
| Villeroy | Bois-Francs | Centre du Québec | 51 |
| Vimy-Ridge | Thetford Mines | Québec | 53 |
| Visitation-de-Champlain | Trois-Rivières | Centre du Québec | 51 |
| Wakefield | Hull | Outaouais | 52 |
| Wakefield Est | Hull | Outaouais | 52 |
| Wakeham | Gaspé | Gaspésie | 49 |
| Walthan & Bryson | Campbell's Bay | Outaouais | 51 |
| Warden | Granby | Richelieu | 45 |
| Warwick | Bois-Francs | Centre du Québec | 51 |
| Waterloo | Granby | Richelieu | 45 |
| Waterville | Sherbrooke | Estrie | 49 |
| Weedon (Centre et Canton) | Sherbrooke | Estrie | 49 |
| Wendover et Simpson | Drummondville | Centre du Québec | 51 |
| Wentworth | Saint-Jérôme | Laurentides-Lan. | 50 |
| Wentworth-Nord | Saint-Jérôme | Laurentides-Lan. | 50 |
| Westbury | Sherbrooke | Estrie | 49 |
| Weymontachie | La Tuque | Centre du Québec | 51 |
| Wickham | Drummondville | Centre du Québec | 51 |
| Windsor | Sherbrooke | Estrie | 49 |
| Winneway (Réserve indienne) | Ville-Marie | Abitibi-Témisc. | 47 |
| Wotton Canton | Asbestos | Estrie | 48 |
| Wottonville | Asbestos | Estrie | 48 |
| Wright | Maniwaki | Outaouais | 52 |
| Yamachiche | Louiseville | Centre du Québec | 51 |
| Yamaska | Sorel | Richelieu | 45 |
| Yamaska-Est | Sorel | Richelieu | 45 |
| York | Gaspé | Gaspésie | 49 |

| Branches | S.S.C. | Page |
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| La Sarre | Abitibi-Témisc. | 46 |
| Témiscamingue Sud | Abitibi-Témisc. | 46 |
| Témiscamingue Sud | Abitibi-Témisc. | 46 |
| Hull | Outaouais | 52 |
| Île Perrot | Richelieu | 45 |
| Repentigny | Laurentides-Lan. | 50 |
| Havre Saint-Pierre | Côte Nord | 48 |
| Québec | Québec | 52 |
| Thetford Mines | Québec | 53 |
| Campbell's Bay | Outaouais | 51 |
| Bois-Francs | Centre du Québec | 51 |
| Hull | Outaouais | 52 |
| Sorel | Richelieu | 45 |
| Île Perrot | Richelieu | 45 |
| Valleyfield | Richelieu | 45 |
| St-Joseph | Québec | 52 |
| Rimouski | Bas du Fleuve | 47 |
| Asbestos | Estrie | 48 |
| Trois-Pistoles | Bas du Fleuve | 47 |
| Trois-Rivières | Centre du Québec | 51 |
| Trois-Rivières | Centre du Québec | 51 |
| Mont-Laurier | Laurentides-Lan. | 50 |
| Drummondville | Centre du Québec | 51 |
| St-Hyacinthe | Richelieu | 45 |
| Lévis | Québec | 52 |
| Mont-Laurier | Laurentides-Lan. | 50 |
| Québec | Québec | 52 |
| Amqui | Bas du Fleuve | 47 |
| Chandler | Gaspésie | 49 |
| Val d'Or | Abitibi-Témisc. | 46 |
| Saint-Jérôme | Laurentides-Lan. | 50 |
| Saint-Jérôme | Laurentides-Lan. | 50 |
| Roberval | Saguenay | 53 |
| Saint-Jérôme | Laurentides-Lan. | 50 |
| La Sarre | Abitibi-Témisc. | 46 |
| Lac Mégantic | Estrie | 48 |
| Val d'Or | Abitibi-Témisc. | 46 |
| La Sarre | Abitibi-Témisc. | 46 |
| Québec | Québec | 52 |
| Granby | Richelieu | 45 |
| Sherbrooke | Estrie | 49 |
| St-Joseph | Québec | 52 |
| Valleyfield | Richelieu | 45 |
| Longueuil | Richelieu | 45 |
| Val d'Or | Abitibi-Témisc. | 46 |
| Île Perrot | Richelieu | 45 |
| Île Perrot | Richelieu | 45 |
| Saint-Jérôme | Laurentides-Lan. | 50 |
| Cowansville | Richelieu | 45 |
| Longueuil | Richelieu | 45 |
| Bois-Francs | Centre du Québec | 51 |
| Québec | Québec | 52 |
| Ville-Marie | Abitibi-Témisc. | 47 |
| Québec | Québec | 52 |
| La Sarre | Abitibi-Témisc. | 46 |
| Amos | Abitibi-Témisc. | 46 |

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|---|---|
| iébec | 52 |
| ntre du Québec | 51 |
| iébec | 53 |
| ntre du Québec | 51 |
| taouais | 52 |
| taouais | 52 |
| spésie | 49 |
| taouais | 51 |
| helieu | 45 |
| ntre du Québec | 51 |
| helieu | 45 |
| rie | 49 |
| rie | 49 |
| ntre du Québec | 51 |
| rentides-Lan. | 50 |
| rentides-Lan. | 50 |
| rie | 49 |
| tre du Québec | 51 |
| tre du Québec | 51 |
| rie | 49 |
| tibi-Témisc. | 47 |
| rie | 48 |
| rie | 48 |
| aouais | 52 |
| tre du Québec | 51 |
| helieu | 45 |
| helieu | 45 |
| pésie | 49 |

Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

*FMU-0234*

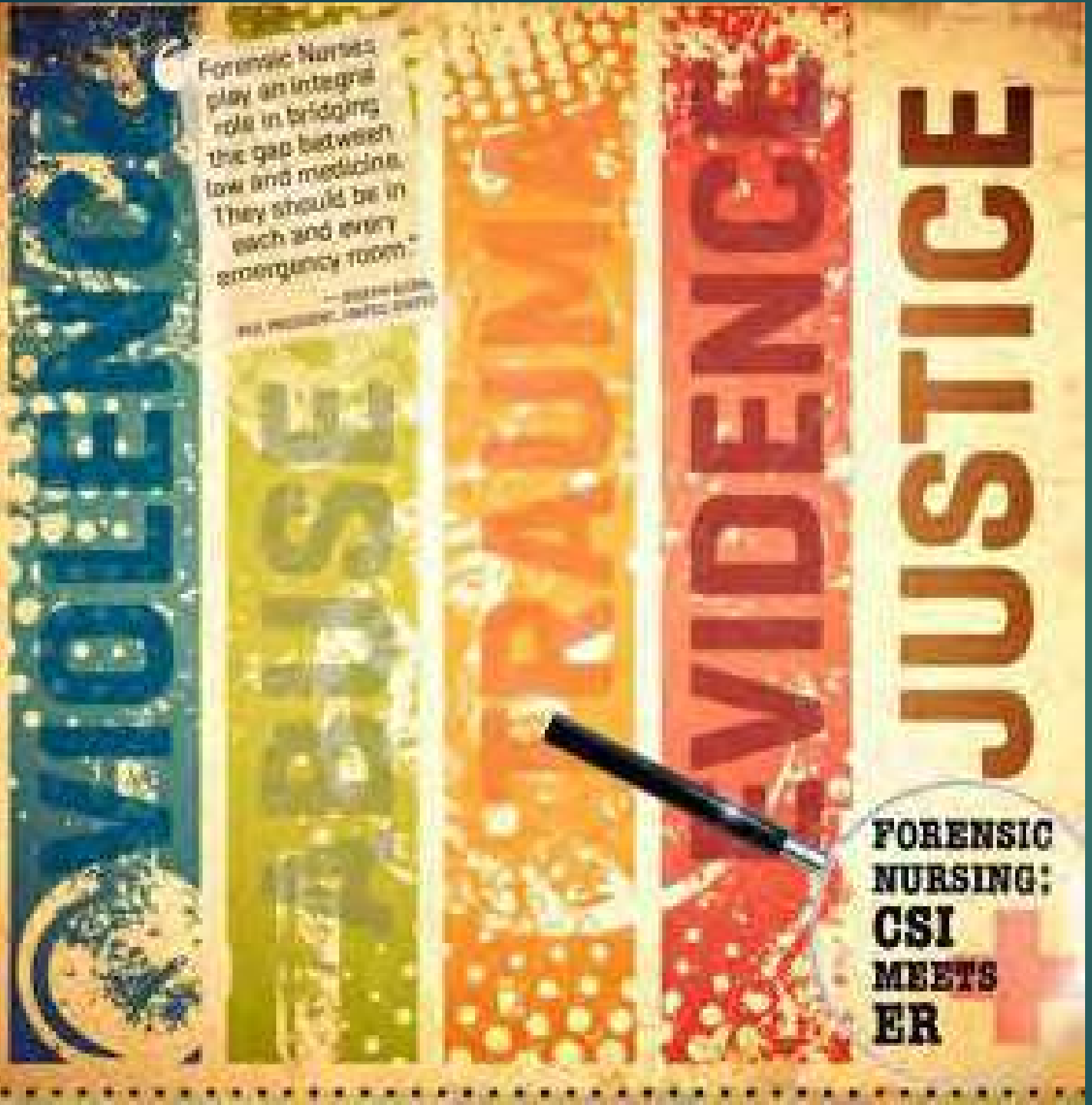
## SALLE D'URGENCE - DOCUMENT SUPPLÉMENTAIRE
## EMERGENCY ROOM - CONTINUATION RECORD

| Date (YYYY/MM/JJDD) : | Page : |
|---|---|
| Poids Weight (kg) : | Allergies : |

| NOTES D'ÉVOLUTION / PROGRESS NOTES | | |
|---|---|---|
| HEURE / TIME (00:00) | ORDONNANCES ORDERS | OBSERVATION PROGRESS NOTES |
| ☐ | Patient accompanied by | |
| ☐ | Are the parents aware of the situation | |
| ☐ | Referred by/ sent by | |
| ☐ | School level | |
| ☐ | Name, location of school | |
| ☐ | Current family situation | |
| ☐ | Who lives in the household | |
| | | |
| ☐ | Date and time of last assault | |
| ☐ | Relation to abuser(s) | |
| ☐ | Does patient live with abuser | |
| ☐ | Location of assault | |
| ☐ | Physical and psychosocial symptoms since assault | |
| | | |
| ☐ | Past medical and mental health history: | |
| | ASQ score: | |
| | | |
| | | |
| ☐ | Past history of physical/sexual assault | |
| | | |
| ☐ | Who is the patient leaving with | |
| ☐ | Contact information for follow-up | |
| ☐ | | |
| ☐ | Patient safety assured short term | |
| ☐ | Was police called? Event number | |
| ☐ | Is DYP aware? Name of worker involved | |
| | DYP recommends - | |
| | | |
| | | |

# SA Interview Flow Cheat sheet

<table>
<tr><td rowspan="3">PRE</td><td colspan="3">Welcome – we are a team and work together</td></tr>
<tr><td>Adolescent – interview alone</td><td>Less than 14 – discloses aggression</td><td>Less than 14 – does not disclose</td></tr>
<tr><td>Tell me what brings you?<br>It must be difficult to share</td><td>Separate accompanying adult and child</td><td>Separate accompanying adult and child</td></tr>
<tr><td></td><td>Do you have questions?</td><td>Do you have questions?</td><td>Do you have questions?</td></tr>
<tr><td rowspan="3">INTERVIEW</td><td><u>Explain next steps</u>:<br>Interview and questionnaire to complete<br>Consent<br>Physical exam & sampling</td><td><u>Explain next steps</u>:<br>Interview and questionnaire to complete<br>Consent<br>Physical exam & sampling</td><td><u>Explain next steps</u>:<br>Interview and questionnaire to complete<br>Consent<br>Physical exam & sampling</td></tr>
<tr><td rowspan="2"><u>Interview</u>: Adolescent ALONE<br>Begin with Consent F1<br>Ask broad questions<br>Forms and questionnaire F2-4<br>Sexual intercourse in last 5 days<br>Review of Symptoms F5 (only first half)</td><td><u>Interview</u>: Parent ALONE<br>Begin with Consent<br>Forms and questionnaire F2-4<br>Review of Symptoms F5<br>Past medical history and socio-family questions<br><br>Explain to parents importance of not reacting during interview with child or physical exam</td><td><u>Interview</u>: Parent ALONE<br>Begin with Consent<br>Forms and questionnaire F2-4<br>Review of Symptoms F5<br>Past medical history and socio-family questions<br><br>Explain to parents importance of not reacting during interview with child or physical exam</td></tr>
<tr><td><u>Bring child back in the room</u><br>Ask general questions about friends, activities, school, etc.<br>Ask: “Do you know why you are here today?”<br>Your adult (mom, SW, etc) tells me you are complaining of…….<br>Can you tell me more?<br>Ask questions around symptoms<br>Can ask some direct questions</td><td><u>Bring child back in the room</u><br>Ask general questions about friends, activities, school, etc.<br>Ask: “Do you know why you are here today?”<br>Your adult (mom, SW, et) tells me you are complaining of…….<br>Ask questions around symptoms ONLY</td></tr>
<tr><td rowspan="2">PLAN & SET UP</td><td colspan="3">Patient and accompanying person wait in WR across GR17<br>SA RN completes F9 (based on F3 information)<br>If patient is amnesic or does not recall, do ALL the samples<br>Discuss with MD samples required and patient safety<br>- Based on F9 and consent: trousse samples<br>- Based on risk: STIs, Blood serology, other</td></tr>
<tr><td colspan="3">Set up equipment for sampling – WEAR GLOVES and MASK for all trousse handling</td></tr>
<tr><td>EXAM</td><td colspan="3"><u>Exam</u><u>- sampling</u><br>Physical exam – By MD<br>Trousse samples based on F9<br>STIs samples (sent to Lab)</td></tr>
<tr><td>DISCHARGE</td><td colspan="3"><u>Conclusion</u> <u>of interview:</u><br>Verify contact information<br>Verify telephone number to reach patient<br>Ensure prescription or first dose is given if necessary for STIs, contraception, other<br>Ensure patient safety</td></tr>
</table>




# Nursing Response to Sexual Assault in the PED

APRIL 2025

DENISE KUDIRKA APN PED

# Objectives

- Review of Sexual abuse concepts
- Learn to recognize Sexual abuse
- Understand importance of SA Disclosure and the required interventions
- Identify the needs of a SA patient presenting to the PED
- Know the Goals of Medico-social interventions
- Review PED  SA interview principles
- Know nursing interventions that mitigate trauma

# What is Sexual Assault?
# What is Sexual Abuse?

# Definition – Sexual Assault

**Sexual Assault** involves the use of words or gestures that are sexual in nature, which are imposed against the will of the victim, and without their consent.

The aggressor may use emotional manipulation; bribery; intimidation; threats or harassment; the use of verbal, physical, or psychological abuse [1,2].

# Consent

Consent is agreement by a “legally or functionally competent” individual to engage in sexual activity. Basile, Smith, Black, Mahendra (2015)

An individual is not considered legally or functionally competent if:

- Underage
- Excessively intoxicated with drug or alcohol
- Permanently mentally or physically incapacitated
- Unconscious
- Asleep

- Tea Consent – YouTube
- consent for kids - YouTube

# Teenagers sexual consent

Consent is not valid if the partner is too young and/or in a vulnerability relationship with the partner

The age of consent to sexual activities is 16 years old

- Between 12 to 16 years teenagers can generally consent to sexual gestures if their partner is around the same age

| Younger partner age | Age difference allowed |
|---|---|
| Less than 12 year old | No valid consent |
| 12 and 13 years old | Less than 2 years of difference |
| 14 and 15 years old | Less than 5 years |

Important do not confuse with consent to medico-legal treatment




# WHAT ARE THE DIFFERENT TYPE OF SA?

# Type of SA

## Intra-familial

- Parental incest
  - Most traumatic - parental failure to protect child
  - Other parent reaction
- Sibling incest
  - 50 -80 % Teenager abuser are towards siblings
- Reconstituted family
  - Symbolic relationship as important as genetic relationship
  - Depend on attachment links

# Type of SA

Extra-family SA – Institutional

- Family friend, guardian, neighbor, acquaintance, close friend
  - Known person
  - Authority figure

Cyber SA

- Information gathering to manipulate/meet child/teenager
- Production of juvenile pornography
- Exposition to pornography

# Type of Gesture - without physical contact

- Exhibitionism
- Voyeurism
- Child involvement in verbal sexual proposition
- Exposition to pornography
- Production of juvenile pornography
- On-line luring by cyber-predator

# Type of Gesture - with physical contact but without penetration

Kisses of sexual nature

Touching

- Body or genital area

Masturbation

# Type of Gesture - with penetration

Anal - Vaginal - Oral

With a penis, fingers or an object




Penetration
Child perception
Adolescent perception
Traumatic experience with high rate of body dissociation




# SA Acuity

## WHAT FACTORS INFLUENCE SA SEVERITY?




# SA Acuity Depends on:

SA CHARACTERISTICS

AGGRESSOR CHARACTERISTICS

CHILD / TEENAGER CHARACTERISTICS

# SA Characteristics

TYPE OF GESTURES

COERCION AND/OR VIOLENCE

LENGTH AND FREQUENCY OF SA

SA CONTEXT

# Coercion and/or Violence

Type of atmosphere

- Threatening
  - Towards the victim
  - Towards the victim's family
- Humiliating
- Pervert with deviant behavior
- Sexual exploitation (pimping)
- Human trafficking

# Frequency and Length

Chronic aggression

- Frequent and over a long period of time
- Have the most severe consequences
- Evaluate length of aggression
  - First SA episode to Disclosure of SA
  - The silence observed is detrimental even in the absence of SA

# Context of Aggression

- Unpredictability and irregularity of recurrence of SA are aggravating factors
  - It produce a state of hypervigilance and anguish
- SA at home destroys the safety a home should provide
- Ritualized SA in religious sect are consider pervert SA

# Aggressor Characteristics

VICTIM AND AGGRESSOR RELATIONSHIP

AGE OF AGGRESSOR

NUMBER OF AGGRESSORS

# AC – Victim and Aggressor Relationship

Closer the relationship more severe are the consequences to the child

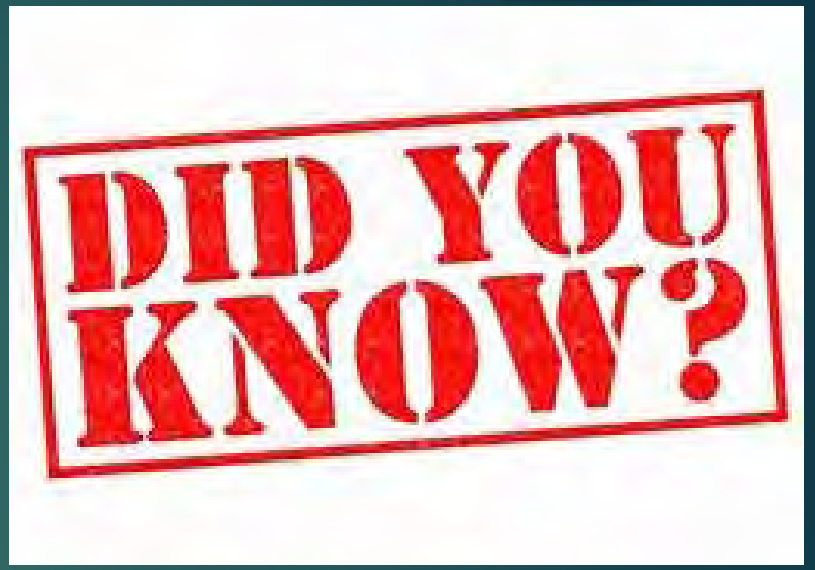
- Breach of trust with adults
- Feeling of betrayal
- Ambivalence and confusion regarding disclosure

Further the relationship more the child's entourage will believe and support the child

# AC – Age of Aggressor

Aggression from non-adult less traumatizing

- Exception about sibling incest



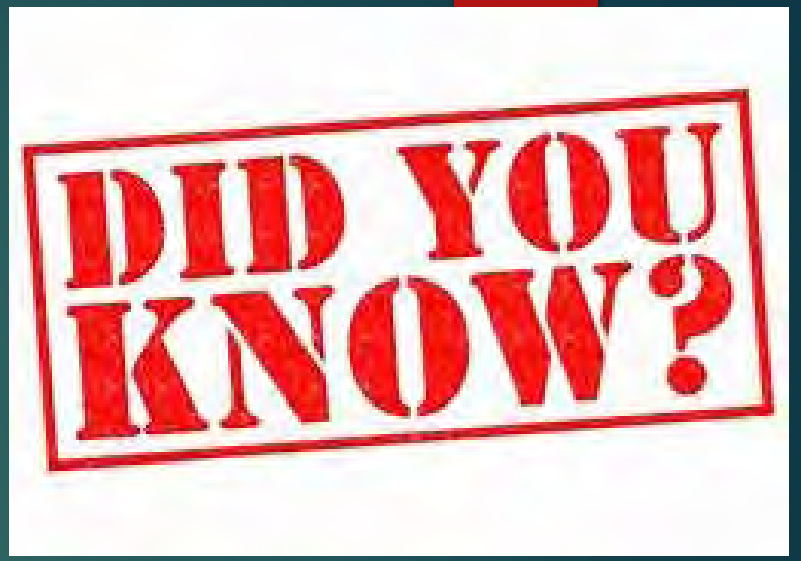

# Usual type of SA

KNOWN ABUSER WITH A CLOSE RELATIONSHIP WITH CHILD

NON “VIOLENT”

PROGRESSIVE IF CHRONIC

VERY FEW DISCLOSURE OF SA TO AUTHORITIES




It is not solely the acuity of the gestures or the relationship with the aggressor that influence the severity of the psychological trauma but also the child/adolescent perception of the assault and the way the family nurture him/her/they after

# Child Characteristics

**Children will REACT**
**By**
**ACTING OUT**



# 0-2 yrs

Interacts with the environment with its senses

Shocked by noise, smell, scary images

Unable to verbally communicate
Unable to understand what happen

Attachment disorder

# 2-3 yrs

Toddler more active

Abuse hinders development

Weight/height, language, motor and cognitive

May have physical or behavioral souvenir

React with behavioral alterations

# 3-5 yrs

Starts decoding emotions and to expressing them with simple words

Egocentric, self attribute the responsibility of events

Oedipal period

May develop disruption to establish relationships with opposite sex

React with somatization, repetitive behavior, regression, inappropriate sexual behavior in games, drawings

No chronology of event, remembers image, snow storm

Chronic abuse amalgamations of events

# 6-12 yrs

Latency period

Know good vs evil

Justice & Intentionality

Understand consequences of abuse on self and others
May develop false belief to explain abuse
May self-depreciate due to comments from those around him/her/they

Sexual preoccupation due to abuse hinders normal development

Anxiety, depression, anger, hypervigilance, attention disorder or sleep disturbance will affect school performance and socialization

# SA Adolescent Characteristics

- Transition from concrete thinking to abstract thinking
- Think being
  - Unique
  - Invulnerable
  - Invincible
- This contributes to the belief that “no one can understand him/her”
- Self-esteem construction
- Formation of sexual, cultural, spiritual and professional identity
- Being independent
- Gain autonomy
- Adapt to sexual maturity
- Establish cooperation relationship with peers
- Preparation to workforce
- Establishing intimate relationship
- Development of core values




# What do you need to take into account while taking care of Adolescents?

# 14- 17 year old - Adolescent Confidentiality

- An agreement between the patient and HCP that information discussed during medical encounters will not be shared with other parties without the patient's explicit consent [1]
- Limits of confidentiality
  - When an HCP deems that an adolescent is at risk of seriously harming themselves or others[20].
  - When an adolescent is in need of protection.
- HCPs are discouraged from asking in the presence of a parent or caregiver whether an adolescent would like time in private, because the adolescent may feel uncomfortable or reluctant to, agree.

CPS Policy statement
Agostino, H., Toulany, A., (2023). Considerations for privacy and confidentiality in adolescent health care service delivery
Canadian Paediatric Society, Adolescent Health Committee Adolescent Health Committee Paediatr Child Health 2023 28(3):172–177.

# Suspect SA when.....

# Possible Presenting complaints of SA

Genito-Urinary Physical complaints:

- Foreign body
- Painful defecation or urination
- Vaginal discharge, bleeding or itching
- TSIs, Pregnancy

Traumatic marks

- Oral complaints
- Grasp or rope marks

General somatic complaints

- Headache, abdominal pain, constipation, diarrhea, encopresis, general fatigue, eating-disturbances,

# Possible Presenting complaints of SA

Psychological complaints:

- Abrupt behavioral changes
- Self-destructive behaviors
- Sexualized behaviors inappropriate for developmental level

Social issues

- Runaway behavior in teens
- Loss of memory for events following social gathering
- Intimate partner violence

# PC – Parent/Caregiver report

## Parents concern about

- New apparently sexualized behavior
- More general behavioral changes
- Child “Abnormal” genital anatomy
- Unexplained injury
- Genital discharge, pain, bleeding

# PC – Parent/Caregiver report

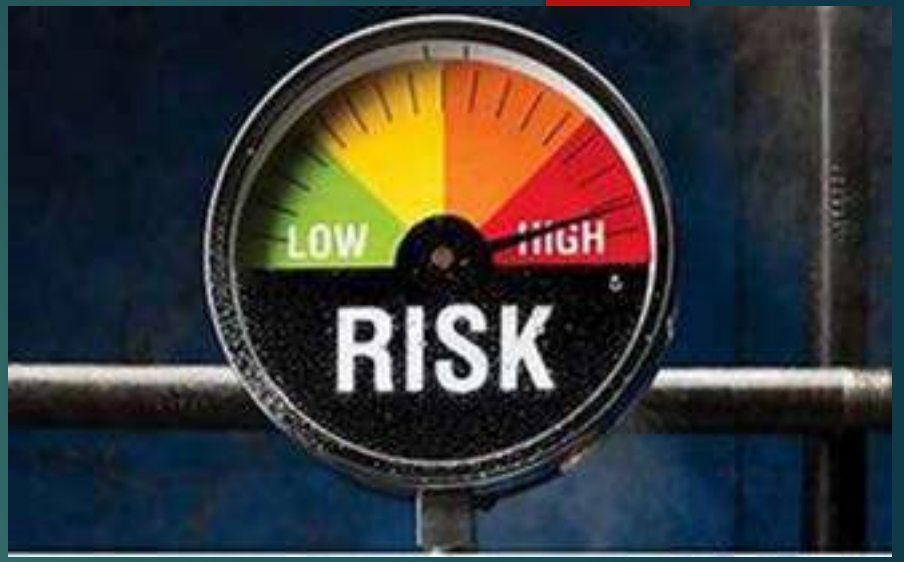
## Child/Adolescent talking about

- "Abnormal" genital anatomy
- Abnormal interest or fear about STIs
- Fear of pregnancy
- Excessive contraceptive control, a desire for contraception without reason

# PC – Parent/Caregiver report

Child exhibit new behavior of

- Excessive fear of undergoing an examination of the genitals
- Excessive shamelessness
- Abnormal modesty in everyday life
- Fear of any physical contact




# Developmental Delay /Special needs child

# Developmental Delay /Special needs child




- Depends on others for care
- Lack of social judgment
- Lack of knowledge about sexuality
- Impulsivity and disinhibition
- Habituation and desensitization to physical contact
- Isolation
- Inability to defend oneself
- Communication difficulties
- Sensitivity to suggestion
- Misinterpretation of the surroundings of victimization symptoms

# SA Consequences



# Patient's reaction during SA Traumatic memory - Sideration

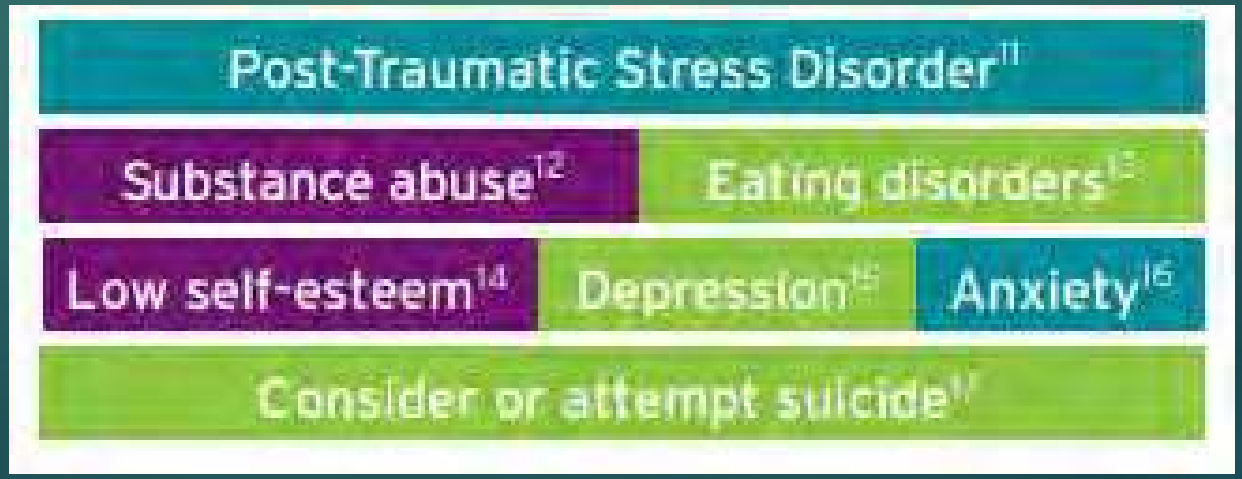
- Event encapsulated in amygdale
  - Stress hormone, Blasting Alarm
- Brain protective disjunction
  - Emotional and physical anesthesia (sideration)
    - Irreality sensation, becoming a spectator
    - Cannot: move, talk, ask for help
    - Emotionally disconnected: indifferent to situation, seems to tolerate violence
- Hippocampus unable to process event: spatiotemporal (Place, time)
  - Unable to recall what happen, where, who
  - Flashback: what was said, felt, smelled

# SA Adolescent Consequences

May experience

| | |
|---|---|
| **Poor academic performance** | **Sexual risk taking behavior** |
| **Pregnancy** | **Self-harm** |

May suffer from mental health conditions



# SA Consequences
# PTSD Risk Factors

- Assaulted by a group
- Suffering from Acute Stress Disorder after assault
- Subjected to several acts during assault
- Injured during assault
- History of earlier traumatization

# SA Consequences
# Indications of PTSD/ Severe Depression

At moment of aggression patient presented with Tonic Immobility

- Froze of felt paralyzed
- Unable to move even though not restrained
- Body was trembling or shaking
- Unable to call out or scream
- Felt numb or no pain
- Felt feeling of fear/panic
- Feared for you life/going to die
- Felt detached from self
- Felt detached of what was going on




PHOTO FRANÇOIS ROY, LA PRESSE

Karine Macdonald et Cynthia Blais, lundi

**« Il y a des résultats. Il y a aussi beaucoup de services. L'aide est là, il ne faut pas avoir peur de la demander. »**

— Cynthia Blais

Inceste:




# SA Disclosure

WHAT INFLUENCES SA DISCLOSURE?

HOW DOES CHILDREN DISCLOSE SA?

WHAT HINDERS SA DISCLOSURE?

# All SA Survivor Experience

Fear of aggressor and reprisals

Feel alone in experiencing such a situation

Feel guilty and ashamed of what happen

Think of being responsible of the situation

Have confused feelings towards the attacker

Fear legal proceedings

Fear disrupting the lives of their loved ones

Fear reactions or remarks of family/friends

# Child and Adolescent SA are

- Afraid of being responsible for the breakdown of the family
- Afraid of their parents reaction
- Afraid of disappointing their parents
- Afraid of losing their autonomy
- May have not being listened to
- May have been discouraged in their attempts to disclose the SA
- Are not sure if what happened was “abnormal”

# Disclosure depends

Child age

How the disclosure is received

- Perception of the SA victim about
  - How well they will be listen to
  - How available the parent is to receive the disclosure
    - If the adult is known to offer affective support

# Type of Disclosure

Spontaneous

Accidental

Deliberate

Following a triggering event

# Spontaneous Disclosure
## Like if it was just normal

Sophie 5 years old tell her educator, that she has a boy friend since last week. He has shown her how to do caress on penis to provide pleasure to boys.

- the child does not realize that he or she is revealing a SA
- It is often done so without realizing it
- More frequent in preschooler
- The adult receiving this type of disclosure must be attentive and listen (à l'écoute) et know how to respond to the choking unforeseen revelation and react with calm

# Deliberate Disclosure

George 15 years old

He take an appointment with the school nurse and report that he has been victim of SA from his soccer coach.

George has taught about the consequences of the disclosure

- The child
  - Know what he/she is doing
  - Has taught about risk and benefit of disclosure
  - Has decided with whom he/she wishes to share the information
- More frequent with school age and teenagers
- The adult receiving this type of disclosure must believe and protect the child because they were chosen to receive this secret. The child must feel that telling this person was the right thing to do/the right choice to be made.

# Accidental Disclosure

- Julia (7 years old) has been sexually assaulted by a first cousin. The school nurse inform the DYP.
- DYP worker interviews Julia's brother Bob (10 year old) and discover that he has been also assaulted in the past

- An accidental disclosure by a third party
- May occur following a combination of circumstances that results in the complete or partial disclosure of the victim
- The child has little or no control over the circumstances of the disclosure
- Can occur with children of any age
- The child may feel relieved, devastated, or neutral about the disclosure

# Following a triggering event

- Julia 5 yrs and Paula 7 yrs are assaulted by their brother. He forces them to drink alcohol. They get scared and run away to tell their grand-mother

- the child experiences an event closely or loosely associated with sexual violence which prompts him/her to disclose
- This type of disclosure involves less anticipation or reflection for the child than deliberate disclosure
- Can occur with children of all ages

What is the most common fear that contribute to a delayed disclosure?


Not
Being Believed

Disclosure is one of the most important step on the journey  to recovery

# Messages to convey after survivor discloses SA

**Listen, Listen, Listen….**

**Validate the disclosure**

- I'm sorry this happened. This must be really tough for you
- Thank you for telling me/I am glad you told me
- It took a lot of courage to share this with me

**Let them control the pace and the content of what they whish to share**

- Disclosing at their own pace will allow them to take some control on the situation

Lanthier, S. Du Mont, J., Mason, R. (2018). Responding to Delayed Disclosure of Sexual Assault Health Settings: A Systematic Review. Trauma Violence and Abuse, 19,3, 251-265.

# Messages to convey after survivor discloses SA

**Providing emotional support**

- You are not alone
- SA nurse tries to understand what the survivor is going through
- Not treating the person differently after disclosure

- Being empathic
- Be neutral and non-judgmental
- Normalized reactions
- Telling that the SA is not to be blamed for the situation
  - It's not your fault. You didn't do anything to deserve this

# Specific interventions when a child discloses a SA

# Child Disclosure – Memory suggestibility

- Young children memory are susceptible to
  - Misleading suggestions
  - False memories
- **Children testimony must be protected**

**Never collect SA information in front of a child**

Hritz, A.C., Royer, C.E., Helm, R.K., Burd, K.A., Ojeda, K., & Ceci, S.J., (2015). Children's suggestibility research: Things to know before interviewing a child. Anuario de Psicologia Juridica, 15(1), 3 -12.

# Child Disclosure

- **Listen, Listen, Listen....**
- Avoid questioning
- Refrain from asking close-ended questions
- Prevent the child from repeating the details of his story
- Do not use leading question

# Child Disclosure

- Tell the child that he/she did the right thing by talking to you
- Reassure the child that you will do everything you can to help him/her
- Do not promise to keep secret about what he/she confide. Explain that you need to talk to the people who ensure children's safety
- Explain to the child that it is not his/her fault
- Do not talk about the aggressor like a bad person but a person that is ill
- Children may become silent or withdraw their disclosure
- DYP signalization is mandatory

# Hearsay – Oui dires

Out-of-court statement which is being offered in court for the truth of what was asserted.

- Hearsay evidence is inadmissible
- Exceptions: When victim may never repeat information
  - Developmental delay
  - Young child
- Document (see documentation section)






# WHAT ARE THE GOALS OF A MEDICO-SOCIAL INTERVENTION?

# Goals of the Medico-social interventions

- Support the victim and their family
- Assess and respond to patient needs
- Ensure patient's safety
- Provide information to the person and their parents
- Reassure the person about their physical integrity
- Detect and treat lesions
- Prevent pregnancy
- Detect and treat to prevent an STI
- Collect evidence






# The SA history taken in the ED is not a forensic interview

# Steps of the Medico-social intervention

In the Emergency Department

Step 1 Accueil and emotional support

Step 2 Planning of the intervention

Step 3 Medico-social history taking

Step 4 Medical and Medico-social exam, test, and specimen

Step 5 Nursing care and treatment

Step 6 Information and support, DYP signalization, statement to the police, reference/consult to SA clinic

At the Clinic

Step 7 Medical follow-up

Step 8 Psychosocial follow-up

# SA Nurse Role

- Accueil the victim and his parents
- Gather the history to guide his intervention (type of kit)
- Performs a basic skin exam (depending on history)
- Proceed to sample collection (skin, oral or blood if indicated)
- Summarizes the elements of his/her evaluation to the physician
- Prepares patient and equipment for gynecological exam and sample collection
- Provides support to patient and Assist physician during exam and samples collection
- Seal the Medico-legal kit,  and store it in the lock refrigerator or hand it to police
- Provides information to parents/victims during the intervention
- Support victims and parents
- Ensure that DYP signalization has been made
- Informed of follow-up and next step
- Recommend intervention by the social worker

# SA Child/Adolescent Needs

- Accueil and Emotional Support
- Protection
- Medical Health care
- Information about police and judicial procedures
- Indemnisation
- Fonctionels

# 1- Accueil and Emotional Support



Create a Safe, Trusting relationship, Respectful and Nonjudgmental

- Provide a safe private environment
- Provide access to a victim advocate during the stay (Non-offending adult)

- Reassure
  - Your are safe here
  - You did the right thing by coming the ED

Take into account

- Patient's gender/identification
- Patient's age
- Patient's and family beliefs, culture….
  - Call for a trained hospital interpreter

# 1- Accueil and emotional support

## Be Emphatic



- Believe the child/adolescent
- Accept that the adolescent expectations may differ from our adult expectations
- Adapt your level of communication to the patient's level of understanding
- Listen first to promote emotion expressions
  - Doubts
  - Feeling of guiltiness
  - Anger

# Emotions

- The parents emotions
  - Assess parent's emotional state prior he/she meets their adolescent
  - Ask the Adolescent if she/he wish to see his/her mother/father
- The child /adolescent
  - Look beyond the apparent reaction
  - During this stressful situation the patient may be submissive, vindictive, inconsistent, too reasonable, etc.
  - Strive to read the reaction of the victim throughout the encounter
  - Recognize clumsy attempts to regain control of their life even when it though expression of anger
- Be in tune with your own emotions

# Presenting to the PED scenarios

- Prolong delay between SA and PED visit
- DYP signalization NOT already done
  - Brought by parent **Never take history in front of child and do not leave patient alone**
  - Alone (adolescent)
  - Brought by a teacher, group home worker, school counselor (parent aware or not)
- DYP signalization done
  - Brought by police immediately or after deposition
    - Take their report
  - Brought by DYP
    - Accompanied with adult

# 1- Accueil and Emotional Support How to start?

- Present yourself, your are part of a team
- Ask about the adolescent /parent expectation
- Explain
  - SA nurse role
  - Medical exam to note any injuries and ensure every thing is normal
  - Limit of the Trousse
- When a discomfort / uneasiness appear (patient or SA Nurse)
  - State with words the discomfort
- Explain the different steps
- Foster adolescent autonomy and decision making

# Ages 2-5 years, 6-9 years, 11 and older

# 2- Planning of the intervention



# Goal of Medico-legal/Medico-social kits

- Standardize the samples taken during the forensic examination
- Guarantee the integrity of samples and the chain of custody
- Collection of objective scientific evidence that can shed light on certain aspects of sexual assault
- Support the legal process of a victim of sexual assault who decides to file a complaint against his attacker

# Medico-legal kit (Trousse)



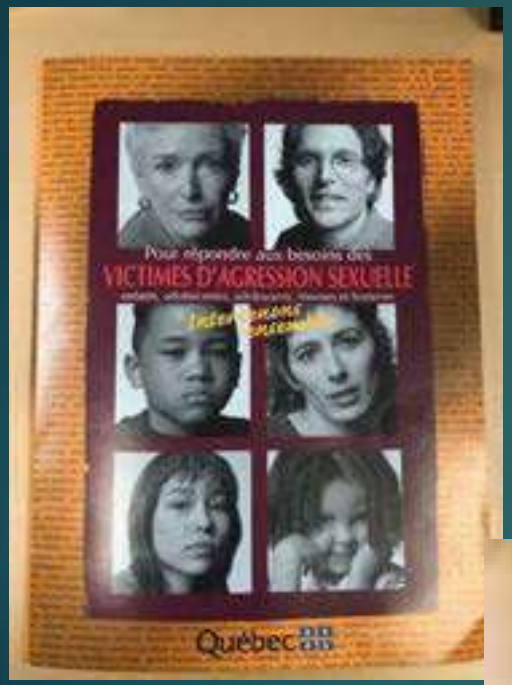
- Box containing material to collect the necessary forensic samples during the medico-legal examination
- Envelope containing 14 forms,
- Memory aid to guide the interventions.

# Medico-legal kit (Trousse)



- Contribute in the identification of the aggressor (DNA research)
- Corroborate the victims' statements

# Medico-social kit






- Envelope containing 11 of the same forms found in the medico-legal kit
- Memory aid to guide the interventions

# Lame de réserve






# Medico-legal kit versus Medico-Social kit?

# Medico-legal kit (Trousse)
# ALL 4 conditions are met

- The victim (≥ 14 years) or their legal guardian (< 14 years) provides consent to have a medico-legal exam done

  AND

- Based on the history, patient was in contact with assailant's DNA (sperm, blood, saliva)

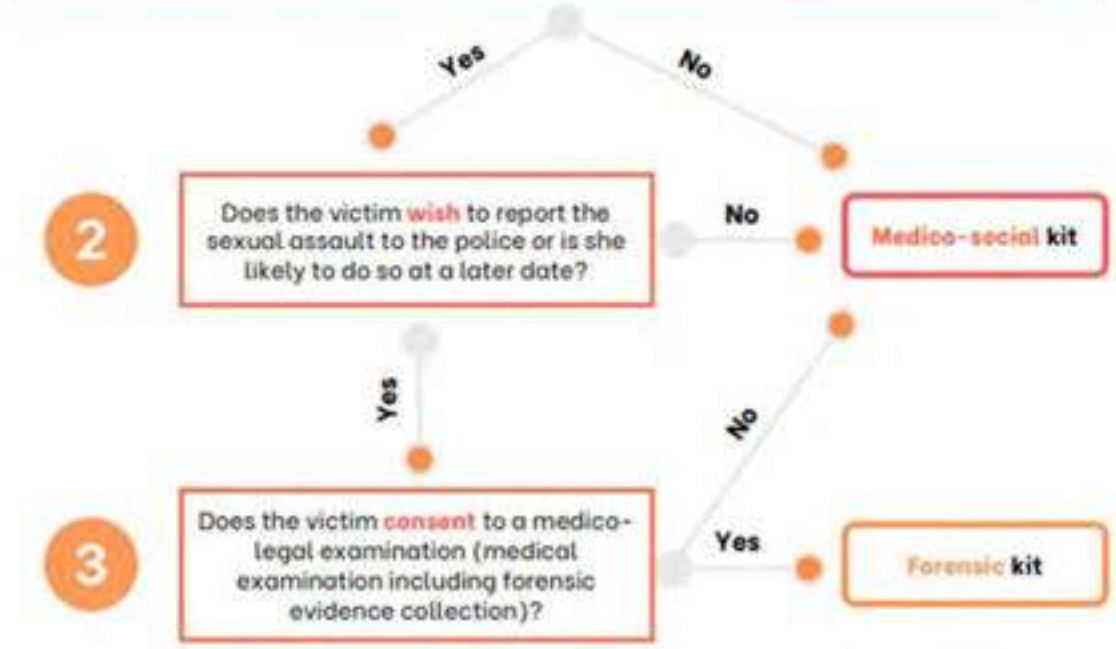
  AND

- The sexual abuse occurred within the previous 5 days for cases of vaginal penetration; ≤ 2 days for anal penetration; ≤ 2 days for samples from the surface of the body; ≤ 1 day for oral penetration

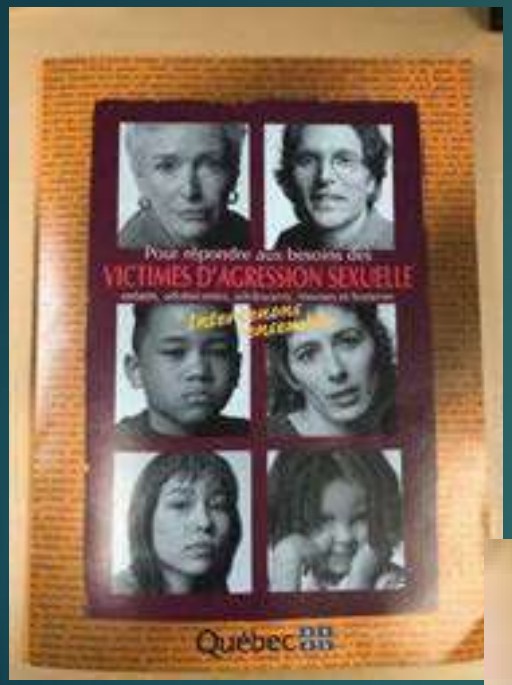
  AND

- A police report is filed, or is likely to be filed.

| Time elapsed since the sexual assault | 24 hrs or less | 48 hrs or less | 5 days or less | 6 days or more |
|---|---|---|---|---|
| Possible circumstances | • Oral penetration<br>• Blood, semen or saliva on the skin or hair<br>• Anal penetration<br>• Vaginal penetration<br>• Intoxication or memory loss<br>• Clothing or relevant objects | • Blood, semen or saliva on the skin or hair<br>• Anal penetration<br>• Vaginal penetration<br>• Intoxication or memory loss<br>• Clothing or relevant objects | • Vaginal penetration<br>• Intoxication or memory loss<br>• Clothing or relevant objects | • Clothing or relevant objects |



# Medico-social kit






- More than 5 days

Or

- No Medico-legal specimens (attouchement)
- Patient and/or parents do not whish to press charges

# Who can consent?



# Consent

- Less than 14 year old
  - Parent
  - Legal guardian
- 14 years and older
  - Adolescent
- DYP in exceptional cases, or judge court order

# 14- 17 year old - Adolescent Consent

- Children 14 to 17 can make decisions alone about care that is not necessary for their states of health
- Exception
  - Permission of a child's parents or tutor is required if the health care involves a serious risk to health and could cause serious and permanent side effects.
- Child interest when the parents or tutor of a child 14 to 17 years old make a decision about a child's health

Right to Refuse Care

- A child 14 to 17 can refuse any type of health care, either necessary or not necessary
- However, if the child's parents or tutor don't agree with the refusal, and want the child to receive the care anyway, they need a judge's permission.

# Consent
# How to establish sobriety?
## Est-ce que tu as pris de l'alcool ou de la drug contre ton gré?

- Judgment call, no written guidelines
- Slept it off, awake, alert, able to have a conversation
- Consentement libre et éclairé
  - Able to understand
  - Able to identify the pros and cons
  - Able to repeat in owns word what was proposed
- Ask physician collaboration if necessary

# Exceptions

Polytrauma/Coma

- Collect urine and blood for toxicology keep until patient can consent up to 14 days
- After 14 days patient still unconscious parental or legal guardian can consent

Intoxication

- Urine and blood samples for Toxicology and Legal purposes on hold
- When patient is sober can consent
- No gynecological or other sample can be collected

# 3 - Medico-social history taking



- Child less than 14 year old that disclosed SA
- Child less than 14 year old that did not disclosed SA
- Adolescent

# General Principles
# Less than 14 year old

- Interview PARENT ALONE
- Explain to parent importance of not reacting during child's interview and physical exam
- Confirm words used for genital parts
- Inform child that
  - No rush to answer questions
  - Not required to give an answer, to say if does not know
  - To tell if does not understand the question
  - There is no good or bad answer

# Less than 14 year old Aggression NOT disclosed

- Explain the presenting complaint
  - Your mom tells me that you have pain when you do pipi
- Ask general questions about school, friends
- Ask the child if there are
  - Abdominal pain, headache
  - Burning
  - Issue going to the bathroom….
- Explain that you will do a physical exam
- Observe patient's behavior verbal and non verbal

# Less than 14 year old
## Aggression disclosed

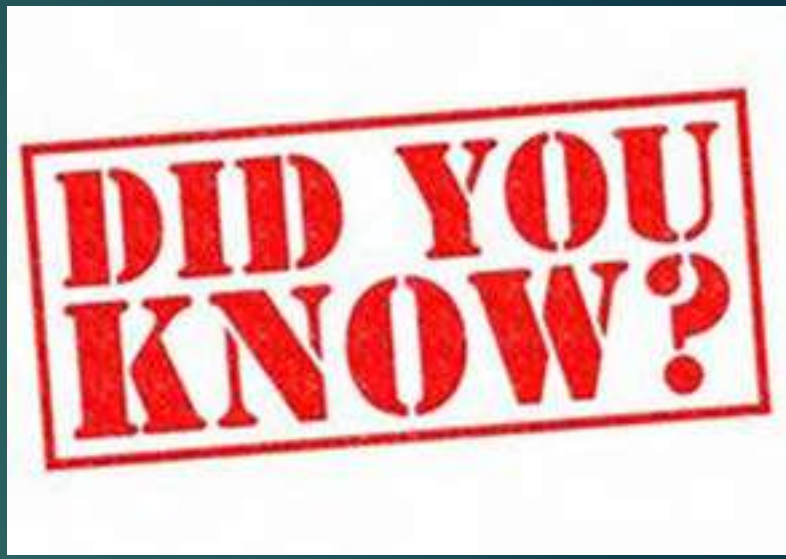
- Ask general questions about school,  friends
- Ask the child if there are
  - Abdominal pain, headache
  - Burning
  - Issue going to the bathroom….
- Confirm SA gesture
  - Your mom/dad told me that you were touched XYZ
  - Is that right?
  - Can your tell more?
  - Can ask direct questions

# 14 year old and older Adolescent

- See adolescent alone
  - Ask parents to leave
  - Ask confidential questions: sexually active, contraception, abortion…
  - Parents can come back if adolescent consents/ whishes

**NEVER interview Adolescent with BOYFRIEND/GIRLFRIEND**

# 4 - Medical and Medico-social exam, test, and specimen




Victims of SA have the right to refuse

a medical exam

a medico-social or a medico-legal exam

These examinations are not mandatory for the legal procedures

# 4 - Medical and Medico-social exam, test, and specimen

- Child presence of parent to support child
  - No speculum
  - Gynecological exam should not be painful or frightful
  - Parental disagreement or incest, it is preferable, if a third party is present, that it is neither the mother nor the father.
- Adolescent consent for parent presence
- Medical intervention
  - Search for visible traces of violence
  - Reassurance to adolescent/parent of normal anatomy
    - Most exam are non-specific

# 4 - Medical and Medico-social exam, test, and specimen

Medical exam consist:

- Physical exam
- Gynecologic or genitalia exam
- Specimen collection (ITSS)

Medico-legal exam consist:

- Physical exam
- Medico-legal specimen collection (blood test for DNA profile of aggressor

- NB. Any medical examination has a medico-legal value. The physician can ask to testify in court about his/her medical examination

# 4 - Medical and Medico-social exam, test, and specimen



- Offer “help” versus “control”
  - Explain what is going to happen
  - Offer the patient choices
- Use Patient’s coping methods
- Never use force or restraint
- Never use sedation (unless need operating room for medical treatment)
- Provide choice for SA survivor to regain control on owns life

# 4 - Medical and Medico-social exam, test, and specimen

## Medical Specimens

- ITSS
- B-HCG
- Toxicology

## Medico-legal Specimens

- DNA collection
- Lame de réserve

Physicians will chart that the absence of lesion does not prove that the there was no SA

# Medico-legal Specimens
# DNA collection from Blood, Saliva or Semen

Collect trace of Body fluids on

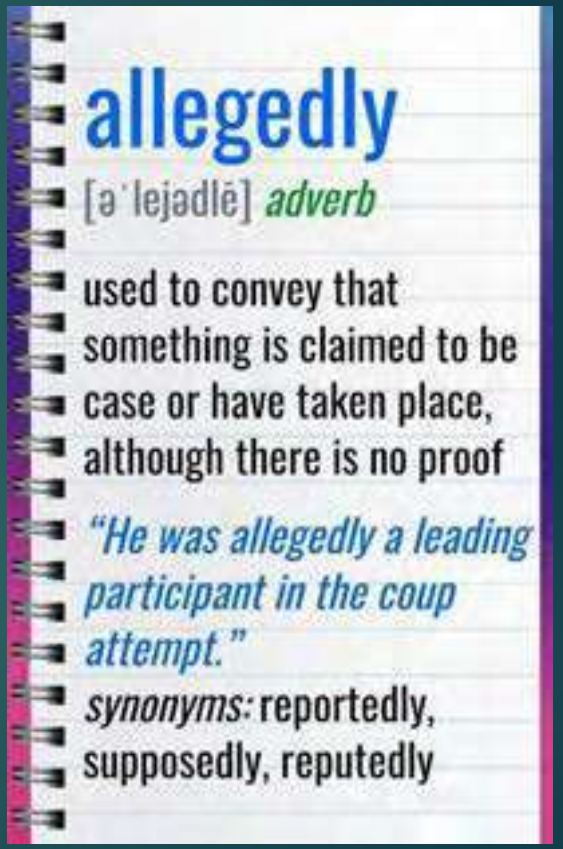
- Skin (under finger nails), Mouth, Genitals
- Clothing
- Foreign body




Fingers does not yield DNA

# Documentation

- Use Medico-legal documents
- Write as objectively as possible
  - No interpretations
- Spontaneous disclosure
  - Note the exact words of the child (verbatim)
  - Note the context child stated information
  - Note the name of the persons present during disclosure



DATE OF EXAMINATION

(If different from that entered on Form 1)

Information gathered from: (Check more than one box if necessary) ☐ the victim ☐ another person (specify): _____

**DESCRIPTION OF THE SEXUAL ASSAULT FOR THE PURPOSES OF THE FORENSIC EXAMINATION**

Year Month Day

**Date and time of the sexual assault** ▶

If more than one sexual assault occurred, **give the date and time of the last one.**

**Violence and physical constraints**

The victim was:

☐ Tied up ☐ Scratched ☐ Bitten ☐ Squeezed ☐ Other

☐ Burned ☐ Strangled ☐ Pushed ☐ Hair pulled

☐ Cut ☐ Hit ☐ Held in place

Object used: _____

**Aggressor(s)**

Number: _____ ☐ Not known Sex: ☐ M ☐ F Relationship to victim: _____

Injuries to the aggressor by the victim: ☐ Yes ☐ No ☐ Not known

If answer is yes, specify (bruise, cut, bite, etc.): _____

**For use only in exceptional situations.**
**Write down the exact words spoken spontaneously by the victim during the interview.**
**(Without giving a full account of the incident).**

**Fill in only if the victim:**

☐ is a young child

☐ has a severe or profound intellectual disability

☐ has significant memory problems

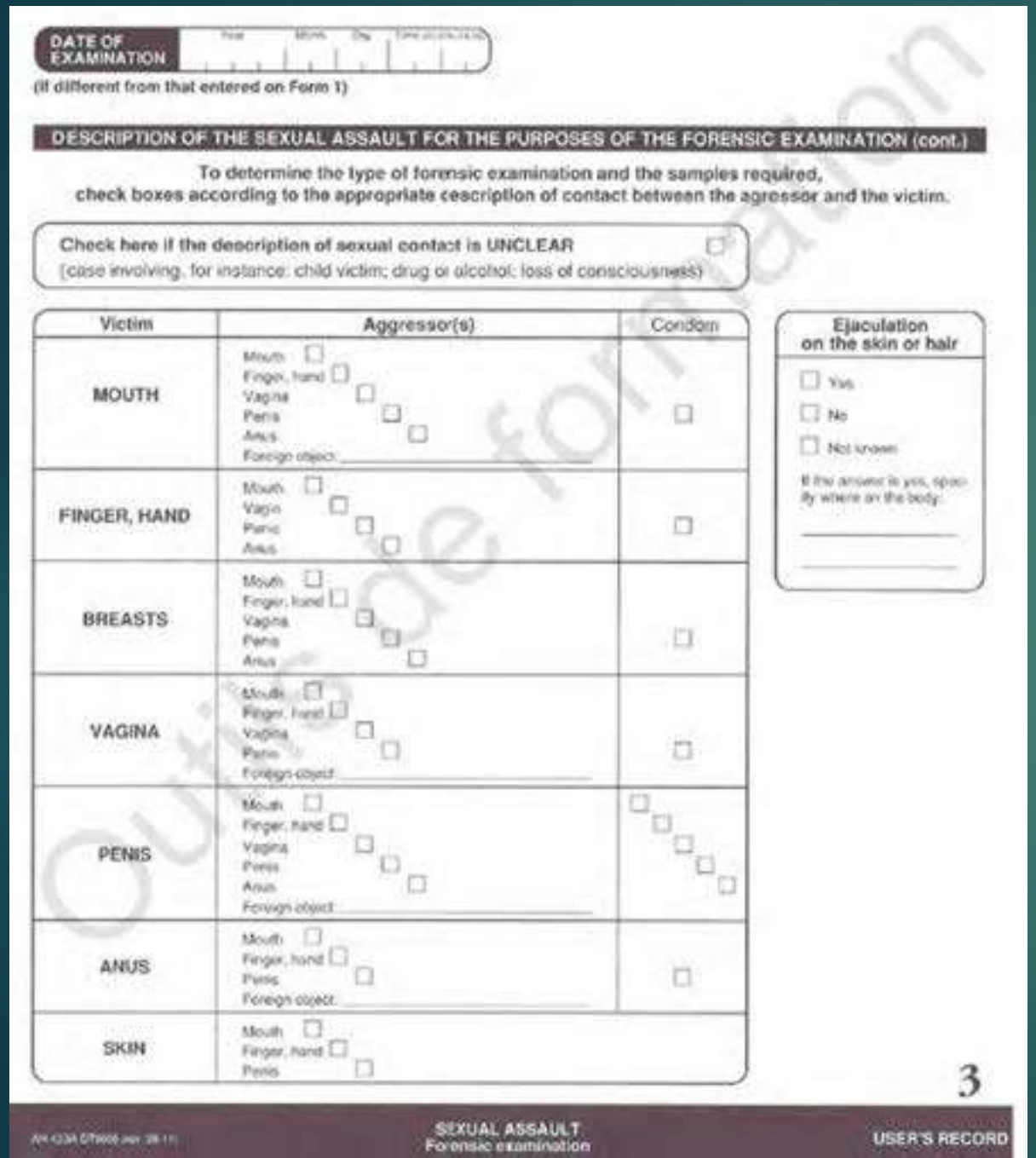
☐ is very seriously injured (life in danger)

2

SEXUAL ASSAULT

Guide de formation

*Notez les mots exacts de l'enfant, s'il y a révélation, noter les circonstances de la révélation et le nom des personnes présentes lors de la révélation*



DATE OF EXAMINATION (if different from that entered on Form 1)

**DESCRIPTION OF THE SEXUAL ASSAULT FOR THE PURPOSES OF THE FORENSIC EXAMINATION (cont.)**

To determine the type of forensic examination and the samples required, check boxes according to the appropriate description of contact between the aggressor and the victim.

Check here if the description of sexual contact is UNCLEAR ☐
(case involving, for instance: child victim; drug or alcohol; loss of consciousness)

| Victim | Aggressor(s) | Condom |
|---|---|---|
| MOUTH | Mouth ☐ Finger, hand ☐ Vagina ☐ Penis ☐ Anus ☐ Foreign object: | ☐ |
| FINGER, HAND | Mouth ☐ Vagina ☐ Penis ☐ Anus ☐ | ☐ |
| BREASTS | Mouth ☐ Finger, hand ☐ Vagina ☐ Penis ☐ Anus ☐ | ☐ |
| VAGINA | Mouth ☐ Finger, hand ☐ Vagina ☐ Penis ☐ Foreign object: | ☐ |
| PENIS | Mouth ☐ Finger, hand ☐ Vagina ☐ Penis ☐ Anus ☐ Foreign object: | ☐ |
| ANUS | Mouth ☐ Finger, hand ☐ Penis ☐ Foreign object: | ☐ |
| SKIN | Mouth ☐ Finger, hand ☐ Penis ☐ | |

**Ejaculation on the skin or hair**

☐ Yes
☐ No
☐ Not known

If the answer is yes, specify where on the body:

3

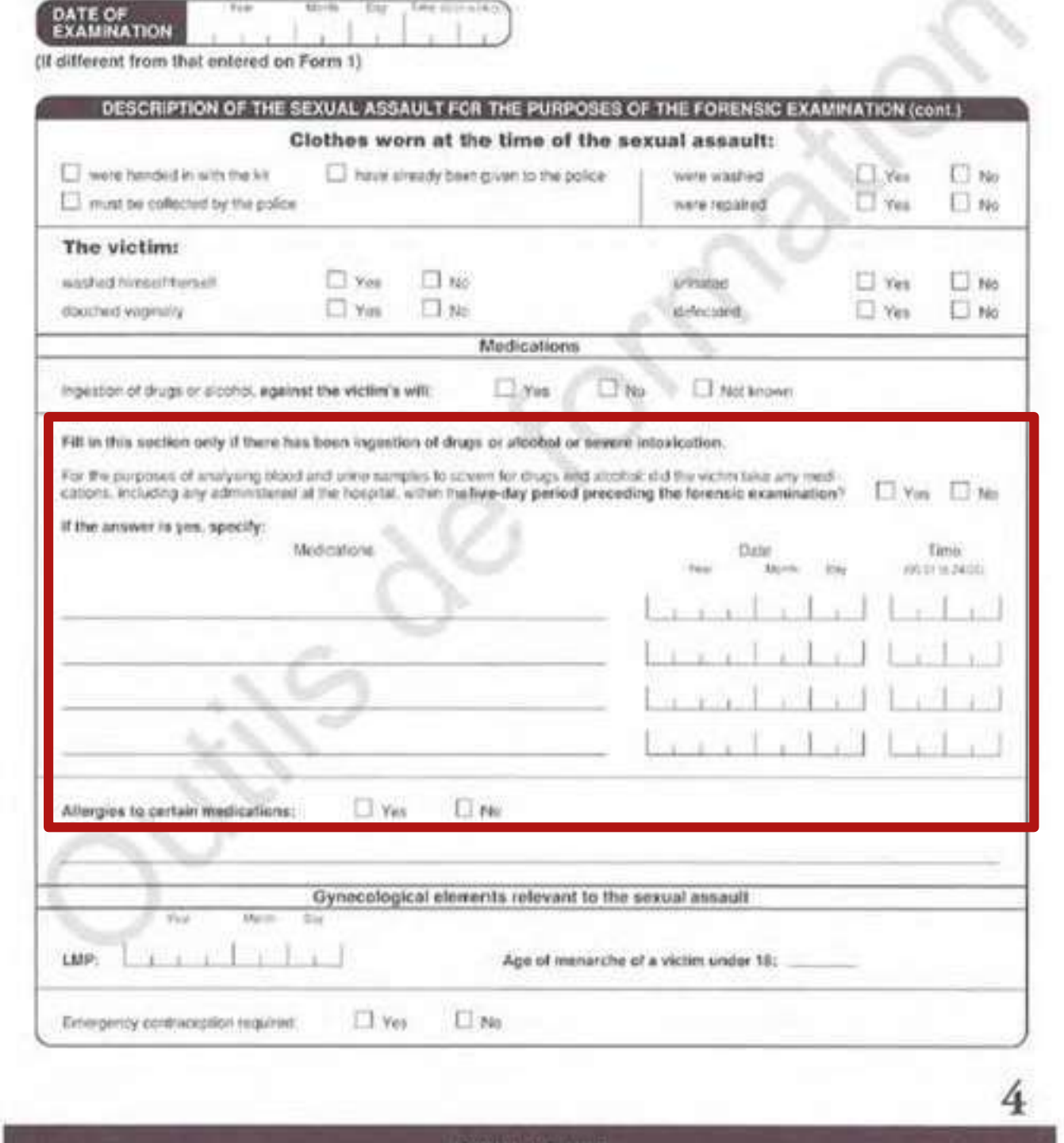
SEXUAL ASSAULT
Forensic examination

USER'S RECORD

Outside formation

If not clear
Column Victim, column Aggressor
This grid will help you determine what specimens must be collected

Link with Form #9


DATE OF EXAMINATION

(If different from that entered on Form 1)

DESCRIPTION OF THE SEXUAL ASSAULT FOR THE PURPOSES OF THE FORENSIC EXAMINATION (cont.)

Clothes worn at the time of the sexual assault:

☐ were handed in with the kit ☐ have already been given to the police
☐ must be collected by the police

were washed ☐ Yes ☐ No
were repaired ☐ Yes ☐ No

The victim:

washed himself/herself ☐ Yes ☐ No
douched vaginally ☐ Yes ☐ No
urinated ☐ Yes ☐ No
defecated ☐ Yes ☐ No

Medications

Ingestion of drugs or alcohol, against the victim's will: ☐ Yes ☐ No ☐ Not known

Fill in this section only if there has been ingestion of drugs or alcohol or severe intoxication.

For the purposes of analysing blood and urine samples to screen for drugs and alcohol, did the victim take any medications, including any administered at the hospital, within the five-day period preceding the forensic examination? ☐ Yes ☐ No

If the answer is yes, specify:

Medications | Date (Year, Month, Day) | Time

Allergies to certain medications: ☐ Yes ☐ No

Gynecological elements relevant to the sexual assault

LMP: (Year, Month, Day) Age of menarche of a victim under 18:

Emergency contraception required: ☐ Yes ☐ No

4

## Any Voluntary or Involuntary ingestion of:

- Alcohol, Medications (prescribed or over the counter)
- Medication administered at the hospital
- Illicit drugs (cocaine, pot, ….)

DATE OF EXAMINATION

(If different from that entered on Form 1)

## DESCRIPTION OF THE SEXUAL ASSAULT FOR THE PURPOSES OF THE FORENSIC EXAMINATION (cont.)

### Sexual activity within the five-day period preceding the forensic examination

*For the purposes of identifying the aggressor(s) using genetic profiles:*
Did the victim have sexual intercourse (oral, vaginal or anal), involving possible ejaculation with persons other than the assailant(s) within the **five-day period preceding the forensic examination?**

☐ Yes ☐ No

If so, the last occasion was: Year Month Day Time (24 hr clock)

Use of: ☐ Condom ☐ Lubricant ☐ Spermicide ☐ Diaphragm

☐ Other (specify):

### Relevant physical symptoms during and after the sexual assault
**(If the symptoms are related to relevant past history, describe past history**

## PHYSICAL EXAMINATION

| BP | Pulse | Height | Weight |
|---|---|---|---|
| | | | |

| Observations | Normal | | Specify type and site of injuries on anatomic diagrams |
|---|---|---|---|
| | Yes | No | |
| Head and face | | | |
| Mouth and throat | | | |
| Neck | | | |
| Breasts (inspection only if not routinely done) | | | |
| Heart and lungs | | | |
| Chest and back | | | |
| Abdomen | | | |
| Limbs | | | |

### For children and adolescents:

Persons present during the examination (name and relationship to the victim):

Stage of sexual maturation (Tanner): 1 2 3 4 5

Reactions during the examination, if relevant:

5



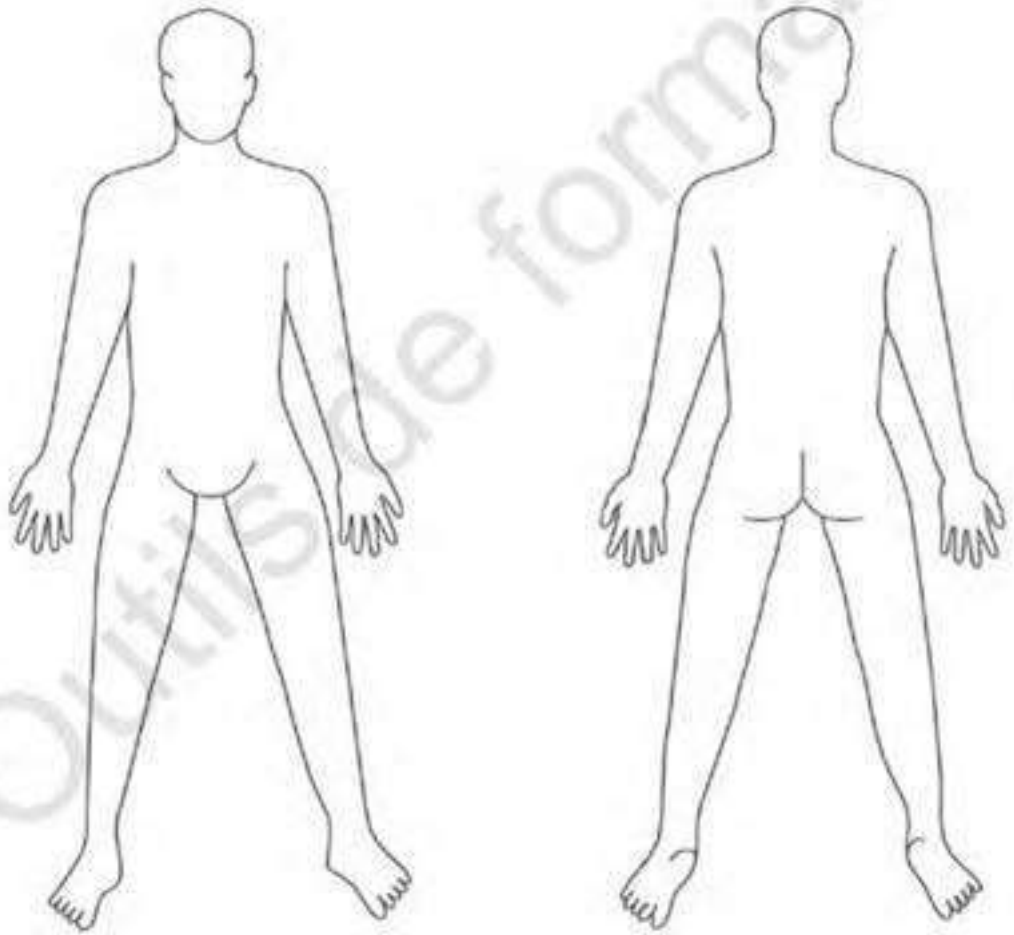
Online information

DATE OF EXAMINATION

(If different from that entered on Form 1)

**ASEXUAL ANATOMIC DIAGRAMS (CHILD AND ADULT) – Indicate the site of injuries described in Form 5**

Complete the breast line for a female victim.

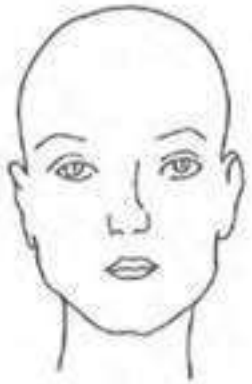


Outil de formation

DATE OF EXAMINATION

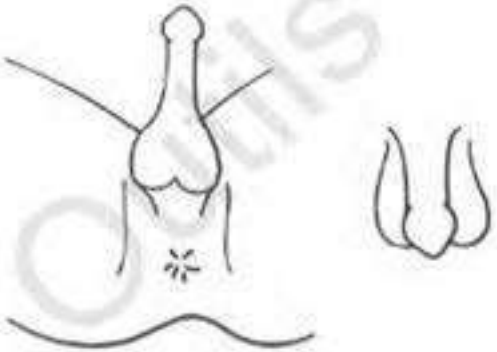
(If different from that entered on Form 1)

**ASEXUAL ANATOMIC DIAGRAMS (CHILD AND ADULT) – Indicate the site of injuries described in Form 5**





**ASEXUAL ANATOMIC DIAGRAMS (CHILD AND ADULT) – Indicate the site of injuries described in Form 5**



**Positions during examination**

☐ Knee chest

☐ Other: _____

| | Normal | | Specify type and site of injuries on anatomic diagrams |
|---|---|---|---|
| | Yes | No | |
| Urethra | | | |
| Prepuce | | | |
| Glans | | | |
| Penis | | | |
| Scrotum | | | |
| Anus | | | |

Outils de formation

DATE OF EXAMINATION (Year / Month / Day / Time (use 24 hours))

(if different from that entered on Form 1)

## ANATOMIC DIAGRAMS (PRE-PUBERTAL FEMALE, ADOLESCENT FEMALE, AND ADULT FEMALE)

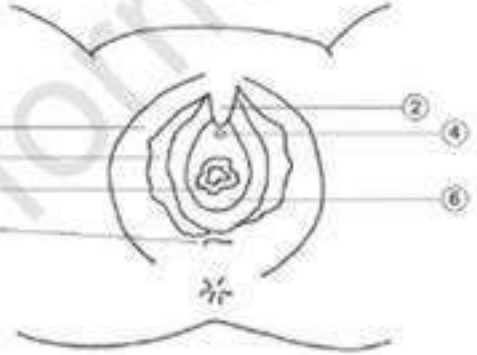
**Positions during examination**

☐ Supine with stirrups ☐ Frog leg ☐ Knee-chest ☐ Other: _____

PREPUBESCENT




ADOLESCENT AND ADULT







| | Normal | | Specify type and site of injuries on anatomic diagrams |
|---|---|---|---|
| | Yes | No | |
| (1) Labia majora | | | |
| (2) Clitoris | | | |
| (3) Labia minora | | | |
| (4) Urethra | | | |
| (5) Hymen | | | |
| (6) Fourchette | | | |
| (7) Perineum | | | |
| Anus | | | |
| **Adolescent or adult, if penetration** | | | |
| Vagina | | | |
| Cervix | | | |
| Uterus and adnexa (examination is not routine) | | | |

Ons deformation

DATE OF EXAMINATION

(if different from that entered on Form 1)

◆ ONLY TAKE THE NECESSARY SAMPLES

| Site | Circumstances | TYPES OF SPECIMENS (check those taken) Specimens for the laboratory of the designated centre | DNA and other specimens for the Forensic Laboratory |
|---|---|---|---|
| ORAL | No fellatio | | 1A ☐ Oral specimen: use two swabs, one for each cheek, rub for about 15 seconds for each swab; let dry. |
| | Fellatio | ☐ Chlamydia ☐ Gonorrhea | 2A ☐ Rinse mouth with 15 ml of physiological serum. Collect in the small bottle with the blue cap in the kit.<br>2B ☐ After two or three washes, take further specimens with swabs as described at point 1A. |
| ANAL | If penetration (before VAGINAL) | ☐ Chlamydia ☐ Gonorrhea<br>☐ Routine cultures (if symptoms) | 2E, 2F ☐ Detection of sperm: take sample with a swab and smear on a slide; let dry before enclosing in envelope. |
| VAGINA AND CERVIX | If penetration | ☐ Chlamydia (NAAT) ☐ Gonorrhea<br>☐ Routine cultures ☐ Pap test<br>☐ Trichomonas | 1B ☐ Two swabs (see 1C); let dry.<br>1C ☐ One slide with a blue edge (one drop of physiological serum and vaginal secretions from area swab at 1B); let dry without fixation. |
| | | ☐ Additional DNA slide (To be preserved at the designated centre) | 1D ☐ Vaginal douche: introduce 10 ml of physiological serum and aspirate the greatest quantity possible. |
| PENIS AND URETHRA | | ☐ Chlamydia ☐ Gonorrhea<br>(Do not do these on the urine) | 2GI ☐ Bite, saliva or sperm from the aggressor on victim's penis: wipe first with a moist swab, then with a dry swab; keep both.<br>N.B. Indicate sperm or saliva on Form 10. |
| CUTANEOUS | If saliva or sperm stains, or bites | | 2GI ☐ and 2GII ☐<br>Bite, saliva or sperm on vulva, anus or elsewhere: wipe first with a moist swab, then with a dry swab; keep both.<br>N.B. Indicate sperm or saliva on Form 10. |
| FOREIGN OBJECTS | SANITARY NAPKINS OR TAMPONS | | 2D ☐ Fibre, body hair, nail clippings if relevant, etc.: put sample in the envelope provided in the kit.<br>Put sanitary napkins or tampons in the white bag marked for this purpose. |
| BLOOD | | ☐ Alcohol or drugs ☐ HCG<br>☐ Syphilis ☐ VIH<br>Hepatitis: ☐ A ☐ B (Ac/Ag) ☐ C | 1E ☐ Genetic profile (DNA), detection of alcohol or drugs.<br>Take 5 ml to 10 ml of blood. |
| URINE | | ☐ Alcohol or drugs ☐ HCG<br>☐ Chlamydia ☐ Gonorrhea | 2G ☐ Detection of alcohol or drugs. Take 20 ml to 50 ml of urine. |
| CLOTHING (including diapers) | | | 3A ☐ B, C, D, E<br>Stained or torn clothes: place articles in separate paper bags; identify contents on the application. |

**DATE OF EXAMINATION** Year | Month | Day | Time (00:01 to 24:00)

(If different from that entered on Form 1)

**IMPORTANT** → AD- AFFIX SELF-ADHESIVE LABEL – SAMPLES – on each of the 4 copies of Form 10 (see Form 13)

## REMEMBER

- To avoid all contamination, put the urine container and the mouth wash container in the polythene bag identified for this purpose.
- Identify specimens using the self-adhesive labels in the kit.
- Write your initials on each label used.
- Put all unused material, in its original condition, back into the kit.
- Put samples in kit.
- Put small clothes in the paper bags, and then put the paper bags in the kit.
- Put larger clothes in the paper bags, and then put the paper bags in the large bag and seal it.
- Seal the kit, write your initials on the seal, and destroy unused seals.

**SAMPLES**

**Basic forensic evidence kit**

| | | Done | Not done |
|---|---|---|---|
| 1A | Oral | ☐ | ☐ |
| 1B | Vaginal swabs | ☐ | ☐ |
| 1C | Vaginal slide | ☐ | ☐ |
| 1D | Vaginal douche | ☐ | ☐ |
| 1E | Blood | ☐ | ☐ |

**Toxicological analysis**

Detection of drugs or alcohol ☐ Yes ☐ No

**Additional material (as needed)**

| | | Done | Not done |
|---|---|---|---|
| 2A | Mouth rinse | ☐ | ☐ |
| 2B | Oral swabs (if fellatio) | ☐ | ☐ |
| 2CI | Cutaneous, if detecting: ☐ sperm ☐ saliva | ☐ | ☐ |
| | Site _____ | | |
| 2CII | Cutaneous, if testing for: ☐ sperm ☐ saliva | ☐ | ☐ |
| | Site _____ | | |
| 2D | Foreign objects | ☐ | ☐ |
| 2E | Anal swabs | ☐ | ☐ |
| 2F | Anal slide | ☐ | ☐ |
| 2G | Urine | ☐ | ☐ |

| | | | |
|---|---|---|---|
| 3 CLOTHING | 3A | 3B | 3C |
| | 3D | 3E | 4 Other |



Outils de formation

**DATE OF EXAMINATION** Year / Month / Day / Time (24 h)

(If different from that entered on Form 1)

## FORENSIC INTERVENTIONS

Write your initials in the appropriate boxes

| Intervention | Physician(s) | Nurse(s) | Psychosocial worker(s) | Other(s) |
|---|---|---|---|---|
| Medical examination | | | | |
| Taking forensic specimens | | | | |
| Manipulate and identify the additional slide, and preserve it at the designated centre | | | | |
| Manipulation and identification of blood sample | | | | |
| Manipulation and identification of urine sample | | | | |
| Manipulation and identification of other samples | | | | |
| Sealing kit | | | | |
| Manipulation and identification of clothing | | | | |

## INTERVENTIONS, TREATMENTS AND CARE

Additional interventions, tests, samples or examinations

- ☐ • Medical imaging
- ☐ • Sutures
- ☐ • Consultation: _____
- ☐ • Other: _____

### Care and treatment

- ☐ • Emergency contraception
- ☐ • Hepatitis B vaccine
- ☐ • Tetanus vaccine
- ☐ • Hepatitis B immunoglobulin
- ☐ • Antibiotic _____
- ☐ • Other: _____

☐ CVC (crime victims compensation) ☐ CSST

## MANDATORY REPORTING TO THE DIRECTOR OF YOUTH PROTECTION FOR YOUTH UNDER 18

Name of person who took the report

## IDENTIFICATION OF CASE WORKERS

**Physician**

| Name (in block letters) | Signature | Initials | Permit No. | Telephone No. |
|---|---|---|---|---|
| | | | | |

**Nurse**

| Name (in block letters) | Signature | Initials | Telephone No. |
|---|---|---|---|
| | | | |

**Psychosocial worker**

| Name (in block letters) | Signature | Initials | Telephone No. |
|---|---|---|---|
| | | | |

**Other**

| Specify your occupation | Name (in block letters) | Signature | Initials | Telephone No. |
|---|---|---|---|---|
| | | | | |



Guide de formation

**DATE OF EXAMINATION** Year Month Day Time

(If different from that entered on Form 1)

**HANDING IN OF FORENSIC EVIDENCE KIT OR OF THE MEDICAL/SOCIAL RECORDS KIT**

| | | | | |
|---|---|---|---|---|
| Case worker handing in kit | Name (in block letters) | | Signature | Telephone No. |
| Police officer receiving kit | Name (in block letters) | | Signature | Telephone No. |
| | Badge No. | Police force file No. | Date | Year Month Day Time |

**PRESERVATION OF FORENSIC EVIDENCE KIT**

If the person examined did not consent to having the forensic evidence kit given immediately to the police, it will be preserved in a refrigerator to which access is controlled.

**Unless otherwise agreed with the victim, the samples will be destroyed after a maximum period of 14 days.**

| Deadline for destruction of kit | Kit seal No. |
|---|---|
| Year Month Day | AD- |

12

SEXUAL ASSAULT
Forensic examination

USER'S RECORD

***Give detachable portion to the person examined***

**INFORMATION CONCERNING THE PRESERVATION OF THE FORENSIC EVIDENCE KIT**

Not applicable ☐

You must contact the social worker to:

- inform him or her of your decision to have the forensic evidence kit given to the police and make an appointment to sign the consent form for that purpose.

Before: Year Month Day

Name of the person to contact | Telephone No.

After the above date, the samples in the forensic evidence kit will be destroyed unless otherwise agreed with the victim.
The forms will remain in the medical file, however.

**INFORMATION AND FOLLOW-UP**

If you have any questions or concerns, you can contact:

| Name (in block letters) | Telephone No. |
|---|---|
| Name (in block letters) | Telephone No. |

Additional information concerning medical or psychosocial follow-up:

Medical follow-up

Psychosocial follow-up



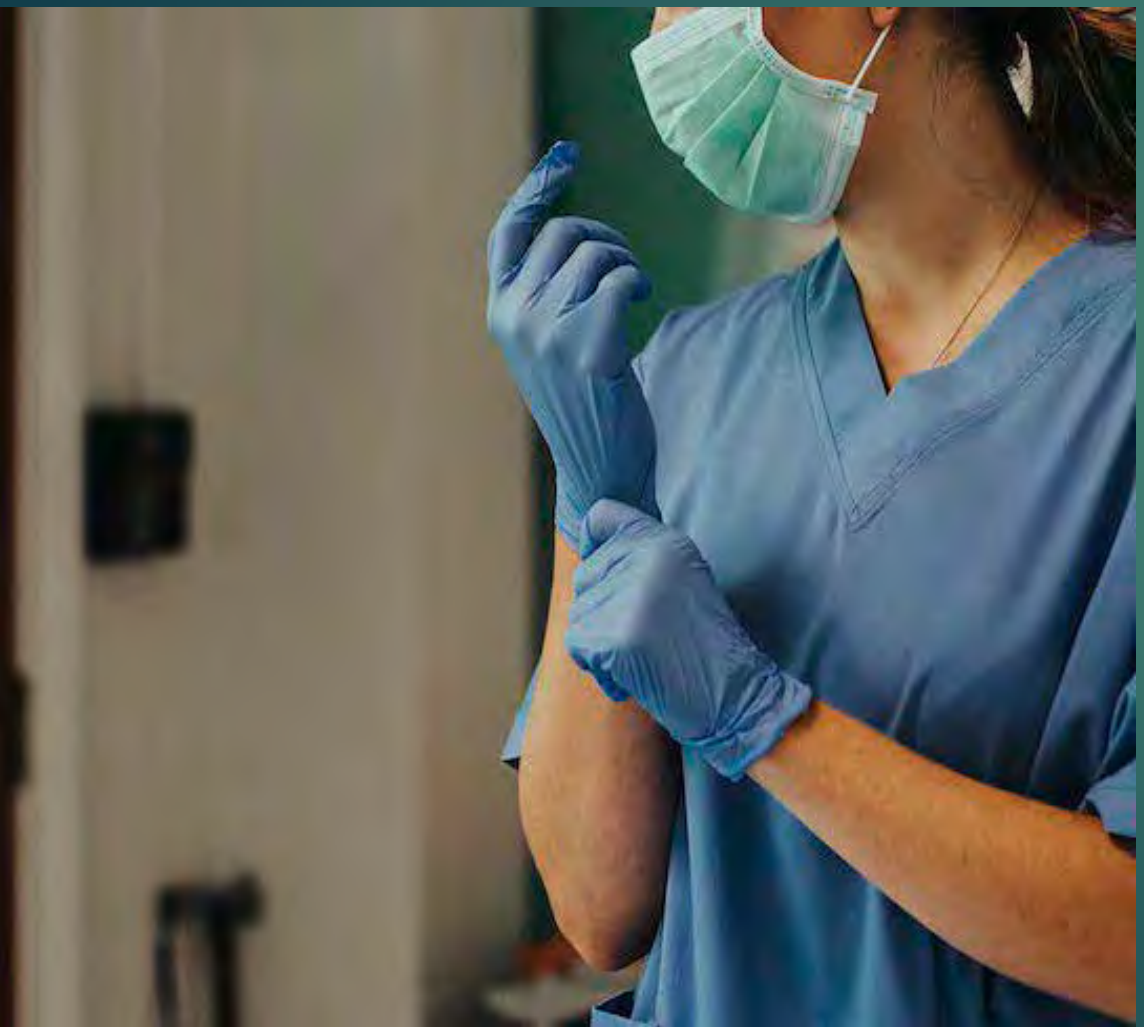

# Can the Medical exam prove the SA?

THE MEDICAL EXAM CONTRIBUTE TO THE VALIDATION OF FACTS

WHEN ARE THE RESULTS AVAILABLE (MONTHS)


Collect
Evidences

# 4 – Evidences collection



## Prevent contamination

- Disinfect surface
- Cover with paper
- Wear Gloves and mask

## Prevent tempering

- Never leave specimen box unattended
- Lock incomplete trousse in fridge
- Do not use self-swabs
- Wait at bathroom door for urine specimen

# Chain of Custody



Chronological legal paper trail

Indicates

- Collection
- Custody
- Control
- Transfer
- Analysis
- Disposition

of physical or electronic evidence

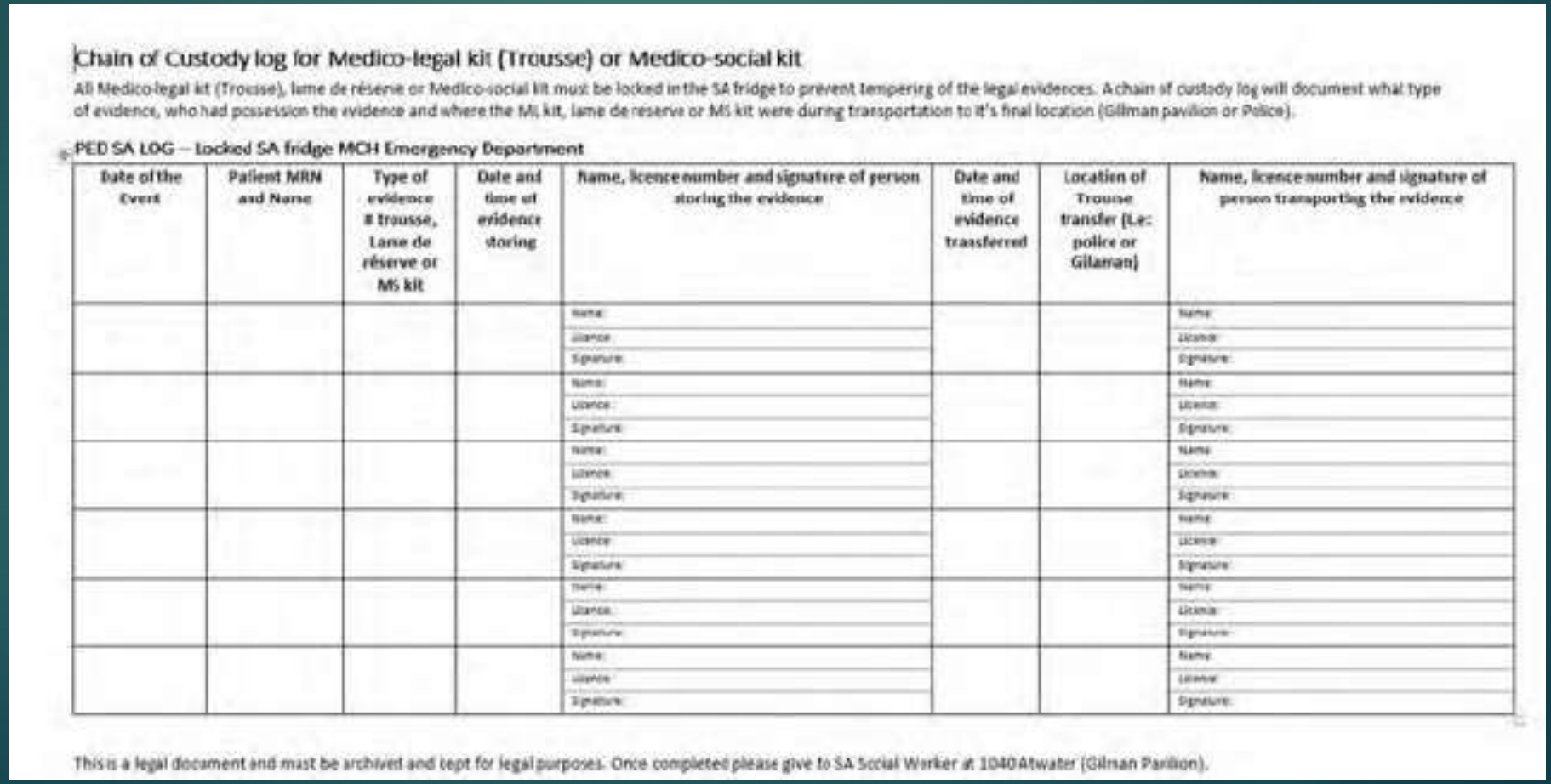
# Locked SA Fridge



Kept in Green Narcotic cupboard



# Chain of Custody log for Medico-legal kit, Medico-social envelop and Lame de réserve



Chain of Custody log for Medico-legal kit (Trousse) or Medico-social kit

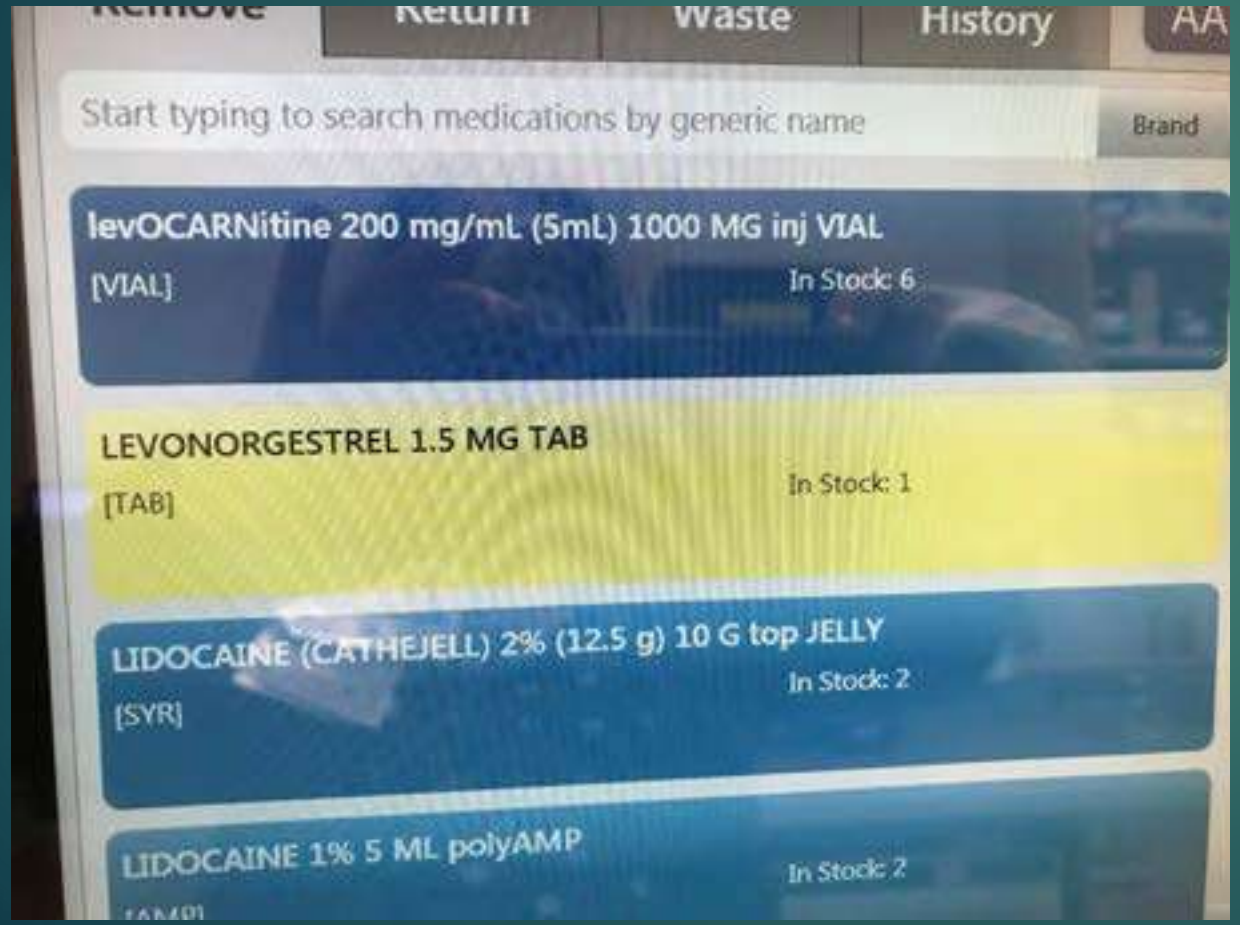
All Medico-legal kit (Trousse), lame de réserve or Medico-social kit must be locked in the SA fridge to prevent tempering of the legal evidences. A chain of custody log will document what type of evidence, who had possession the evidence and where the ML kit, lame de reserve or MS kit were during transportation to it's final location (Gillman pavilion or Police).

PED SA LOG – Locked SA fridge MCH Emergency Department

| Date of the Event | Patient MRN and Name | Type of evidence # trousse, Lame de réserve or MS kit | Date and time of evidence storing | Name, licence number and signature of person storing the evidence | Date and time of evidence transferred | Location of Trousse transfer (i.e: police or Gilaman) | Name, licence number and signature of person transporting the evidence |
|---|---|---|---|---|---|---|---|
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |
| | | | | Name:<br>Licence:<br>Signature: | | | Name:<br>Licence:<br>Signature: |

This is a legal document and must be archived and kept for legal purposes. Once completed please give to SA Social Worker at 1040 Atwater (Gilman Pavilion).

# 5 – Medical / Nursing Interventions
# Emergency contraception

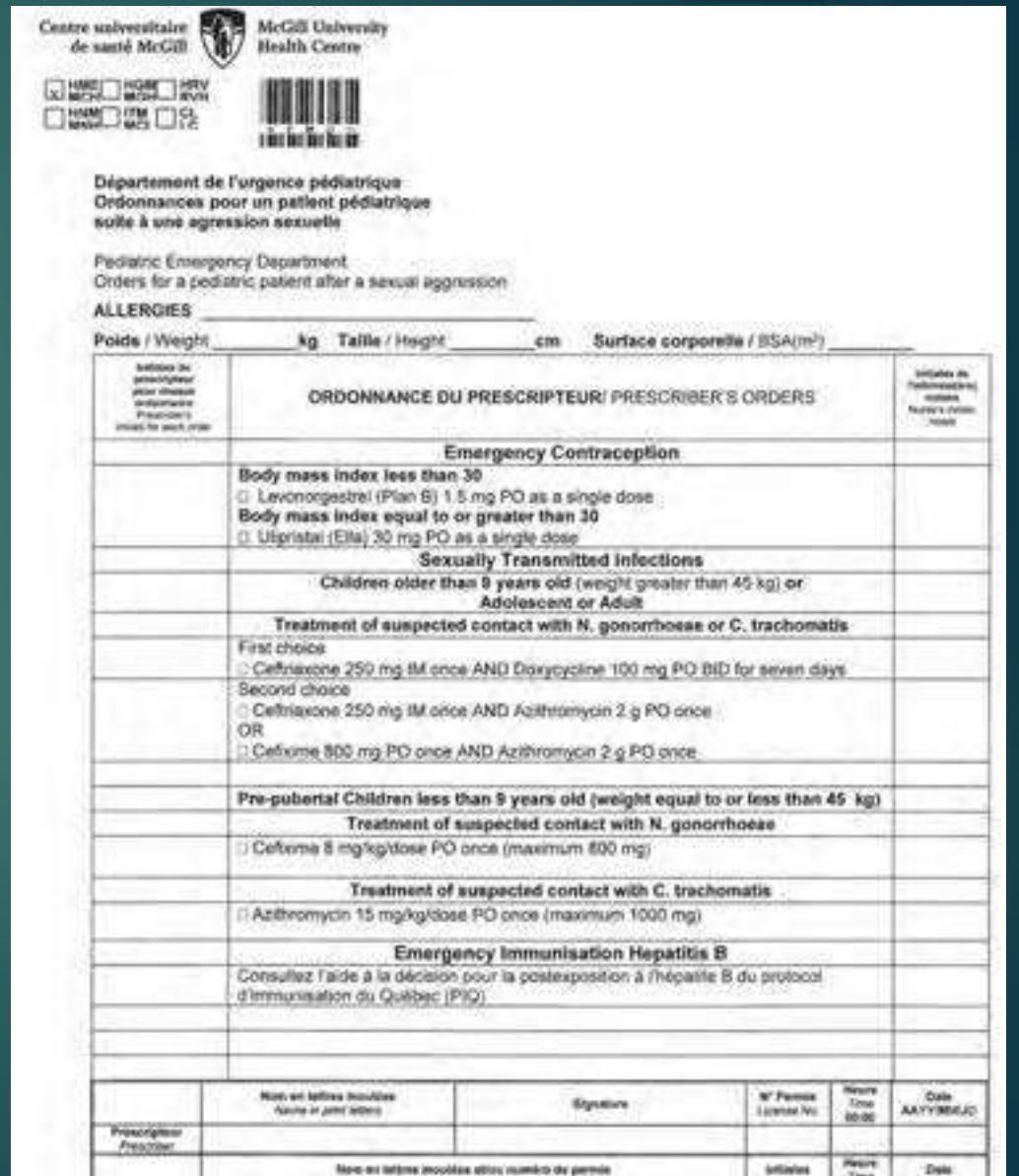





# Prevention of Sexually Transmitted Infection

- Chlamydia
- Gonorrhea
- Hepatitis B
- HIV



Centre universitaire de santé McGill
McGill University Health Centre

**Département de l'urgence pédiatrique**
**Ordonnances pour un patient pédiatrique suite à une agression sexuelle**

Pediatric Emergency Department
Orders for a pediatric patient after a sexual aggression

**ALLERGIES** _____

**Poids** / Weight _____ **kg** **Taille** / Height _____ **cm** **Surface corporelle** / BSA(m²) _____

| | **ORDONNANCE DU PRESCRIPTEUR/** PRESCRIBER'S ORDERS | |
|---|---|---|
| | **Emergency Contraception** | |
| | **Body mass index less than 30**<br>☐ Levonorgestrel (Plan B) 1.5 mg PO as a single dose<br>**Body mass index equal to or greater than 30**<br>☐ Ulipristal (Ella) 30 mg PO as a single dose | |
| | **Sexually Transmitted Infections** | |
| | **Children older than 9 years old** (weight greater than 45 kg) **or Adolescent or Adult** | |
| | **Treatment of suspected contact with N. gonorrhoeae or C. trachomatis** | |
| | First choice<br>☐ Ceftriaxone 250 mg IM once AND Doxycycline 100 mg PO BID for seven days | |
| | Second choice<br>☐ Ceftriaxone 250 mg IM once AND Azithromycin 2 g PO once<br>OR<br>☐ Cefixime 800 mg PO once AND Azithromycin 2 g PO once | |
| | | |
| | **Pre-pubertal Children less than 9 years old (weight equal to or less than 45 kg)** | |
| | **Treatment of suspected contact with N. gonorrhoeae** | |
| | ☐ Cefixime 8 mg/kg/dose PO once (maximum 800 mg) | |
| | **Treatment of suspected contact with C. trachomatis** | |
| | ☐ Azithromycin 15 mg/kg/dose PO once (maximum 1000 mg) | |
| | **Emergency Immunisation Hepatitis B** | |
| | Consultez l'aide à la décision pour la postexposition à l'hépatite B du protocol d'immunisation du Québec (PIQ) | |

| | Nom en lettres moulées / Name in print letters | Signature | N° Permis / License No. | Heure / Time 00:00 | Date AA/YY/MM/JJ |
|---|---|---|---|---|---|
| Prescripteur / Prescriber | | | | | |
| | Nom en lettres moulées et/ou numéro de permis | | Initiales | Heure / Time | Date |

Step 6
Information and support
DYP signalization
Dénonciation to the police
Reference/consult to SA clinic

# Interventions to mitigate SA effects

**Providing tangible aid**

- Assess safety: physical and emotional safety
- Clarification about misconception about sexual assault myths
  - victim cannot being blame for the assault
  - Sexual consent is freely given, reversible, informed and specific
- Foster person's control over the situation
  - You decide what you think is best for you

# Step 6 – Information & Support

Provide information about SA clinic follow up

- Next appointment in 3 weeks
- Evaluation SA team
- Help filling CAVAC application



# Step 6 Protect - Assess Home Safety

Can patient be safely discharge home with parents?

- Does the aggressor live in the same household?
- Is the contact between the child and the aggressor avoided?
- Do the parents blame the child for the SA?
- Are the parents inadequate?
- Are the parents protecting the child or the adolescent?
- Is the adolescent behaving dangerously?

# Step 6 Protect – DYP signalization

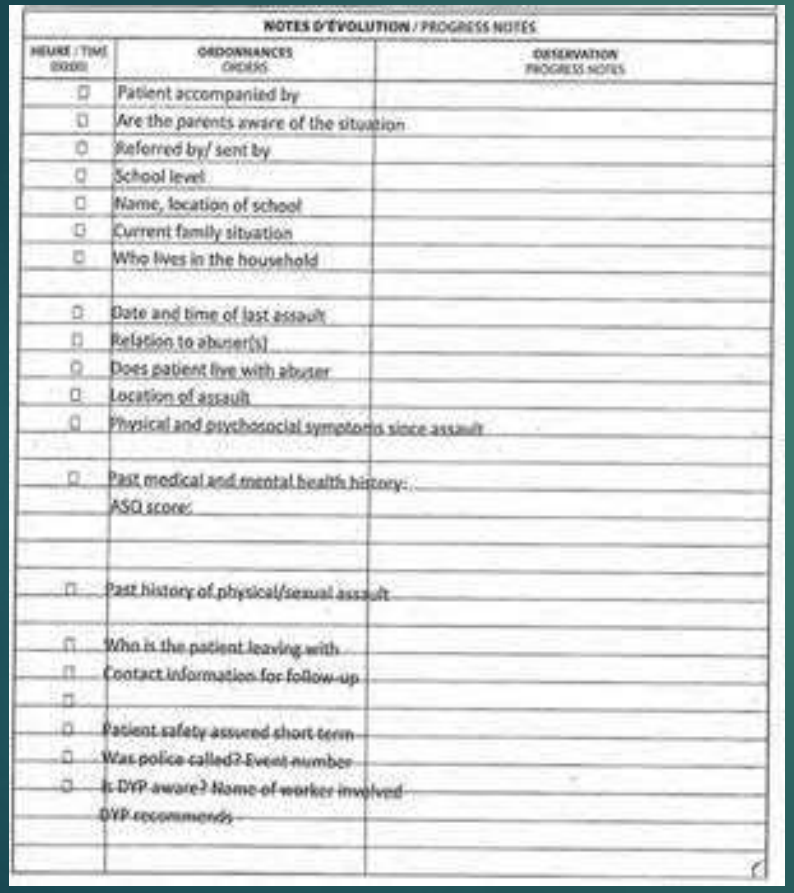
All situations believed to involve sexual or physical abuse of a child must be reported to the DYP, regardless of the perpetrator and the steps taken by the child's parents.



# Question to assess safety

- Does the aggressor live in the same household?
- Is the contact between the child and the aggressor avoided?
- Do the parents blame the child for the SA?
- Are the parents inadequate?
- Are the parents protecting the child or the adolescent?
- Is the adolescent behaving dangerously?

# Information to gather for DYP signalization



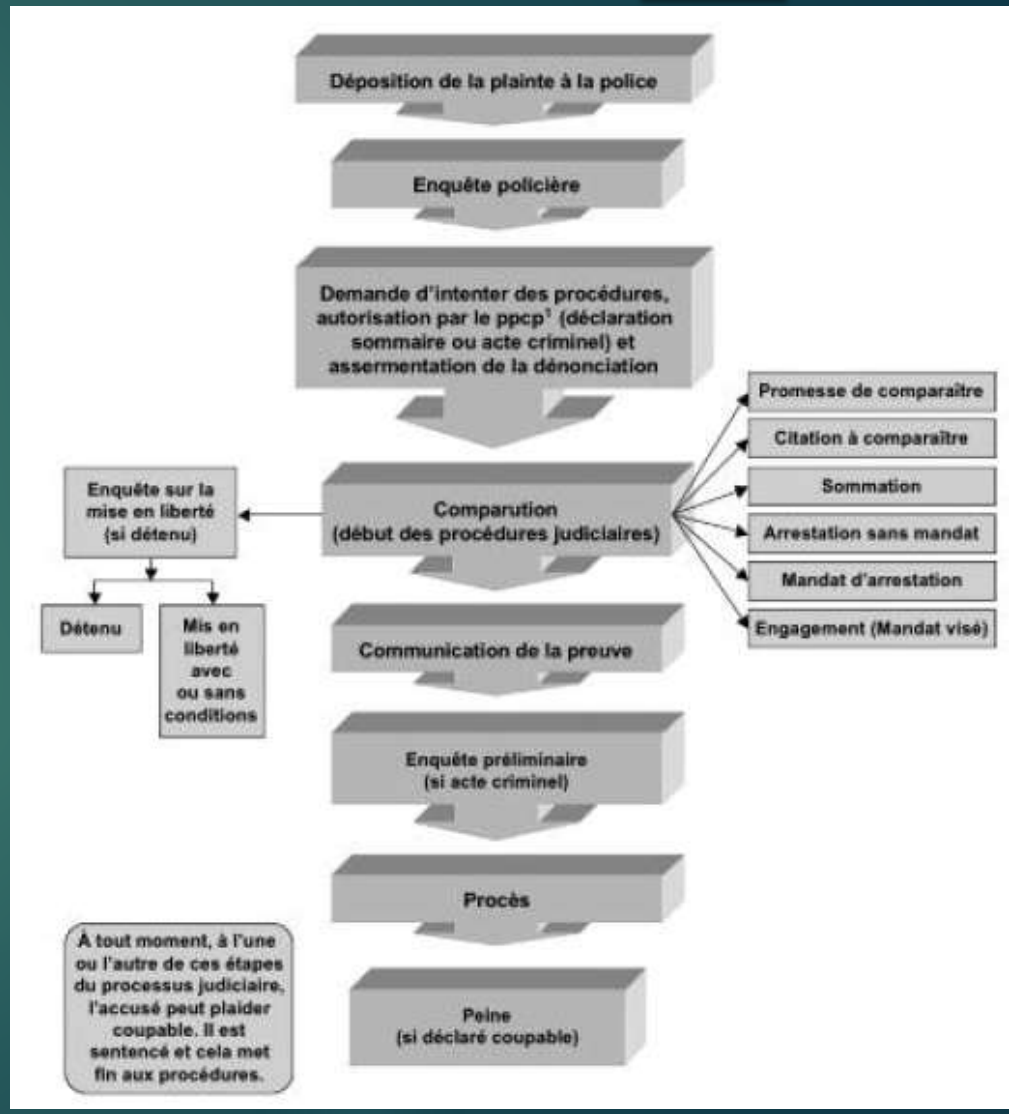
NOTES D'ÉVOLUTION / PROGRESS NOTES

| HEURE / TIME | ORDONNANCES ORDERS | OBSERVATION PROGRESS NOTES |
|---|---|---|
| ☐ | Patient accompanied by | |
| ☐ | Are the parents aware of the situation | |
| ☐ | Referred by/ sent by | |
| ☐ | School level | |
| ☐ | Name, location of school | |
| ☐ | Current family situation | |
| ☐ | Who lives in the household | |
| | | |
| ☐ | Date and time of last assault | |
| ☐ | Relation to abuser(s) | |
| ☐ | Does patient live with abuser | |
| ☐ | Location of assault | |
| ☐ | Physical and psychosocial symptoms since assault | |
| | | |
| ☐ | Past medical and mental health history: | |
| | ASQ score: | |
| | | |
| | | |
| ☐ | Past history of physical/sexual assault | |
| | | |
| ☐ | Who is the patient leaving with | |
| ☐ | Contact information for follow-up | |
| ☐ | | |
| ☐ | Patient safety assured short term | |
| ☐ | Was police called? Event number | |
| ☐ | Is DYP aware? Name of worker involved | |
| | DYP recommends | |
| | | |
| | | |

- Name, profession and contact information of reporter
- Victim's name, DOB, address, personal phone number, school
- Name of parents / legal guardians address
- Nature of SA, frequency
- Link between aggressor and patient
- Emotional reaction of child/adolescent
- Emotional reaction of parents
- Parent's ability to protect patient
- Whether a police report was done
- Any other children involved
- Other pertinent information

# Step 6 -Dénonciation to the police

Who press charges?



# Dealing with the police

- No enqueteur in PED
- Trousse picked up by patrouilleur.

- How to ask them to leave?

# Interventions to mitigate SA effects

- Mobilizing the person support system
  - Assess that SA survivor is not isolated
  - Encourage parents to seek help for themselves
- Inform parents of maternal interventions
  - Elaborating: encourage child to talk about their experience (discuss emotional reaction
  - Soothing: attempt to comfort child's distress
  - Orienting: attempted to guide the child's recovery process (structure, autonomy)
- Adolescent provide information and discuss options
- Referral to the Adolescent clinic

# Ressources

- Local Youth Protection Agency
- DYP Batshaw 514-935-6196
- Centre de Jeunesse de Montreal 514-896-3100
- Monteregie Ouest 1800-361-5310
- IVAC 514-906-3019
- CAVAC 1866-532-2822
- Centre Marie Vincent 514-3626226
- La Traversee:450-465-5263
- CALAC 514-6842198
- Montreal sexual assault center: 514 934-0354, poste 47456



# Debrief

- Contact Kelly and Denise
- Discussion how it went, issues and what can be done to improve or support

# Take home points

- Believe, do not judge
- Protect Children testimony, due to children memory suggestibility
  **NEVER TAKE SA HISTORY IN FRONT OF CHILD**
- Protect Teenager confidentiality
- Document facts no interpretation

# References


- Saint-Pierre, F. & Viau, M.-F. (2010). L'enfant vicitme d'aggression sexuelle. Comprendre et aider. Edutuibs du CHU Sainte-Justine, p. 226.
- Salmona, M. (2018). La mémoire traumatique: violences sexuelles et psycho-trauma. Les cahiers de la justice, (1), 69-87.


1
2
3

# 14 year old and less

## Aggression disclosed

- Ask general questions about school, friends
- Ask the child if there are
  - Abdominal pain, headache
  - Burning
  - Issue going to the bathroom….
- Confirm SA gesture
  - Your mom/dad told me that you were touched XYZ
  - Is that right?
  - Can your tell more?
  - Can ask direct questions

## Aggression not disclosed

- Explain the presenting complaint
  - Your mom tells me that you have pain when you do pipi
- Ask general questions about school, friends
- Ask the child if there are
  - Abdominal pain, headache
  - Burning
  - Issue going to the bathroom….
- Explain that you will do a physical exam
- Observe patient's behavior verbal and non verbal

13 yo female history of sexual abuse by mother's boyfriend. (Boyfriend has a history of drug use). Patient disclosed event to mom who brought her to the hospital.

Triage –

SA 48h ago. Vaginal and rectal pain. Abdominal pain x 1 day. Afebrile. Abdomen soft, mild suprapubic pain when palpated. Pt reports that he bit her breast.

BP 101-60 HR 72 RR 14 O2 100% T 36.8PO

P2 in Green 16

**See copy of triage sheet

SA team called in

SA nurse pre-briefs with SW and then completes interview

**See SA documentation sheet

If nurse and SW ask to interview patient alone, mom is hesitant. Patient prefers mom stays. All agree

For the interview – be brief and to the point (for time constraint purposes). Tell the story as described below.

It is disclosed in the interview that parents are divorced. Patient lives with mom. Mom's boyfriend has been living with them for 1 year. Mom had a work event in the evening 2 days ago and patient was home with the boyfriend. The boyfriend came into the patients room while she was studying, sitting next to her on the bed. He began rubbing her leg, touching her back. She was scared and tried to push his hand a way but he was insistent. He then sexually assaulted her (vaginal and anal penetration), he bit her breast. She is unsure if he used a condom but does not think he did. She was scared to tell her mom but told her today after mom questioned why she had been spending so much time in her room and not answering her friends calls.

Mom discloses that the boyfriend is known to have used heroin in the past but currently only uses cocaine/weed. She kicked him out of the house this morning after learning of the assault. She called the police then brought daughter to the ED.

Both mom and patient are upset/tearful. Mom feels guilty "how did she not see this?" Mom wants the trousse in order to pursue the boyfriend. Patient is worried it will be painful, a bit hesitant, but consents to all testing. Mom is supportive of daughter. "I'm nervous/scared, but ok let's do it"

Trousse questionnaire

- Was she scratched, restrained, strangled, burnt, pushed, pulled by the hair, hit etc
    - Pt reports that she was pushed and held on the bed.

- Did she inflict injury to him
    - She scratched his face and then he held her wrists down. Also managed to scratch his hands
- Did her mouth touch any part of his body.
    - He tried to kiss her
- Which body part of the victim touched which body part of the aggressor
    - Her breast and his mouth
    - Kissed her mouth
    - Vaginal was touched by penis and hand
    - Anal penetration
- Does she have the clothes she was wearing during the aggression
    - They are at home and were washed
- Did she shower
    - Yes
- Has she urinated? Bowel movement?
    - Yes urinated, but not BM yet
- Does pt take drugs/alcohol/meds?
    - No
- Does she have a BF/GF?
    - No
- Has she had sex in the last 5 days with someone else
    - No, not sexually active

After interview, nurse to obtain consent for medical/legal sampling

- Need to obtain parental consent

Then speaks to MD Discussion will happen in Green 19

- Review history
- Determine which swabs to do
- Determine if need for additional BW or urine

MD orders trousse and additional BW

- Anal chlamydia/ghonnorea sample
- Vaginal chlamydia/ghonnorea/trichomonase and culture
- Blood for Beta, syphilis, hep A,B,C, HIV
- Urine for chlam/ghon

Nurse prepares/set up for trousse

Nurse performs sampling

Calls in MD for physical exam and sampling

- Once samples obtained. MD should discuss treatment options for STIs, pregnancy.

- If suggests plan B and antibiotics – mother questions if necessary. She does not have STIs therefore does not think he would. Is plan B absolutely necessary? MD should provide explanation and mother will agree.
- If MD does not bring up medication – mother should ask could my daughter be pregnant? Are there any medications she should take?

Once all samples completed nurse/SW/MD leave room

Discussion with SW, nurse and MD about DYP, pt disposition and follow up

END OF CASE

# Triage of Sexual Assault complaint

June 8th 2026

Denise Kudirka APN PED

# Objectives

- Triaging a patient or a family with a presenting complaint of sexual abuse/sexual assault
- Learn how to recognize a Sexual abuse
- Learn how to launch the SA team
- Know the interventions required for the SA victim to:

# What is Sexual Assault?
# What is Sexual Abuse?

# Definition – Sexual Assault

**Sexual Assault** involves the use of words or gestures that are sexual in nature, which are imposed against the will of the victim, and without their consent.

The aggressor may use emotional manipulation; bribery; intimidation; threats or harassment; the use of verbal, physical, or psychological abuse [1,2].

# Definitions – Sexual Abuse (Child Sexual Assault)

World Health Organization definition:

“The involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent to, or violates the laws”

# Consent

Consent is agreement by a “legally or functionally competent” individual to engage in sexual activity. Basile, Smith, Black, Mahendra (2015)

An individual is not considered legally or functionally competent if:

- Underage
- Excessively intoxicated with drug or alcohol
- Permanently mentally or physically incapacitated
- Unconscious
- Asleep

- Tea Consent – YouTube
- consent for kids - YouTube

# Teenagers sexual consent

Consent is not valid if the partner is too young and/or in a vulnerability relationship with the  partner

The age of consent to sexual activities is 16 years old

- Between 12 to 16 years teenagers can generally consent to sexual gestures if their partner is around the same age

| Younger partner age | Age difference allowed |
|---|---|
| Less than 12 year old | No valid consent |
| 12 and 13 years old | Less than 2 years of difference |
| 14 and 15 years old | Less than 5 years |

Important do not confuse with consent to medico-legal treatment

# SA Disclosure

# All Survivor of SA will experience

- Fear the aggressor and are afraid of reprisals
- Impression of being alone in experiencing such a situation
- Feel guilty and ashamed of what is happening to them
- Are afraid of not being believed
- Have the impression of being responsible for what happens to them
- Have sometimes confused feelings towards the attacker
- Fear legal proceedings
- Fear disrupting the lives of their loved ones
- Fear the reactions or remarks of those around them

# Child and Adolescent response to SA - Silence

- Afraid of being responsible for the breakdown of the family
- Afraid of the reaction of their parents, particularly adolescents, because they fear losing the autonomy acquired
- Afraid of disappointing their parents
- May have not being listened to or were discouraged in their attempts to disclose the sexual assault
- Are not sure that what is happening is abnormal

# Consequences

- Time delay in disclosure
- Young child keep silence about SA
- Children communicate about the event by reacting to it, acting out

# Type of SA

# Type of SA

## Whit physical contact

Kisses of a sexual nature

Touching: breasts, thighs, buttocks, genitals, anus

Masturbation of the victim by the aggressor, and vice versa

Oral-genital contact

Penetration

Penis rubbing on victim body's and vice versa

Sexual violence

Sexual exploitation: pimping, human trafficking

## Without physical contact

Exhibitionism

Sexual harassment

Voyeurism

Child involvement in verbal sexual proposition

Juvenile pornography

Exposition to pornography

On-line luring by cyber-predator

# Type of aggressors

- Incest
  - Father, mother, grand-parents, siblings (including half-brother, half-sister).
- Other intrafamilial SA
  - Parent of reconstituted family, parent of a foster family
  - Extended family
- Sexual assault by a third party or extrafamily assault
  - Person in authority (teacher, professional, coach, etc.)
  - Family friend, guardian, neighbor, acquaintance, close friend
  - Unknown person

# Triage presenting complaints

# PC – Parent/Caregiver report

Concern about:

- New apparently sexualized behavior
- More general behavioral changes
- Child “Abnormal” genital anatomy
- Unexplained injury
- Genital discharge, pain, bleeding

Child talks about:

- “Abnormal” genital anatomy
- Abnormal interest or fear about STIs
- Fear of pregnancy
- Excessive contraceptive control, a desire for contraception without reason

Child exhibit new behavior of:

- Excessive fear of undergoing an examination of the genitals
- Excessive shamelessness
- Abnormal modesty in everyday life
- Fear of any physical contact;

# Possible Presenting complaints of SA

Physical complaints:

- Foreign body in the vagina or rectum,  genitourinary complaints, painful defecation or urination, vaginal discharge, bleeding or itching, grasp or rope marks, oral complaints, STDs, pregnancy
- General somatic complaints: headache, abdominal pain, constipation, diarrhea, encopresis, general fatigue, eating-disturbances

# Possible Presenting complaints of SA

Psychological complaints:

- Abrupt behavioral changes: aggressivity, depression, suicidal behaviors, withdrawal, low self esteem, nightmares, phobias, regression, school problems
- Self-destructive behaviors: substance abuse, sleep disorders, prostitution, cutting, or other self-mutilation
- Sexualized behaviors inappropriate for developmental level: excessive masturbation, forcing sexual acts on other children (sexual acting-out)
- Runaway behavior in teens, loss of memory for events following social gathering, intimate partner violence

# When you suspect SA

# Know – How to Be

Establish trust with child or adolescent
  - Avoid using physical touch to comfort
- Be empathic
- Be respectful
- Commitment to the SA survivor without identification
- Keep a “healthy distance”
- Offer “help” versus “control”
  - Explain what is going to happen
  - Offer the patient choices
- Believe the SA survivor

# At triage - How to ask

- Gather brief summary of abuse from most appropriate source
  - Police, DYP worker
  - Parent/ Care giver. Beware of need adolescent consent
- If possible avoid collecting information from adolescent
  - In order to limit repeating, and reliving the assault
- **Never collect the information from child or in front of a child (less than 14 years old)**
  - **To protect child testimony due to children memory suggestibility**
- Do not use leading question

# What to collect – Keep to facts

- When the abuse/assault occurred or last contact with alleged offender
- Type of contact (genital-genital, oral-to-genital, genital-anal, digital-genital/anal contact)
- Physical symptoms (ano-genital pain/bleeding/discharge)
- Parent's or caretaker's excessive distress
- Mental health symptoms (suicidality, …)
- Involvement of DYP and/or Police

# Messages to convey after survivor discloses SA

- Thank you for telling me
- It took a lot of courage to share this with me
- I’m sorry this happened. This must be really tough for you
- **It’s not your fault**. You didn’t do anything to deserve this
- You are not alone
- I care about you. I am here to listen or help in any way I can
- I wonder of there’s anyone you’d feel comfortable talking about this
- You decide what you think is best for you

# Triage Algorithm

# Pre-Triage

**Pre-Triage**

Ask : “Is it a confidential matter?”

Ensure confidentiality and gather information **in** pre-triage room

**DO NOT gather information in the presence of the child**

Enter presenting complaint: “concern for patient’s welfare SA”

Code them T2

**Triage**: Collect a brief history of the SA from the most appropriate source (police, SW, parent)

Child (less than 14 years old): **NEVER collect history** in the presence of the child

Adolescent: Collect information privately without asking any probing questions. If necessary, additional information can be obtained from the accompanying adult once consent from adolescent is obtained

**Information to be collected:**

- Time of assault or last contact with suspected abuser (less than 7 days or 7 days and more)
- Type of contact (genital, oral, anal, digital)
- Patient's physical sexual assault complaints, examples: ano-genital injury, vaginal or ureteral discharge, anal pain, genital bleeding, etc.
- Patient's psychosocial and behavioral complaints examples: new apparently sexualized behaviors in a child, more general behavior changes, suicidal ideation (complete ASQ), etc.
- Parent's or caretaker's excessive distress
- Patient's safety concerns: alleged abuser living in the same household, alleged abuser having shared custody, inability of parent's or caretaker to ensure child's safety, suspicion of human trafficking etc.
- DYP and/or police involvement

# Triage Category

| Triage category | P1 | P2 | P3 |
|---|---|---|---|
| Patient's physical /mental health<br>Family status | Unstable | Occurrence of suspected sexual assault equal or less than 7 days from the ED visit<br>OR concerns for the following:<br>• Patient's physical sexual assault complaints<br>• Patient's psychological or behavioral complaints<br>• Parent's or caretaker's excessive distress<br>• Patient's safety concerns | Occurrence of suspected sexual assault more than 7 days from the ED visit<br>WITHOUT<br>Any physical, psychological, or safety concerns for child or family |
| Orientation | Red | GREEN 16 | WR in front of GR17 |

**Note: P1 patient with altered level of consciousness and/or hemodynamically instability**

PED physician and Assistant Nurse Manager to determine when SA team should be called in to evaluate patient

# Triage Interventions

**Triage Interventions**

- Keep NPO if fellatio less than or equal to 24 hours
- Ask patient to refrain from urinating or defacating
- Provide a safe, quiet area for the patient and caregivers while waiting for further medical services.
- Inform Assistant nurse manager of patient's presence
- Document FACTS only, do not include interpretations
    - Accompanied by (parents, police, DYP)
    - Referred by DYP,  social service, family physician
    - History taken from (parents, police, teenager…)

## SA nurse on call Interventions

Triage nurse call SA nurse on-call (schedule and phone numbers with nurse's schedule)
Triage nurse provides details SA nurse determine if SA team presence is required
If yes: Triage nurse ask clerk to page psychosocial team (8h00-22h59 social services, 23h00-7h59 spiritual care)
SA nurse and SA psychosocial arrive within 30 -60 minutes of call
SA nurse and SA psychosocial together assess patient and/or family
SA team determine if a medico-legal trousse is required

# The possibility of a medico-legal exam depends on

**Type of contact** (genital-genital, genital-oral, genital-anal, digital-genital/anal etc.)
&
**Time of last contact**

| Important | Type of contact | Medico-legal trousse must bed one in the |
|---|---|---|
| Valid medico-kegak evidence collection depend of type and time of contact | Oral | First 24 hours |
| | Anal or skin | First 36 hours |
| | Vaginal | First 7 days |

# Take home points

- How to Be
- Believe, do not judge
- Protect Children testimony, due to children memory suggestibility **NEVER TAKE SA HISTORY IN FRONT OF CHILD**
- Protect Teenager confidentiality
- Document facts no interpretation

# SA VERIFICATION CHECKLIST 2025

## *Documentation*

Documentation completed on the pre-printed documentation sheet for SA
The name of the DYP worker taking the report is documented
Phone numbers to reach patient and/or family is verified

## *Trousse Forms*

Date and time of the socio-legal or medico-legal trousse is documented in 24h00 format
**10h00 PM = 22h00**
**Stamp** all trousse forms with patient hospital card

F1 The consents are signed by patient, parent or guardian
The date of the transmission to the police is left blank if different than exam date

F5 The physical symptoms are documented

F10 The label « Prélèvements » are placed on all 4 colored copies
All the boxes « fait » or « non fait » are checked
Sites of skin samples are identified on form
The sites skin sampling are indicated on the specimen label (F13) (ex throat, rectum, vagina)
The samples for the trousse are all labeled using the labels on F13 and are **initialed**

F11 The emergency contraception is checked if administered
The initiales (MD or RN) are in all appropriate boxes
The signatures of the SA RN, the MD and the SW are at the bottom of the page
The name of the DYP worker that took the report is written

F12 The # of the bar code of the trousse samples is written
The detachable section of F12 with the number of the SA clinic is provided to the patient and/or family for follow-up

F13 The extra labels are kept **with** the trousse forms

## *Other*

Emergency contraception is administered if necessary
The phone number of the SA clinic is given to the patient and/or family
The trousse is closed and sealed using a label of F14 with the SA RN initials
The lame de réserve is identified with the patient's name and MRN number, and a patient label is added to the blue box
The envelope with the lame de réserve is labelled with the patient's MRN
DYP has been contacted
The hospital samples are labeled and sent to the lab
Consults for SW, Infectious disease, Adolescent Medicine or Psychiatry is made by the physisican as needed

## *The trousse is handed off to the police*

SA nurse have Police officer signs F12 form (prise de possession de la trousse)
SA nurse place in an internal mail envelope, and sent to OACIS for scanning: the F1 - F12 white forms, the ED chart, and the SA nurse documentation sheet.
SA nurse place the Yellow F1-F12 forms in the envelope on top of the Trousse or Medico-social kit. Seal the envelope.
SA nurse hand the Trousse or Medico-social kit envelop to the police officer.
SA nurse give the Pink and Green F1-F12 forms to the police officer.
SA nurse enter patient's information in the custody log, and lock the lame de reserve in the PED SA fridge

## *The Trousse is kept in the SA Fridge prior being picked up by the police*

- *Patient has signed the consent to hand the trousse to the police. The trousse is locked in the SA fridge and the DAY ANM will hand the trousse to the policeman*

SA nurse Photocopy pages F12
SA nurse place in a confidential envelope, and sent to archives for scanning: the F12 photocopies, the white F1-F11 forms, the ED chart, and the SA nurse documentation sheet.
SA nurse place in the SA envelope (either the one on top of the Trousse)**:** the white F12 forms, the F1-F12 yellow, pink, green colored forms. Remember **NEVER place** SA forms inside the trousse
SA nurse enter patient's information in the custody log, and lock the trousse /lame de reserve in the PED SA fridge
SA nurse inform ANM or NIC that trousse is locked in the SA fridge
ANM /NIC, next morning, will call the police ask them to come pick up the trousse
Police come to pick up trousse. ANM/NIC get the trousse. ANM and policeman sign F12.
ANM remove the white F12 and send it to OACIS
ANM place Yellow F1-F12 forms in the envelope on top of the Trousse,
ANM give the Pink and Green F1-F12 forms to the police officer
ANM/NIC enter information and sign the Chain of custody log

## *The Trousse or Medico-social kit are kept at the hospital*

- *Patient may press charges at a later date and Trousse or Medico-social kit must be lock in the Adolescent medicine SA fridge*

Photocopy pages F1 AND F12
Place in a confidential envelope, and sent to archives for scanning: the F1 AND F12 photocopies, the white F2-F11 forms, the ED chart, and the SA nurse documentation sheet.
Place in the SA envelope (either the one on top of the Trousse or in the medico-social kit envelop)**:** the white F1 AND F12 forms, the F1-F12 yellow, pink, green colored forms. Remember **NEVER place** SA forms inside the trousse
SA nurse enter patient's information in the custody log, and lock the trousse/ lame de reserve in the PED SA fridge
The trousse or the Medico-social kit and the lame de reserve must be locked in the PED SA fridge
Inform ANM or NIC that trousse or Medico-social kit is locked in the GREEN pharmacy.
ANM /NIC, next morning, will page the on call adolescent medicine physician to ask them to come pick up trousse or Medico-social envelop
ANM/NIC enter information and sign the Chain of custody log

# Sexual Abuse Tip Sheet

## DO (alliance building)

- Take time for introductions. Explain your role. Make sure the patient knows what to expect.
- Provide a safe space for the LGBTQ2+ population. Ask about pronoun preferences.
- Offer to take breaks as needed (e.g., "take your time. If it at any point it becomes too much, just let me know and we can take a break.")
- Ask open-ended questions: (e.g., "what brings you here today?" not "tell me about the assault.").
- Respond to emotions as they appear – if the patient starts crying, offer tissue and take a break. Do not just move on to the next question. Silence is OK!
- "You are not responsible. None of this is your fault."
- "You are in control of what happens next. We will go at your pace and respect your decisions."
- "There is no right or wrong decision. We are here to support whatever feels right to YOU."
- Explain what the resources in the booklet can do.

## DO NOT

- Ask the patient if they said 'no' explicitly.
- Act like a detective (e.g., try to determine if what happened is true or false).
- Take a checklist approach to the interview.
- Call the patient a 'survivor'.

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# Resource cheat sheet

**CAVAC: Centres d'aide aux victimes d'actes criminels.**

**Services:** Court accompaniment, post-traumatic and psychosocial services, information about your rights and legal options.

**Ligne-Parents :**

**Services:** Consultation service for parents if they are unsure how to speak to their children following the assault, how to treat them, etc.

**Marie Vincent Foundation**:

**Services:** Provides specialized treatment for victims of sexual abuse; specializes in young children as well as adolescents. Offers parenting/family support as well.

## Information Guide for Sexual Assault Victims

### CIPVAS

Victims of sexual violence and their relatives are offered a secure and supportive environment.

(CIPVAS)

(450) 669-8053

### THE NEXT STEPS

You will receive a call from the MCH sexual assault clinic to schedule an appointment within 4-6 weeks or less.
The team consists of a social worker and physician.

(514) 412-4481 x22533






# RESOURCES & SUPPORT

VICTIMS OF SEXUAL ASSAULT AND THEIR FAMILIES

Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

# WHAT HAPPENED TO YOU IS NOT YOUR FAULT

## What is Sexual Assault?

Sexual assault is any form of sexual contact without your consent. It is an act of violence.

Regardless of the circumstance, "no" always means "no". Sexual assault is a traumatic experience. Some people do not remember what happened. You may be in a state of shock and find it hard to believe that this really happened to you.

You may feel guilty, anxious, depressed, angry, numb, embarrassed or ashamed. Some people have nightmares, difficulty eating or sleeping, or are afraid to go outside.

You may also be worried about sexually transmitted infections, pregnancy, HIV or injuries. These are all common concerns after a sexual assault.

## Resources

Sexual Violence Hotline
1-888-933-9007

Tel-aide Outaouais
1-800-461-3083

Kids Help Phone
Call 1-800-668-6868
Text CONNECT to 686868

Suicide Action Montreal 24/7 Crisis Services
1-866-277-3553

### CAVAC

Centre d'aide aux victimes d'actes criminels offers free and confidential support to any victim of a criminal act. Services offered include:

- Accompaniment
- Post-traumatic and psychological interventions
- Legal information

1-866-LE CAVAC (532-2822)

### Marie Vincent Foundation

Foundation that strives for a world without violence toward children and adolescents less than 14 years old

(514) 982-9226

### La traversée

Non lucrative organization that offers psychological evaluation and psychotherapy to victims of sexual violence to children less than 14 years old and their families.

(Saint-Lambert)

(450) 465-5265

### CALACS

West Island Quebec Coalition of Sexual Assault Centers (CALACS) offer psychosocial services, socio-legal support and help for loved ones of sexual assault victims.

(514) 694-2998



Guide d'information à l'intention des victimes d'agression sexuelle

**CIPVAS**

Le soutien et l'accompagnement des victimes de violences sexuelles et de leurs proches

(Laval)

(450) 669-9053

## LES PROCHAINES ÉTAPES

Vous recevrez un appel de la clinique d'agression sexuelle de l'HME pour prendre rendez-vous dans un délai de 4 à 6 semaines au maximum.
L'équipe est formée d'un travailleur social et d'un médecin.

(514) 412-4400 x22533






# RESSOURCES ET SOUTIEN

## VICTIMES D'AGRESSIONS SEXUELLES ET LEURS FAMILLES

Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

# CE QUI VOUS EST ARRIVÉ N'EST PAS DE VOTRE FAUTE

## Qu'est-ce qu'une agression sexuelle ?

L'agression sexuelle est toute forme de contact sexuel sans votre consentement. Il s'agit d'un acte de violence.

Quelles que soient les circonstances, "non" signifie toujours "non". L'agression sexuelle est une expérience traumatisante. Certaines personnes ne se souviennent pas de ce qui s'est passé. Vous pouvez être en état de choc et avoir du mal à croire que cela vous est vraiment arrivé.

Vous pouvez vous sentir coupable, anxieux, déprimé, en colère, engourdi, gêné ou honteux. Certaines personnes font des cauchemars, ont des difficultés à manger ou à dormir, ou ont peur de sortir dehors.

Vous pouvez également vous inquiéter des infections transmises sexuellement, de la grossesse, du VIH ou des blessures. Il s'agit là des inquiétudes les plus courantes à la suite d'une agression sexuelle.

# Ressources

Ligne d'écoute et de référence pour les victimes d'agression sexuelle
1-888-933-9007

Ligne Parents
1-800-361-5085

Tel-jeunes : J'écoute
Appelez le 1-800-263-2266
Texto CONNECT à 58058

Service Aide Juridique Montréal Services de crise 24/7
1-800-217-3553

**CAVAC**

Le Centre d'aide aux victimes d'actes criminels offre un soutien gratuit et confidentiel à toute victime d'un acte criminel. Les services offerts sont les suivants :

- Accompagnement
- Intervention psychosociale et psychothérapie
- Information juridique

1-800-CE CAVAC (1-800-232-2822)

**Fondation Marie Vincent**

Rétablir le lien entre un enfant victime de violence sexuelle et son milieu de vie, tout en assurant sa sécurité et son développement, de même que la prévention de la violence sexuelle auprès des enfants de 14 ans et moins.

(514) 982-9727

**La traversée**

Organisme à but non lucratif qui offre des services d'évaluation psychologique et de psychothérapie aux victimes de violence sexuelle, aux enfants de moins de 18 ans et à leur famille.
(Saint-Lambert)

(450) 465-5263

**CALACS**

Les Centres d'aide aux victimes d'agression sexuelle (CALACS) de l'Ouest-de-l'Île du Québec offrent des services psychosociaux, un soutien socio-juridique et de l'aide aux proches des victimes d'agression sexuelle.

(514) 484-3911



Centre universitaire de santé McGill | McGill University Health Centre

*FMU-6982*

# SAFETY PLAN

**Date** _____
YYYY/MM/DD

## ► Step 1: My Warning Signs

How can I tell that my distress is increasing? What thoughts, images, moods, behaviors, and physical sensations do I start to recognize?

_____
_____
_____

## ► Step 2: Safe Spaces

What environment(s) can I go to that are safe and that will keep me from doing any harm to myself in the moment of distress?

_____

## ► Step 3: My Coping Strategies

What coping strategies can I use to help me live with my negative thoughts and feelings? Identify **6** specific coping strategies.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## ► Step 4: My Distracting Activities

What can I do in the moment of distress to distract myself from my negative thoughts and feelings? Identify **6** specific distracting activities.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## ► Step 5: My Reasons for Living

What are my reasons for living (**4**) and my life goals (**2** short-term goals and **2** long-term goals) that keep me going?

**Reason for living:** _____ **Short-term goal:** _____
**Reason for living:** _____ **Short-term goal:** _____
**Reason for living:** _____ **Long-term goal:** _____
**Reason for living:** _____ **Long-term goal:** _____

## ► Step 6: My Supports

Who are the people (professional contacts and supportive adults and/or friends) I feel most comfortable talking to about what I am going through in the moment of distress?

**Name:** _____ **Contact:** _____
**Name:** _____ **Contact:** _____
**Name:** _____ **Contact:** _____

## ► Step 7: Crisis Line Support

In case of a crisis or severe distress, contact a crisis hotline listed below:

| | | |
|---|---|---|
| **Kids Help Phone** | 1(800)668-6868 | **Text** CONNECT to 686868 (24/7) or **online live chat** (7 pm – 12 am) |
| **Suicide Action Montréal** | (514)723-4000 or 1(866)277-3553 (24/7) | **Text** 535353 (24/7) |
| **Talk Suicide Canada** | 1(833)456-4566 (24/7) | **Text** 45645 (4 pm – 12 am) |

*If you are still experiencing severe distress, and unable to keep yourself safe after following these steps above, go to the nearest hospital **Emergency Room**, or contact **911** to receive help.

Centre universitaire de santé McGill

McGill University Health Centre

*FMU-6982*

# PLAN D'URGENCE

**Date** _____
AAAA/MM/JJ

## ► Étape 1: Mes signes d'alerte

Comment est-ce que je sais que ma détresse augmente? Quels images, humeurs, comportements et sensations physiques surgissent?

_____

_____

_____

## ► Étape 2: Espace sécurisants

À quel endroits est-ce que je serai en sécurité si jamais ma détresse augmente?

_____

## ► Étape 3: Mes stratégies d'adaptation

Quelles stratégies d'adaptation est-ce que je peux utiliser pour m'aider à vivre avec mes pensées et sentiments négatifs? Identifie **6** stratégies d'adaptation spécifiques.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## ► Étape 4: Mes activités de distraction

Qu'est-ce que je peux faire quand je suis en détresse pour me distraire de mes pensées et sentiments négatifs?
Identifie 6 activités de distraction spécifiques

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

## ► Étape 5 : Mes raisons de vivre

Quels sont mes raisons de vivre (**4**) et mes objectifs de vie (**2** à court-terme et **2** à long-terme) qui me permettent de continuer à vivre ?

**Raison de vivre:** _____ **Objectif à court-terme:** _____
**Raison de vivre:** _____ **Objectif à court-terme:** _____
**Raison de vivre:** _____ **Objectif à long-terme:** _____
**Raison de vivre:** _____ **Objectif à long-terme:** _____

## ► Étape 6: Mon réseau de soutien

Qui sont les personnes (contacts professionnels, adultes et/ou amis) avec lesquelles je me sens à l'aise de parler au moment où je suis en détresse?

**Nom:** _____ **Contact:** _____
**Nom:** _____ **Contact:** _____
**Nom:** _____ **Contact:** _____

## ► Étape 7: Lignes de soutien

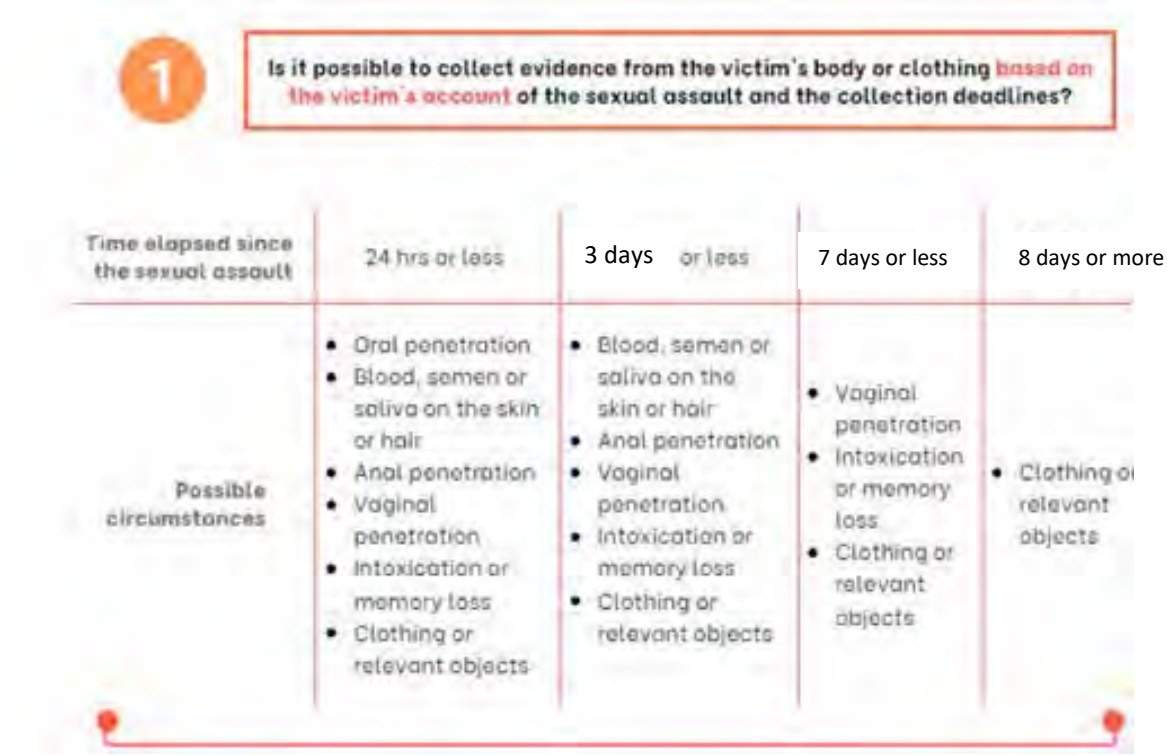
Si aucune de ces personnes n'est disponible, qui est-ce que je peux contacter en cas de détresse grave?

| | | |
|---|---|---|
| **Jeunesse, J'écoute** | 1(800)668-6868 | **Texte** CONNECT à 686868 (24/7) ou **chat en direct en ligne** (19h-24h) |
| **Suicide Action Montréal** | (514)723-4000 ou 1(866)277-3553 (24/7) | **Texte** 535353 (24/7) |
| **Talk Suicide Canada** | 1(833)456-4566 (24/7) | **Texte** 45645 (16h- 24h) |

*Si tu éprouves toujours une grande détresse et que tu es incapable d'assurer ta sécurité après avoir suivi les étapes ci-dessus, rends-toi à la **salle d'urgence** de l'hôpital le plus proche ou compose le **911** pour recevoir de l'aide.

# SA TEACHING – SWABS EXERCISE

## Body fluid (Blood, Saliva or Sperm)




| Site involved | Time elapse | Type of swab |
|---|---|---|
| Bite marks and mouth breast | 20 hrs | Skin swabs to breast<br>Bra collected (no time delay) |
| Bite marks and mouth to breast | 74 hours | No skin swabs<br>Bra collected (no time delay) |
| Fellatio on victim penis | 20 hrs | Skin swabs, underwear |
| Fellatio on victim penis | 74 hours | No swabs to be done – Trousse medico-sociale |
| Female Fellatio and anal penetration | 24 hours | Buccal swabs and anal swabs, underwear |
| Finger inserted in vagina<br>Finger inserted in anus | 24 hours ago | Finger (attouchement) does not leave DNA<br>Trousse medico-sociale |
| Scratched her/his aggressor | | |
| Tampon/condom found in vagina after vaginal penetration | Few days | Collection of foreign body |
| Vaginal penetration | 144 hrs ago | Trousse de base<br>Vaginal swabs and lavage, underwear |

# Prélèvements Enfants Pré-Pubère

## L a v a g e v a g i n a l ( 1D)

La canule et la seringue contenues dans cette enveloppe sont destinées à effectuer des prélèvements au fond du vagin. Ces prélèvements serviront au Laboratoire de sciences judiciaires et de médecine légale pour faire une recherche de phosphatase acide, de spermatozoïdes et éventuellement une recherche du profil génétique (ADN) du suspect. N. B. : Chez les enfants, on utilisera un cathéter plus petit (prendre un cathéter naso-gastrique ou une petite sonde urinaire). Le lavage vaginal, s'il est indiqué, ce qui est rarement le cas chez les enfants, peut être fait sans utiliser de spéculum.

## Pr é l è v eme n t u r é t r a l : j e u n e g a r ç o n

Il est difficile de faire un écouvillonnage urétral chez le garçon prépubère à cause du petit diamètre de l'urètre et parce que c'est douloureux. Pour des raisons pratiques, le prélèvement devrait donc plutôt se faire au méat urinaire à l'aide d'un fin écouvillon monté sur une tige de métal souple tels le CalgiswabMC ou la petite tige de plastique souple dans les enveloppes de prélèvement de TAAN. La tige peut être mouillée avec de l'eau du robinet. On fait tourner l'écouvillon dans le méat au lieu de l'introduire dans l'urètre.

## Changements et précisions dans la trousse médico-légale, 2026 May Dr MacDonald

**Nouveaux délais pour les prélèvements pour ADN :** Les techniques de recherche d'ADN sont maintenant plus sensibles. Par exemple, après 3 jours, même si la personne s'est lavée, on peut retrouver de l'ADN. Vaginal 7 jours (au lieu de 5 jours) , Anal Cutanée 3 jours (au lieu de 2 jours), Buccal 24 hrs (demeure identique).

La recherche d'ADN lorsqu'il y a contact peau à peau Jusqu'à récemment, la recherche d'ADN sur la victime se faisait uniquement s'il y avait présence de sécrétions de l'agresseur : sang, salive, sperme Avec les avancées technologiques au niveau de la recherche d'ADN, on peut maintenant retrouver de l'ADN de l'agresseur sur la peu de la victime, par exemple s'il a **serré la victime aux poignets** ou s'il y a eu **un contact significatif peau à peau (**frotter pendant un certain temps la peau de la victime, y compris la zone génitale et anale). Si pénétration digitale, vaginale ou anale On procède alors à un prélèvement cutané vulvaire ou périanal.

La recherche d'ADN s'il y a eu port du condom par l'agresseur Il est possible de trouver de l'ADN malgré l'utilisation d'un condom. Dabs 27% des situations où un condom a été utilisé, selon les notes sur les formulaires de la trousse médicolégale, un profil génétique a été retrouvé.

Écouvillons anaux/rectaux (2E) et frottis anal/rectal (2F) Écouvillons vaginaux (1B), frottis vaginal (1C) et lavage vaginal (1D) Chez les enfants, on fait seulement un prélèvement cutané dans la région périanale (2CI)] ou on fait seulement un prélèvement cutané vulvaire ou pénien (2CI)] 2

**Pendant l'examen et les prélèvements** : précautions Porter un masque lors des prélèvements et de leur manipulation Porter des gants et les changer fréquemment durant l'examen Éviter tout contact entre les différents prélèvements

**La trousse médicolégale est conservée 6 mois** au centre désigné, si elle n'a pas été remise d'emblée aux policiers. Si la victime accepte qu'on procède avec une trousse médicolégale, mais qu'elle n'est pas certaine de vouloir dénoncer aux services de police, la trousse sera conservée au centre désigné pour 6 mois. Même si la victime décide après un mois qu'elle ne fera pas de dénonciation aux services de police, la trousse est tout de même conservée 6 mois. En effet, la victime pourrait changer d'idée.



# TROUSSE MÉDICOLÉGALE

Pour répondre aux besoins des

## VICTIMES D'AGRESSION SEXUELLE

enfants, adolescentes, adolescents, femmes et hommes

*Intervenons ensemble*

327372

**À utiliser lorsque ces 4 conditions sont remplies :**

- l'agression sexuelle remonte à 5 jours ou moins ;
- la victime d'agression sexuelle a donné son consentement à l'examen médicolégal ;
- la victime porte plainte aux policiers ou est susceptible de le faire ultérieurement ;
- les prélèvements médicolégaux sont indiqués.

**Contenu :**

- un aide-mémoire pour l'intervention médicosociale (imprimé sur la pochette) ;
- les formulaires 1 à 14 servant à l'examen médical et médicolégal de la victime ;
- le matériel approprié pour effectuer les prélèvements nécessaires au cours de l'examen médicolégal ;
- trois étiquettes autocollantes servant de sceaux de sécurité et d'identification pour la trousse et pour le grand sac (formulaire 14).

**Si la victime a décidé de porter plainte :**

- remettre à un policier la trousse médicolégale, incluant les vêtements, si cela est pertinent.

**LES FORMULAIRES DOIVENT ÊTRE RÉPARTIS COMME SUIT :**

- Copies BLANCHES : dans le dossier médical de l'usager.
- Copies JAUNES : dans l'enveloppe sur la trousse médicolégale.
- Copies ROSES : en main propre à un policier.
- Copies VERTES : en main propre à un policier.

**Le policier doit remplir le formulaire de chaîne de possession qui est imprimé au verso de la trousse.**

Si la victime n'a pas consenti à la remise immédiate de la trousse médicolégale aux policiers, vous devez suivre les indications de la section « Conservation de la trousse médicolégale » du formulaire 12.

Québec

# SEXUAL ASSAULT

## Forensic examination

DT9016

DATE OF EXAMINATION | Year | Month | Day | Time (00:01 to 24:00)

## CONSENT

I, _____, hereby consent to:

Initials of victim, parent, tutor or DYP **

1) a medical examination including, if pertinent, a gynecological and genital examination, samples and treatments; ☐

2)

a) a forensic examination which includes a medical examination (as described in point 1), samples and a blood test to determine, among others things a genetic profile (DNA)*; ☐

b) a blood test and a urine sample, which will be used to detect drugs or alcohol, if pertinent; ☐

3) transmission to police of the forensic evidence kit or of the medical/social records kit to assist with the police investigation. ☐

Date (if different from the date of the examination) Year Month Day

**Refusal to consent to items 2 and 3 will in no way affect the quality of care provided, and I am free at any time during the examination to modify this consent in whole or in part.**

Signature: _____ Victim, parent, tutor or DYP **

Date: Year Month Day

* Information concerning the victim's genetic profile will not be kept in the National DNA Data Bank.

** If the victim is under 14 years of age and the parents or tutor refuse to consent to the examination, the DYP may provide authorization for steps 1 and 2 if urgently needed.

# AGRESSION SEXUELLE

## Examen médicolégal

DT9004

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00:01 à 24:00)

## CONSENTEMENT

Je, _____ , consens par la présente à :

Initiales de la victime, du parent, du tuteur ou du DPJ**

1) un examen médical, incluant, si cela est pertinent, un examen gynécologique et génital, des prélèvements et des traitements; ☐

2)

a) un examen médicolégal comprenant un examen médical (tel qu'il est décrit au point 1), des prélèvements et une prise de sang, entre autres pour la recherche du profil génétique (ADN)*; ☐

b) une prise de sang et au prélèvement d'un échantillon d'urine qui seront utilisés pour le dépistage de drogues ou d'alcool, si cela est pertinent; ☐

3) la remise de la trousse médicolégale ou de la trousse médicosociale aux policiers afin qu'elles puissent être utilisées dans le déroulement d'une enquête policière. ▶ Date (si différente de celle de l'examen) Année | Mois | Jour ☐

**Le refus de consentir aux articles 2 et 3 susmentionnés ne modifiera en rien la qualité des soins qui me seront prodigués et je conserve à tout moment au cours de l'examen la liberté de revenir sur ce consentement en entier ou en partie.**

Signature : _____ (Victime, parent, tuteur ou DPJ **)

Date : Année | Mois | Jour

* L'information concernant le profil génétique de la victime n'est pas compilée dans la Banque nationale des données génétiques.

** Si la victime est âgée de moins de 14 ans et que les parents ou le tuteur refusent l'examen, le DPJ peut autoriser les étapes 1 à 2 dans une situation d'urgence.

# AGRESSION SEXUELLE

## Examen médicolégal

DT9005

DATE DE L'EXAMEN — Année / Mois / Jour / Heure (00:01 à 24:00)

**(Si différente de celle inscrite sur le formulaire 1)**

Les renseignements recueillis viennent de : (cocher plus d'une case au besoin) ☐ la victime ☐ autre personne (préciser) : _____

## DESCRIPTION DE L'AGRESSION SEXUELLE AUX FINS DE L'EXAMEN MEDICOLEGAL

**Date et heure de l'agression sexuelle** ▶ Année / Mois / Jour / Heure (00:01 à 24:00)

Si, lors des événements, il y a eu plusieurs agressions sexuelles, **indiquer la date et l'heure de la dernière.**

### Violence et contraintes physiques

La victime a été :

☐ attachée ☐ égratignée ☐ mordue ☐ serrée ☐ autre : _____

☐ brûlée ☐ étranglée ☐ poussée ☐ tirée par les cheveux _____

☐ coupée ☐ frappée ☐ retenue _____

Avec quel objet : _____

### Agresseur(s)

Nombre : _____ ☐ Ne sait pas Sexe : ☐ M ☐ F Lien avec la victime : _____

Blessures infligées à l'agresseur par la victime : ☐ Oui ☐ Non ☐ Ne sait pas

Si oui, préciser (égratignure, coupure, morsure, etc.) : _____

**À utiliser dans une situation exceptionnelle seulement.**
**Inscrire mot à mot les paroles dites spontanément par la victime lors de l'intervention.**
**(Sans faire le récit de l'événement.)**

**Remplir seulement si la victime :**

☐ Est un enfant

☐ A une déficience intellectuelle sévère ou profonde

☐ A des troubles importants de la mémoire

☐ Est blessée très grièvement (danger pour la vie)

# AGRESSION SEXUELLE

## Examen médicolégal

DT9006

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00:01 à 24:00)

**(Si différente de celle inscrite sur le formulaire 1)**

## DESCRIPTION DE L'AGRESSION SEXUELLE AUX FINS DE L'EXAMEN MÉDICOLÉGAL (suite)

**Pour déterminer le type d'examen médicolégal et les prélèvements nécessaires, cocher les parties anatomiques de l'agresseur qui ont été en contact avec celles de la victime.**

**Cocher si la description des contacts sexuels N'EST PAS CLAIRE** ☐
par ex. : enfant; drogue et alcool; perte de conscience; etc.

| Victime | Le ou les agresseurs | Condom |
|---|---|---|
| **BOUCHE** | Bouche ☐<br>Doigt, main ☐<br>Vagin ☐<br>Pénis ☐<br>Anus ☐<br>Corps étranger : _____ | ☐ |
| **DOIGT, MAIN** | Bouche ☐<br>Vagin ☐<br>Pénis ☐<br>Anus ☐ | ☐ |
| **SEINS** | Bouche ☐<br>Doigt, main ☐<br>Vagin ☐<br>Pénis ☐<br>Anus ☐ | ☐ |
| **VAGIN** | Bouche ☐<br>Doigt, main ☐<br>Vagin ☐<br>Pénis ☐<br>Corps étranger : _____ | ☐ |
| **PÉNIS** | Bouche ☐<br>Doigt, main ☐<br>Vagin ☐<br>Pénis ☐<br>Anus ☐<br>Corps étranger : _____ | ☐ ☐ ☐ ☐ ☐ |
| **ANUS** | Bouche ☐<br>Doigt, main ☐<br>Pénis ☐<br>Corps étranger : _____ | ☐ |
| **PEAU** | Bouche ☐<br>Doigt, main ☐<br>Pénis ☐ | ☐ |

**Éjaculation sur la peau ou les cheveux**

☐ Oui
☐ Non
☐ Ne sait pas

Si oui, à quel endroit sur le corps?

_____

_____

# AGRESSION SEXUELLE

## Examen médicolégal

DT9007

DATE DE L'EXAMEN — Année / Mois / Jour / Heure (00:01 à 24:00)

**(Si différente de celle inscrite sur le formulaire 1)**

## DESCRIPTION DE L'AGRESSION SEXUELLE AUX FINS DE L'EXAMEN MÉDICOLÉGAL (suite)

### Les vêtements portés lors de l'agression sexuelle :

- ☐ sont remis avec la trousse
- ☐ ont déjà été remis aux policiers
- ☐ doivent être récupérés par les policiers

ont été lavés ☐ Oui ☐ Non

ont été réparés ☐ Oui ☐ Non

### La victime :

| | | | | | |
|---|---|---|---|---|---|
| s'est lavée | ☐ Oui | ☐ Non | a eu une miction | ☐ Oui | ☐ Non |
| s'est donné une douche vaginale | ☐ Oui | ☐ Non | a eu une défécation | ☐ Oui | ☐ Non |

### Médicaments

Ingestion, **contre sa volonté**, de drogues ou d'alcool : ☐ Oui ☐ Non ☐ Ne sait pas

**Section à remplir seulement s'il y a eu ingestion de drogues ou d'alcool ou intoxication sévère :**

Aux fins de l'analyse des prélèvements de sang et d'urine pour la recherche de drogues et d'alcool : y a-t-il eu prise de médicaments, y compris ceux donnés à l'hôpital, dans les **5 jours précédant l'examen médicolégal?** ☐ Oui ☐ Non

**Si oui, spécifier :**

| Médicaments | Date (Année / Mois / Jour) | Heure (00:01 à 24:00) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Allergie à certains médicaments :** ☐ Oui ☐ Non

### Éléments gynécologiques pertinents à l'agression sexuelle

DDM : (Année / Mois / Jour)

Ménarche chez les moins de 18 ans : _____ ans

Besoin de contraception d'urgence : ☐ Oui ☐ Non

# AGRESSION SEXUELLE

## Examen médicolégal

DT9008

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00:01 à 24:00)

**(Si différente de celle inscrite sur le formulaire 1)**

## DESCRIPTION DE L'AGRESSION SEXUELLE AUX FINS DE L'EXAMEN MÉDICOLÉGAL (suite)

### Relation sexuelle dans les 5 jours précédant l'examen médicolégal

***Aux fins de l'identification du ou des agresseurs par la recherche de profils génétiques,*** la victime a-t-elle eu un rapport sexuel (buccal, vaginal ou anal) avec possibilité d'éjaculation avec **d'autres personnes que le ou les agresseurs dans les 5 jours précédant l'examen médicolégal?** → ☐ Oui ☐ Non

**Si oui, dernière date :** Année | Mois | Jour | Heure (00:01 à 24:00)

**Utilisation :** ☐ Condom ☐ Lubrifiant ☐ Spermicide ☐ Diaphragme

☐ Autre (préciser) : _____

### Symptômes physiques pertinents durant et à la suite de l'agression sexuelle
### (Si les symptômes sont reliés à des antécédents pertinents, décrire ces antécédents)

## EXAMEN PHYSIQUE

| T.A. | Pouls | Taille | Poids |
|---|---|---|---|
| | | | |

| Observations | Normal Oui | Normal Non | Décrire les lésions et les localiser sur les schémas anatomiques |
|---|---|---|---|
| Tête et visage | | | |
| Bouche et gorge | | | |
| Cou | | | |
| Seins (pas de palpation de routine) | | | |
| Cœur et poumons | | | |
| Thorax et dos | | | |
| Abdomen | | | |
| Membres | | | |

**Pour les enfants, les adolescentes et les adolescents :**

Personnes présentes lors de l'examen (nom et lien avec la victime) :

Stade de maturation sexuelle (Tanner) : 1 2 3 4 5

Réactions lors de l'examen si cela est pertinent :

# AGRESSION SEXUELLE

## Examen médicolégal

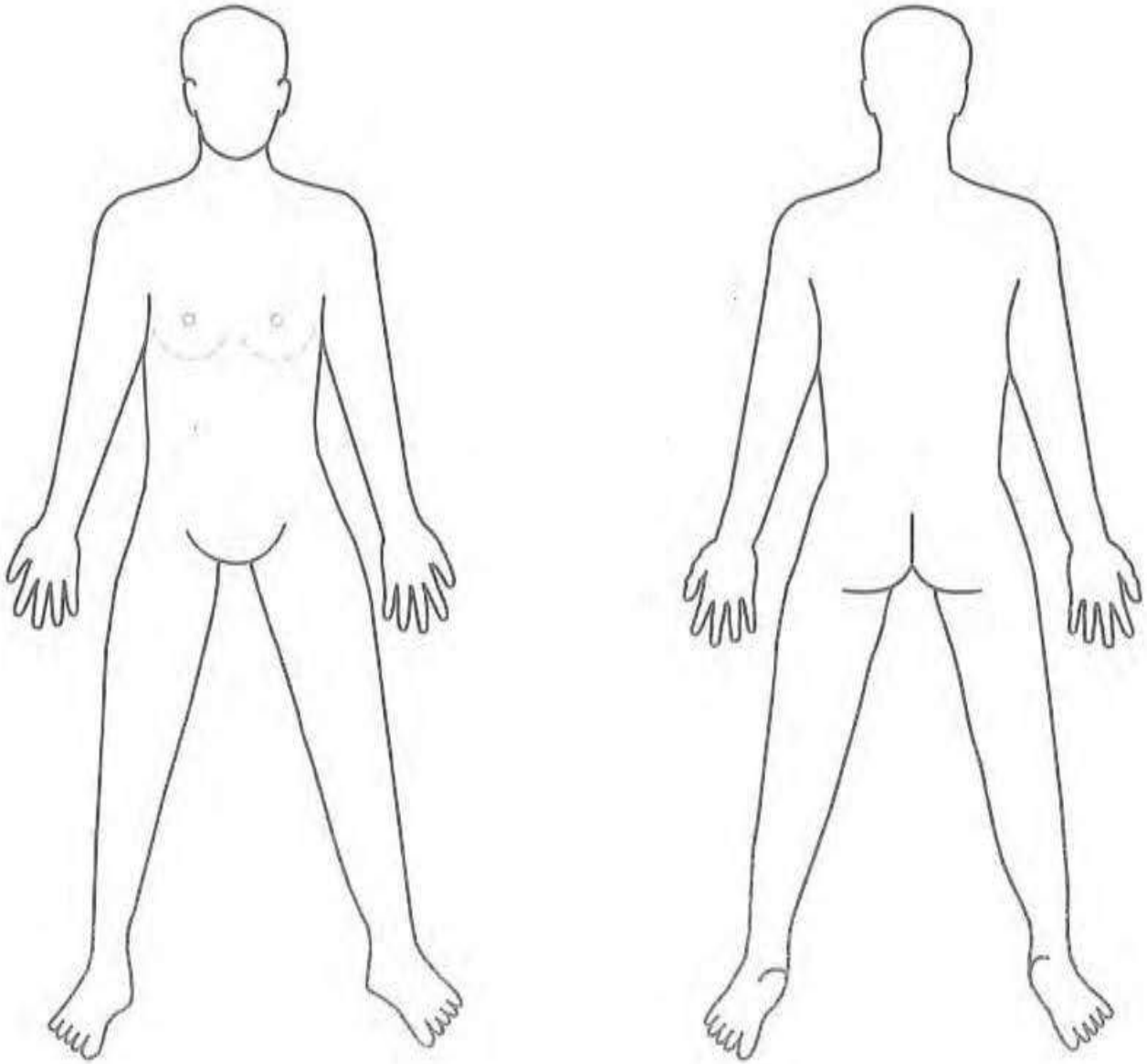
DT9009

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00.01 à 24.00)

**(Si différente de celle inscrite sur le formulaire 1)**

SCHÉMAS ANATOMIQUES ASEXUÉS (ENFANT ET ADULTE) – Localiser les lésions décrites dans le formulaire 5

**Compléter la ligne des seins pour une victime de sexe féminin.**



# AGRESSION SEXUELLE

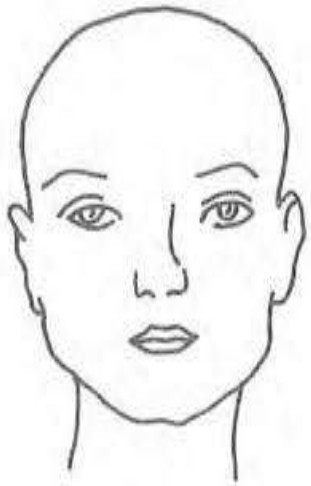
## Examen médicolégal

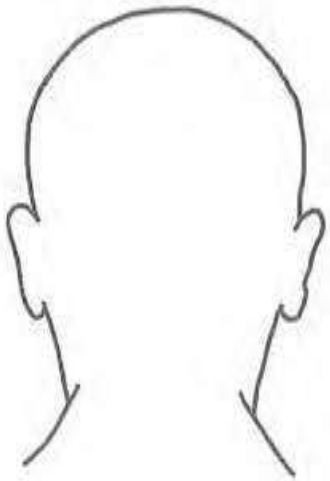
DT9010

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00.01 à 24.00)

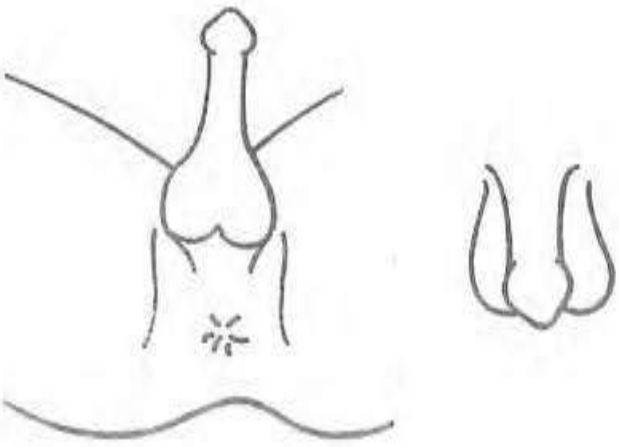
**(Si différente de celle inscrite sur le formulaire 1)**

## SCHEMAS ANATOMIQUES ASEXUÉS (ENFANT ET ADULTE) – Localiser les lésions décrites dans le formulaire 5





## SCHEMAS ANATOMIQUES (ENFANT ET ADULTE) – Localiser les lésions décrites dans le formulaire 5



**Positions lors de l'examen**

☐ Génupectorale

☐ Autre : _____

| | Normal | | Décrire les lésions et les localiser sur les schémas anatomiques |
|---|---|---|---|
| | Oui | Non | |
| Urètre | | | |
| Prépuce | | | |
| Gland | | | |
| Pénis | | | |
| Scrotum | | | |
| Anus | | | |

# AGRESSION SEXUELLE

## Examen médicolégal

DT9011

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00.01 à 24.00)

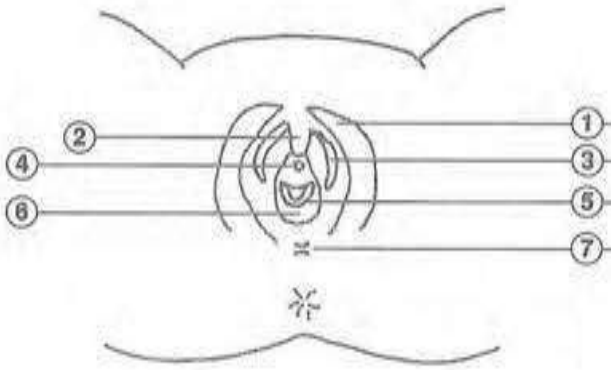
**(Si différente de celle inscrite sur le formulaire 1)**

## SCHÉMAS ANATOMIQUES (FILLE PRÉPUBÈRE, ADOLESCENTE ET ADULTE)

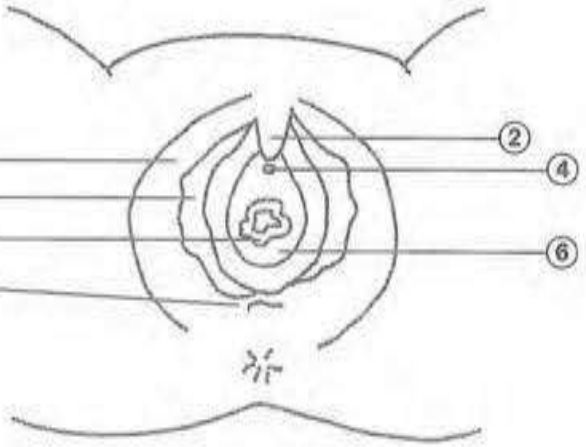
**Positions lors de l'examen**

☐ Gynécologique ☐ Grenouille ☐ Génupectorale ☐ Autre : _____

**PRÉPUBÈRE**




**ADOLESCENTE ET ADULTE**




| | Normal | | Décrire les lésions et les localiser sur le schéma anatomique approprié |
|---|---|---|---|
| | Oui | Non | |
| ① Grandes lèvres | | | |
| ② Clitoris | | | |
| ③ Petites lèvres | | | |
| ④ Urètre | | | |
| ⑤ Hymen | | | |
| ⑥ Fourchette postérieure | | | |
| ⑦ Périnée | | | |
| Anus | | | |
| **Adolescente et adulte si pénétration** | | | |
| Vagin | | | |
| Col utérin | | | |
| Utérus et annexes (pas d'examen de routine) | | | |

# AGRESSION SEXUELLE

## Examen médicolégal

DT9012

DATE DE L'EXAMEN — Année / Mois / Jour / Heure (00:01 à 24:00)

**(Si différente de celle inscrite sur le formulaire 1)**

### ◆ NE FAIRE QUE LES PRÉLÈVEMENTS NÉCESSAIRES

| Site | Circonstances | TYPES DE PRÉLÈVEMENTS (cocher ceux qui ont été faits) — Prélèvements pour le laboratoire du centre désigné | Prélèvements ADN et autres pour le Laboratoire de sciences judiciaires |
|---|---|---|---|
| BUCCAL | Pas de fellation | | 1A ☐ Prélèvement buccal : prélever deux écouvillons, un pour chaque joue, en frottant pendant environ 15 secondes pour chacun des écouvillons; laisser sécher. |
| BUCCAL | Si fellation | ☐ Chlamydia ☐ Gonorrhée | 2A ☐ Rinçage buccal avec un volume de 15 ml de sérum physiologique. Récupérer dans le petit contenant à bouchon bleu inclus dans la trousse.<br>2B ☐ Après 2 ou 3 rinçages de la bouche, effectuer un nouveau prélèvement buccal sur écouvillons, tel que décrit au point 1A. |
| ANAL | **Si pénétration (avant VAGINAL)** | ☐ Chlamydia ☐ Gonorrhée<br>☐ Culture générale (si symptômes) | 2E, 2F ☐ Prélever avec un écouvillon et l'étaler sur une lame. Laisser sécher le tout avant de remettre dans l'enveloppe. |
| VAGINAL ET COL UTÉRIN | Si pénétration | ☐ Chlamydia (TAAN) ☐ Gonorrhée<br>☐ Culture générale ☐ Test Pap<br>☐ Trichomonase | 1B ☐ 2 écouvillons (voir 1C) : laisser sécher.<br>1C ☐ 1 lame à bordure bleue (1 goutte de sérum physiologique et des sécrétions vaginales provenant d'un des écouvillons de 1B) : laisser sécher sans fixation. |
| VAGINAL ET COL UTÉRIN | Si pénétration | ☐ Lame de réserve pour l'ADN (À conserver au centre désigné) | 1D ☐ Lavage vaginal : introduire 10 ml de sérum physiologique et retirer par aspiration la quantité maximale. |
| PÉNIS ET URÈTRE | | ☐ Chlamydia ☐ Gonorrhée (Peut être fait sur l'urine) | 2CI ☐ Morsure, salive ou sperme de l'agresseur au niveau du pénis : essuyer avec un écouvillon humide, essuyer ensuite avec un écouvillon sec : garder les deux. N.B. : Inscrire sur le formulaire 10 sperme ou salive. |
| CUTANÉ | Si tache de salive, de sperme, ou morsure | | 2CI ☐ et 2CII ☐ Morsure, salive ou sperme au niveau de la vulve, de l'anus ou autres : essuyer avec un écouvillon humide, essuyer ensuite avec un écouvillon sec : garder les deux. N.B. : Inscrire sur le formulaire 10 sperme ou salive. |
| CORPS ÉTRANGERS, SERVIETTES HYGIÉNIQUES OU TAMPONS | | | 2D ☐ Fibre, poil, rognures d'ongles s'il y a lieu, etc. : placer le prélèvement dans l'enveloppe incluse dans la trousse. Placer les serviettes ou les tampons dans le sac blanc réservé à cette fin. |
| SANGUIN | | ☐ Alcool ou drogues ☐ HCG<br>☐ Syphilis ☐ VIH<br>Hépatite : ☐ A ☐ B (Ac/Ag) ☐ C | 1E ☐ Profil génétique et recherche d'alcool et de drogues. Prélever de 5 à 10 ml de sang. |
| URINAIRE | | ☐ Alcool ou drogues ☐ HCG<br>☐ Chlamydia ☐ Gonorrhée | 2G ☐ Recherche d'alcool et de drogues : 20 à 50 ml d'urine. |
| VESTIMENTAIRE (incluant les couches) | | | 3A ☐ B, C, D, E Vêtements tachés ou déchirés : mettre dans des sacs de papier séparés; indiquer le contenu sur la requête. |

# AGRESSION SEXUELLE

## Examen médicolégal

DT9013

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00:01 à 24:00)

(Si différente de celle inscrite sur le formulaire 1)

**IMPORTANT** → **AD-** APPOSER ÉTIQUETTE AUTOCOLLANTE – PRÉLÈVEMENTS – sur chacune des 4 copies du formulaire 10 (voir formulaire 13)

## NOTEZ BIEN

- Pour éviter toute contamination, replacer le contenant d'urine et le contenant de rinçage buccal dans le sac de polythène réservé à cette fin.
- Identifier les prélèvements en utilisant les étiquettes autocollantes incluses dans la trousse.
- Mettre vos initiales sur chacune des étiquettes.
- Replacer tout le matériel non utilisé et intact dans la trousse.
- Replacer les prélèvements dans la trousse.
- Mettre les petits vêtements dans les sacs de papier et ensuite dans la trousse.
- Placer les vêtements plus volumineux dans les sacs de papier et ensuite, les regrouper dans le grand sac et apposer un scellé.
- Sceller la trousse, mettre vos initiales sur le scellé et détruire les scellés non utilisés.

### PRÉLÈVEMENTS

#### Trousse médicolégale de base

| | | Fait | Non fait |
|---|---|---|---|
| 1A | Écouvillons buccaux | ☐ | ☐ |
| 1B | Écouvillons vaginaux | ☐ | ☐ |
| 1C | Lame de frottis vaginal | ☐ | ☐ |
| 1D | Lavage vaginal | ☐ | ☐ |
| 1E | Sang | ☐ | ☐ |

#### Analyse toxicologique

Recherche de drogues ou d'alcool ☐ Oui ☐ Non

#### Matériel complémentaire (à prélever au besoin)

| | | Fait | Non fait |
|---|---|---|---|
| 2A | Rinçage buccal | ☐ | ☐ |
| 2B | Écouvillons buccaux (si fellation) | ☐ | ☐ |
| 2CI | Cutané, si recherche de : ☐ sperme ☐ salive<br>Site _____ | ☐ | ☐ |
| 2CII | Cutané, si recherche de : ☐ sperme ☐ salive<br>Site _____ | ☐ | ☐ |
| 2D | Corps étrangers | ☐ | ☐ |
| 2E | Écouvillons anaux | ☐ | ☐ |
| 2F | Lame de frottis anal | ☐ | ☐ |
| 2G | Urine | ☐ | ☐ |

| | | | |
|---|---|---|---|
| 3 VÊTEMENTS | 3A | 3B | 3C |
| | 3D | 3E | 4 Autres |

# AGRESSION SEXUELLE

## Examen médicolégal

DT9014

DATE DE L'EXAMEN — Année | Mois | Jour | Heure (00:01 à 24:00)

**(Si différente de celle inscrite sur le formulaire 1)**

### INTERVENTIONS MÉDICOLÉGALES

**Mettre vos initiales dans les cases appropriées**

| Interventions | Médecin(s) | Infirmière(s) | Intervenant(s) psycho-social(aux) | Autre(s) |
|---|---|---|---|---|
| Faire l'examen médical | | | | |
| Faire les prélèvements médicolégaux | | | | |
| Manipuler, identifier la lame de réserve et la conserver au centre désigné | | | | |
| Manipuler et identifier le prélèvement sanguin | | | | |
| Manipuler et identifier l'échantillon d'urine | | | | |
| Manipuler et identifier les autres prélèvements | | | | |
| Sceller la trousse | | | | |
| Manipuler et identifier les vêtements | | | | |

### INTERVENTIONS, TRAITEMENTS ET SOINS

**Autres interventions, tests, prélèvements ou examens**

- ☐ • Imagerie médicale
- ☐ • Sutures
- ☐ • Consultation : _____
- ☐ • Autres : _____

_____

**Traitements et soins**

- ☐ • Contraception d'urgence
- ☐ • Vaccin hépatite B
- ☐ • Vaccin tétanos
- ☐ • Immunoglobuline hépatite B
- ☐ • Anxiolytique _____
- ☐ • Autres : _____

☐ IVAC ☐ CSST

### SIGNALEMENT OBLIGATOIRE AU DIRECTEUR DE LA PROTECTION DE LA JEUNESSE POUR LES MOINS DE 18 ANS

Nom de l'intervenante ou de l'intervenant ayant reçu le signalement :

### RENSEIGNEMENTS SUR LES INTERVENANTS

**Médecin**

| Nom (en lettres moulées) | Signature | Initiales | N° de permis | N° de téléphone |
|---|---|---|---|---|
| | | | | |

**Infirmière**

| Nom (en lettres moulées) | Signature | Initiales | N° de téléphone |
|---|---|---|---|
| | | | |

**Intervenante ou intervenant psychosocial**

| Nom (en lettres moulées) | Signature | Initiales | N° de téléphone |
|---|---|---|---|
| | | | |

**Autre**

| Inscrire votre fonction | Nom (en lettres moulées) | Signature | Initiales | N° de téléphone |
|---|---|---|---|---|
| | | | | |

## INFORMATION CONCERNING THE PRESERVATION OF THE FORENSIC EVIDENCE KIT

Not applicable ☐

You must contact the social worker to:

- inform her or him of your decision to have the forensic evidence kit given to the police and make an appointment to sign the consent form for that purpose.

Before: Year Month Day

| Name of the person to contact | Telephone No. |
|---|---|
| | |

**After the above date, the samples in the forensic evidence kit will be destroyed unless otherwise agreed with the victim.**
**The forms will remain in the medical file, however.**

## INFORMATION AND FOLLOW-UP

If you have any questions or concerns, you can contact:

| Name (in block letters) | Telephone No. |
|---|---|
| | |
| Name (in block letters) | Telephone No. |
| | |

Additional information concerning medical or psychosocial follow-up:

medical follow-up

psychosocial follow-up

## CONSERVATION DE LA TROUSSE MÉDICOLÉGALE

Si la personne examinée n'a pas consenti à la remise immédiate de la trousse médicolégale aux policiers, la trousse sera conservée dans un réfrigérateur à accès contrôlé.

**À moins d'entente avec la victime,**
**les prélèvements seront détruits après un délai maximal de 14 jours.**

Date limite de destruction de la trousse

N° du sceau de la trousse

## REMISE DE LA TROUSSE MÉDICOLÉGALE OU DE LA TROUSSE MÉDICOSOCIALE

| | | | |
|---|---|---|---|
| **Intervenante ou intervenant qui remet la trousse** | Nom (en lettres moulées) | Signature | N° de téléphone |
| **Policière ou policier qui prend possession de la trousse** | Nom (en lettres moulées) | Signature | N° de téléphone |

N° de matricule | N° de dossier du corps policier | Date: Année Mois Jour Heure (00:01 à 24:00)

## AGRESSION SEXUELLE

### Examen médicolégal

DT9015

DATE DE L'EXAMEN: Année Mois Jour Heure (00:01 à 24:00)

(Si différente de celle inscrite sur le formulaire 1)

# ÉTIQUETTES AUTOCOLLANTES

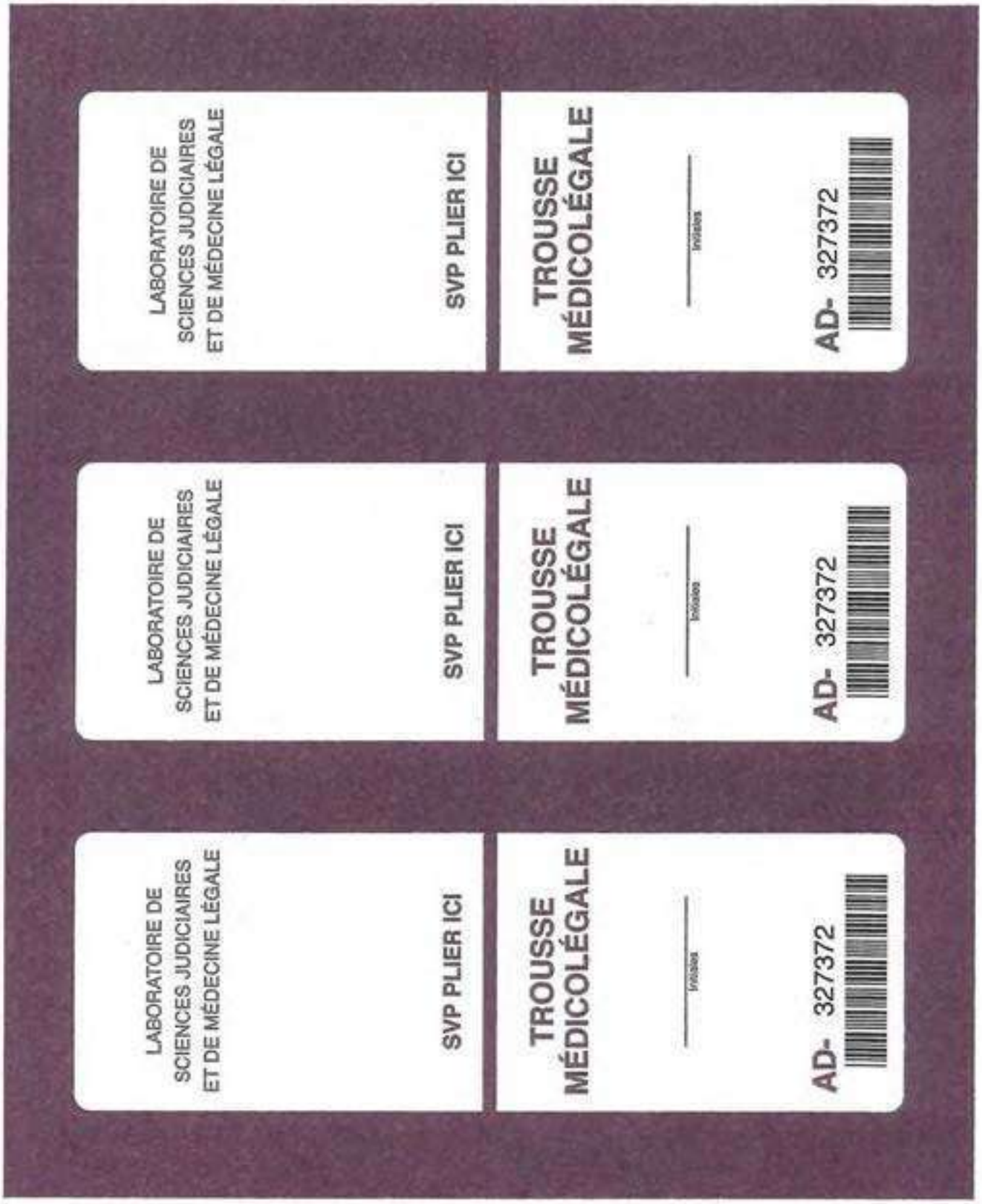
**SVP : METTRE VOS INITIALES ET COLLER SUR LES PRÉLÈVEMENTS CORRESPONDANTS**

| | | |
|---|---|---|
| 1A BUCCAL<br>AD- 327372<br>Initiales | 1B SÉCRÉTIONS VAGINALES<br>AD- 327372<br>Initiales | 1C FROTTIS VAGINAL<br>AD- 327372<br>Initiales |
| 1D LAVAGE VAGINAL<br>AD- 327372<br>Initiales | 1E SANG<br>AD- 327372<br>Initiales | 2A RINÇAGE BUCCAL<br>AD- 327372<br>Initiales |
| 2B BUCCAL<br>AD- 327372<br>Initiales | 2C CUTANÉ (I)<br>AD- 327372<br>Initiales | 2C CUTANÉ (II)<br>AD- 327372<br>Initiales |
| 2D CORPS ÉTRANGER<br>AD- 327372<br>Initiales | 2D SERVIETTES HYGIÉNIQUES/TAMPONS<br>AD- 327372<br>Initiales | 2E ÉCOUVILLON ANAL/RECTAL<br>AD- 327372<br>Initiales |
| 2F FROTTIS ANAL/RECTAL<br>AD- 327372<br>Initiales | 2G URINE<br>AD- 327372<br>Initiales | 3A VÊTEMENTS<br>AD- 327372<br>Initiales |
| 3B VÊTEMENTS<br>AD- 327372<br>Initiales | 3C VÊTEMENTS<br>AD- 327372<br>Initiales | 3D VÊTEMENTS<br>AD- 327372<br>Initiales |
| 3E VÊTEMENTS<br>AD- 327372<br>Initiales | 4 AUTRE<br>AD- 327372<br>Initiales | PRÉLÈVEMENTS<br>AD- 327372<br>Initiales |
| PRÉLÈVEMENTS<br>AD- 327372<br>Initiales | PRÉLÈVEMENTS<br>AD- 327372<br>Initiales | PRÉLÈVEMENTS<br>AD- 327372<br>Initiales |

(voir formulaire 10)

# SCELLÉS AUTOCOLLANTS

**SVP : METTRE VOS INITIALES ET SCELLER**
**LA TROUSSE ET LE SAC DE POLYTHÈNE (AU BESOIN)**



# Youth Protection

## An introduction: understanding your role

Lance W Lamore, MSW, PSW

# Objectives:

- When to make a signalement and the articles of compromission
- How to make a signalement, what will be asked of you, what can be shared with you
- Intake: RTS, SES, VCT
- Evaluation and Orientation
- Application of Measures
- Personalized reviews and orientation tables
- Permanency Planning
- Foster care
- Group homes and Units
- Clinical support services
- Medical services
- Indigenous communities

# Professional obligation

- Duty to report
- Gathering information
- Whoever receives the information, and has the concerns, must report
- Youth protection concerns vs confidentiality
- Professional Orders
- What are your experiences? Impressions?

# Youth Protection Act

**What to report**

The Youth Protection Act (YPA)

The YPA (L.R.Q., Chapter P-34.1) has been in force in Quebec since 1979 and has seen several modifications.

The YPA applies to :

children and youth under the age of 18 whose security or development is, or may be, considered to be in danger/compromised

The YPA, under article 38 (***refer to handout regarding specific information related to each article***), stipulates that children and youth are in need of protection in any of the following 6 situations:

| | |
|---|---|
| **38A** | **abandonment;** |
| **38B1 i, ii, iii and 38B2** | **neglect;** |
| **38C and 38C1** | **psychological ill-treatment;** |
| **38D1 and 38D2** | **sexual abuse;** |
| **38E 1 and 38E2** | **physical abuse;** |
| **38F** | **serious behavioural disturbance** |

# Where to signal?

- Signalements are made by territory/geographical location ***(refer to handout for locations in Quebec)***
- Batshaw Youth and Family Centres or Centre Jeunesse et de la Famille Batshaw—all Anglophone clients on the **island of Montreal** and all Jewish families (Anglophone and Francophone)
- Centre Jeunesse Montreal—Department Protection de la Jeunesse (DPJ)—all Francophone families on the **island of Montreal**
- Centre Jeunesse Monteregie—Vaudreuil Dorion/Chateauguay/Valleyfield/Ile Perrot etc
- Centre Jeunesse Laval
- Tulattavik (Nunavik—Ungava Bay coast)—Kuujjuaq etc
- Inuulitsivik (Nunavik—Hudson Bay coast)—Puvirnituq etc
- Cree Territories

# Signalement

- Your name, professional title, professional address, and contact information
- Name of child, date of birth, names and dates of birth of the parents, phone number and addresses of parents
- Country/city of origin, citizenship, status, cultural background, religious affiliation
- Who has custody of the child, visitation schedule
- School/daycare/hospital/ CLSC of the child
- Do either parent have other children—their names, addresses, and contact information
- Services in place for the child/family in the past and currently
- ***Refer to handout***

# Signalement continued

- Risk factors related to article 38
- Report facts over feelings—evidence based
- Report risk to the child, even if revealed to be in the past
- Report new information related to risk as it is received, to either add to the signalement or re-signal new risk factors
- Retention or non-retention of the signalement must be communicated to the declarant—ensure you have received a decision (may take time for decision to be made)
- You can consult and DYP will decide if it is a signalement

# Intake department

**RTS**—Reception et Traitement des Signalements 8h to 17h weekdays
**SES**—Social Emergency Services 17h to 8h weekdays and 24 hours weekends
**VCT**—Verification Complementaire Terrain

These workers have a 32 delegation under the YPA (can obtain information without consent)

- RTS/SES worker receives the signalement and makes verifications by contacting the CLSC and school/daycare of the child
- They may at times contact the parent and make other verifications in order to make the decision
- If the decision requires further verification, a VCT worker may be asked to meet with the parents and children; they will report their findings and the decision will then be made whether to retain or non-retain the signalement
- The VCT worker may refer to community resources in order to support the family and non-retain the signalement

# Intake Department continued

- If the signalement is retained by RTS/SES/VCT, it will be done so as a Code 1, Code 2, or Code 3
- Code 1 requires immediate evaluation on the same day—within 24 hours
- Code 2 requires evaluation within 48 hours
- Code 3 requires evaluation within 72 hours

However, Code 3s have been known to wait a few months to a year due to wait times as a result of a lack of staff to investigate concerns. This is in violation of the YPA timelines/Harvey Protocols

If a signalement is non-retained, it does not mean that the family will be notified that a signalement has been received and non-retained. The declarant must be notified of the decision under the law

Non-retained signalements will stay in the system for two years and then deleted if there are no other signalements within that two year period

# Evaluation and Orientation

Evaluation and Orientation (E) and (0)workers also have a 32 delegation under the YPA

- Retained signalements will be investigated by E workers, and together with their managers and/or specialistes en activites cliniques (SAC), they will decide the articles of compromission
- The E worker will determine if the security and development of the child is compromised or not—SDC or SDNC and whether the facts are founded (FF) or facts are not founded (FNF). It is possible for there to be SDNC but FF
- If there is SDC and FF, the decision will be made to either sign voluntary measures with the family (if the family is collaborative), or petition youth court for court ordered measures to eliminate the risks to the child(ren)
- The length of measures is generally 6 months to one year; often further youth court hearings occur to extend measures

# Evaluation and Orientation continued

- The evaluation is meant to take a maximum of 3 weeks but can take up to one year or more depending upon the collaboration and/or court process/timing
- Placement of the child(ren) may occur depending upon the level of risk to the child if they were to remain in the care of the parents/caregivers, and can be voluntary or court ordered
- The O worker may be assigned once SDC FF is decided, and they may sign voluntary measures with the family; if court ordered measures are required, the E worker would be responsible for petitioning court (the O worker may begin working with the family while awaiting a Youth Court hearing)
- Referrals for support services/community resources can be made during the either the E or O stage depending on collaboration and consent of the family/child(ren)
- The file of the child(ren) is transferred to the Application of Measures(AM) department if longer term follow up is needed to eliminate risk(s) to the child

# Application of Measures

Application of Measures (AM) workers have a 33 delegation under the YPA which limits their abilities to investigate or obtain information without consent

- AM workers are charged with assisting the family achieve the measures (whether voluntary or court ordered) in order to eliminate the risks to the child(ren)
- AM workers will make referrals to support/community services to assist the family in achieving the measures with the consent of the family/child(ren)
- AM workers may return to court to re-orient the measures or add new articles of compromission (with the exception of physical or sexual abuse which must be investigated by EO workers)
- AM workers and their managers/SACs may propose measures, but the decision regarding measures are determined by the review process (personalized reviews and orientation tables), and it is the Reviewer who decides the measures and placement, if required for the security and development of the child. The decisions are based upon the reports of the AM worker and review meetings with the family

# Personalized reviews and orientation tables

Reviewers have a 32 delegation under the YPA

- Personalized reviews and orientation tables are scheduled by the AM worker and allow the reviewer to meet with the family and child(ren) and determine if the measures proposed by the AM worker and their manager/SAC are appropriate in a legal sense. Reviewers may consult with Youth Protection lawyers to assist in the process
- Reviewers make determinations regarding placements, adoptions, and potential tutorship based upon recommendations of the AM worker and their managers/SACs

# Permanency Planning

Timelines regarding the permanent plan of a child who is under Youth Protection

- Children 0-2 must have a permanent plan within 12 months
- Children 2-5 must have a permanent plan within 18 months
- Children over the age of 6 must have a permanent plan within 24 months

# Permanency Planning

**Preferred Permanent Plans**

- Keeping the child in the family environment
- Returning the child to the family environment

**Alternate Permanent Plans**

- Placing the child with a significant person until the age of majority
- Adoption of the child
- Tutorship under the YPA
- Placing the child in a foster family until the age of majority
- Placing the child in a resource offering specific care until the age of majority
- Developing a permanent plan oriented toward independent living

# Foster care department

- Foster care workers are quality control officers who ensure the quality of current foster homes and assess potential new foster homes based upon Ministerial guidelines. These guidelines cover physical safety of the home, size of rooms, size of windows in children's rooms, number of children per room based upon size, and potential foster caregivers cannot have criminal records, have declared bankruptcy, and must meet strict assessment criteria
- Foster parents are unionized and are responsible for managing financial support for the child and provided a salary to care for the child
- The child receives a $5 a day allowance which amounts to $150/month. The foster caregivers must save this money for the child and are accountable for any funds taken from the child's allowance
- Children receive a small yearly amount for activities and clothing that must be managed and accounted for by the foster caregiver

# Foster care department continued

There are 4 types of foster homes:

- Emergency foster homes
- Regular foster homes
- Mixed bank foster homes
- Kin foster homes (famille d’acceuil a proximite or FAP)

# Emergency foster homes

- Must be available to take a child at any time, day or night (if there is space in the home).
- Children in emergency foster home are meant to stay a few days, but sometimes stay for a year or more due to a lack of foster homes in the system; the homes are meant to stabilize the child temporarily until the decision is made to either return the child to the parent/caregivers or to place the child longer term
- Emergency foster homes are not intended to be long term foster homes but many children have been entrusted for long periods to foster homes, including age of majority placements

# Regular foster home

- Regular foster homes are intended to receive either short-term or long term placements
- They must be open to age of majority placements and for the children to have contacts with the parents
- All foster homes are responsible for transporting the children to medical, cultural, or educational appointments/meetings
- Foster caregivers are not responsible for transporting the children to and from parental visits and they are not responsible for supervising visits between the children and the parents

# Mixed bank foster homes

- These foster caregivers are assessed for long term foster care placements with a view to potentially adopting the child
- The possibility is never guaranteed as adoptability of the child is decided by the courts and the parents may achieve the measures set out by the court within the timeline provided to them
- Once the child is declared adoptable by youth court adjudication, the file of the child is transferred from a foster care worker to an adoption department worker to finalize the process.  The assessment of the foster care worker is used in the proceedings

# Kin foster home (FAP)

- Where possible, the EO and AM workers must explore the possibility of placing the child with family members
- These family members are assessed in the same manner as other potential foster parents; however, the director of youth protection may make certain dispensations regarding the Ministerial Guidelines if it is in the best interests of the child to be placed with family members; they would do so in consultation with the Ministry
- Family members are eligible to become tutors depending upon their performance as foster caregivers and appropriateness

# Foster homes

- All important decisions related to school, medical, and travel must go through the parents unless parental authority has been removed by the youth court; generally, parental authority is first transferred to the director of youth protection but might eventually be transferred to the foster caregiver through further youth court proceedings
- Recently foster caregivers have been granted the right to participate in youth court hearings, and their opinions/views are actively solicited by youth court judges in decision making

# Group Homes

- Children who are placed in group homes have behavioural issues that exclude them from foster care placements; the behaviours require greater supervision and monitoring than a foster home is capable of
- Behaviours such as suicidal ideation/attempts, emotional regulation issues, running away, being unaccountable in the community, school inattendance, or having risking frequentations are exclusion criteria for foster care
- Group homes are staffed by educators and there is a consistent routine or structure that must be followed.  The child must either attend school, or if over the age of 16 and not attending school, they must have a employment
- Time in the community is limited and weekend or weeknight passes may be permitted if the child's situation allows
- Some group homes have specific programs intended to support the child in changing behaviours and making good judgements

# Clinical support services and medical services

- Psychologists—there are a very small number of psychologists who work primarily with children in the units or group homes
- Challenges Program—intended for children who are acting out sexually
- Medical clinic—dedicated staff of nurses and doctor who see children from age 0 to 5 years old at the clinic.  The medical staff also meet with children at the group homes and units

# Indigenous DYP services

- Cree Nation in Quebec has established their own DYP services
- The YPA recently made changes with respect to Indigenous communities whereby Indigenous communities are intended to have dominion over their own youth protection services (not achieved in many regions of Quebec at this point)
- Indigenous communities of origin must be explored when the placement of an Indigenous child is imminent. The communities of the parents, grandparents are explored, even if the child or parent has never resided in that community. This is meant to ensure preservation of the culture of the child.
- Every Indigenous child in placement outside of their community, must have a cultural plan
- Non-Indigenous people can no longer adopt Indigenous children in Quebec; they can still be long term foster caregivers, but not adopt

# Questions?

## AVIS DE RECOURS EN RÉVISION

## RÉVISION

### a) Pouvoir

L'article 135 de la Loi prévoit qu'une personne peut, lorsque sa demande écrite a été refusée en tout ou en partie par le responsable de l'accès aux documents ou de la protection des renseignements personnels ou dans le cas où le délai prévu pour répondre est expiré, demander à la Commission d'accès à l'information de réviser cette décision.

La demande de révision doit être faite par écrit; elle peut exposer brièvement les raisons pour lesquelles la décision devrait être révisée (art. 137).

L'adresse de la Commission d'accès à l'information est la suivante :

**QUÉBEC**

Commission d'accès à l'information
Bureau 2.36
525, boul. René-Lévesque Est
Québec (Québec) G1R 5S9

Tél : (418) 528-7741
Téléc : (418) 529-3102

**MONTRÉAL**

Commission d'accès à l'information
Bureau 900
2045, rue Stanley
Montréal (Québec) H3A 2V4

Tél : (514) 873-4196
Téléc : (514) 844-6170

### b) Motifs

Les motifs relatifs à la révision peuvent porter sur la décision, sur le délai de traitement de la demande, sur le mode d'accès à un document ou à un renseignement, sur les frais exigibles ou sur l'application de l'article 9 (notes personnelles inscrites sur un document, esquisses, ébauches, brouillons, notes préparatoires ou autres documents de même nature qui ne sont pas considérés comme des documents d'un organisme public).

### c) Délais

Les demandes de révision doivent être adressées à la Commission d'accès à l'information dans les 30 jours suivant la date de la décision ou de l'expiration du délai accordé au responsable pour répondre à une demande (art. 135).

La loi prévoit spécifiquement que la Commission d'accès à l'information peut, pour motif raisonnable, relever le requérant du défaut de respecter le délai de 30 jours (art. 135).

# APPEL DEVANT LA COUR DU QUÉBEC

## a) Pouvoir

L'article 147 de la loi stipule qu'une personne directement intéressée peut porter la décision finale de la Commission d'accès à l'information en appel devant un juge de la Cour du Québec sur toute question de droit ou de compétence.

L'appel d'une décision interlocutoire ne peut être interjeté qu'avec la permission d'un juge de la Cour du Québec s'il s'agit d'une décision interlocutoire à laquelle la décision finale ne pourra remédier.

## b) Délais

L'article 149 prévoit que l'avis d'appel d'une décision finale doit être déposé au greffe de la Cour du Québec, dans les 30 jours qui suivent la date de réception de la décision de la Commission par les parties.

## c) Procédure

Selon l'article 151 de la loi, l'avis d'appel doit être signifié aux parties et à la Commission dans les dix jours de son dépôt au greffe de la Cour du Québec.

14 juin 2006
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