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Treatment Protocol

Philosophy: In my work with children and their families, I make every effort to maintain a deep regard for the child, young person and their family members. Through on-going education and professional development, I attempt to provide my clients with service using “best practice” principles as defined by current literature and research. I support the ATTACH White Paper on Coercion and do not use any coercive or intrusive techniques. As a Play Therapist, I incorporate play, art and drama with therapy. Having trained extensively with Daniel Hughes, I use Dyadic Developmental Psychotherapy with children and their caregivers who have attachment –related struggles.

Description of Process:

- **Intake and Admission:** Children and families are most often referred by child welfare agencies. Private referrals are also accepted. Initial phone contact usually discriminates unsuitable referrals and alternate options are given. Admission appointments are arranged with care-givers and care providers. Therapy consent, privacy policy, consents for disclosure if needed, are signed. Therapy consent is required from both parents if they are in the child’s life.
- **Assessment:** All relevant documentation is requested from the guardian. This includes social history, education history (report cards, IEP), psychological assessments, medical and psychiatric reports, parenting capacity assessments. I ask the guardian or care-giver to also give a complete oral history and supply court documents as necessary. As a psychotherapist, I do not make diagnoses and I rely on the assessments provided by other professionals (In Canada, only Psychiatrists and Psychologists can make clinical diagnoses). If at any time during therapy I judge that an particular assessment is necessary, I request and support this referral. Within the context of attachment, I use a checklist that is a compilation of Dr. Becker-Weidman’s Checklist and The Evergreen Checklist. This checklist is not used as a diagnostic tool but rather as a benchmark by which progress can be made. In addition, it is a convenient tool to note current symptoms. Parent and child report of progress are gathered regularly.
- **Treatment Planning:** The session length, frequency and duration of treatment is mutually agreed upon with the caregivers and guardians. Funding often impacts these decisions. Often a 3-6 month contract is established. Treatment goals are discussed and decided upon with mutual agreement. Young persons are often included in this discussion, while children have therapy explained and their oral consent given in their first session.
- **Treatment Techniques used:** see attached list.

Safety/ Risk Management: Physical and psychological safety is maintained by being attuned with children and their parents. Re-regulation of affect and arousal before safety is jeopardized is practiced consistently. Children are told at the outset of therapy that “no one and nothing gets hurt”. If a child is attempting to harm anyone, he or she is prevented from doing so by me or the parents in a nurturing way and in the least restrictive manner possible in order to keep everyone safe. Children have a choice to leave and sit in the waiting room and are not forced to continue participation. I have been trained in managing aggressive behaviour for 18 years.

Evaluation/ Outcomes/ and Follow-up: Parent, guardian and child reports of progress are regularly requested. The checklist mentioned above is used every six months. Therapy is usually diminished gradually and terminated when the clients are satisfied with progress. Clients are invited to re-establish contact if progress is not maintained. No other follow up is done.