Island Health Mental Health and Substance Use – Regional Substance Use Treatment Programs

Referral Package

Referral Process

1. Referral agent forwards the completed referral package to the Regional Triage Committee by scanning and emailing to treatmentcentres@islandhealth.ca
   a. If referring to Edgewood, Cedars, or Ravensview the Release of Information form is completed and sent along with the referral package to treatmentcentres@islandhealth.ca
2. Regional Triage Committee Assistant will screen the referral for completeness.
   a. If incomplete referrals are sent, the referral package is sent back requesting the missing information.
3. If deemed complete, the referral is sent to the Regional Triage Committee for review. The Committee will review the referral within one to two weeks.
4. The accepted referrals will be sent to the appropriate site to be added to the waitlist.
5. The designated site will contact the referral agent of the referral acceptance and provide a wait time estimate.
6. When a bed is available, the referral agent and participant will be contacted to plan intake.

If a referral is not accepted, the referral agent will be notified and provided with a list of resources available and the process for appealing the decision.

For service provider usage to refer individuals for bed-based substance use treatment centres – Coastal Sage Healing House, Edgewood Health Centre, Cedars at Cobble Hill, and Homewood Ravensview

Referral package completion checklist

Please note:

- This package is intended to be completed by a community support team member or a health care professional, in collaboration with the participant. A referring agent can include a counsellor, social worker, physician, psychiatrist, community health team member, psychologist, nurse practitioner, and/or case manager.
- This package can be completed by
- It is preferred that the referral package is completed electronically with page 12 and 13 physically signed

Before submitting to the Regional Triage Committee for processing, please ensure the following tasks are complete:

☐ Complete the included referral form, fill in all applicable boxes

☐ Complete the Release of Information Form for contracted sites (Edgewood Health Centre, Cedars at Cobble Hill and Homewood Ravensview) on page 13.

☐ Include the following collateral information if available and applicable:

- Current and recent psychiatric and/or medical consults
- Hospital admission/discharge notes
- Relevant discharge summaries
- Forensic assessments (if applicable)
- Current MAR or list of medications
- Probation/Bail orders

☐ Current Mental Health certificates (if applicable)

☐ In consultation with the participant, complete and attach the Early Exit Transition Plan form

☐ In consultation with the participant, complete and attach Participant Agreement for the appropriate program. Please ensure that it is signed.

☐ Review program specific participant guide with the participant.

☐ Ensure participant is successfully registered with British Columbia MSP.

☐ For clients being referred from the South Island, please complete the addendum questions on page 15.

The above components constitute a complete referral and will be reviewed by the programs' Regional Triage Committee once received. Additional information to about each site's participant selection criteria can be found on pages 15 and 16.

If you are having problems acquiring or completing the required information and would like support, please contact treatmentcentres@islandhealth.ca to be directed to the proper site contact for further clarification.

Referral Form

Select program:	☐ Coastal Sage Healing House ☐ Cedars at Cobble Hill		☐ Edgewood Health Centre ☐ Homewood Ravensview		
Participant's Referral Information					
Referral Date: (DD/MM/YYYY)					
Participant's Legal Name:		Preferred Name(s):			
Referring agent's contact name:					
If referring agent is hospital, name of hospital & unit:					
Referring organization:					
Ph:		Fax:		Email:	
Community Care Team Information					
MHSU Care Team Name:					
MHSU Care Team Contact Name:		Email:		Ph:	
Family Physician Name:		Fax:		Ph:	
Psychiatrist Name:		Fax:		Ph:	
Community Pharmacy:		Fax:		Ph:	
Client Information					
Date of Birth: (DD/MM/YYYY)		Age:		PHN:	
Gender Identity: (tick all that apply)	☐ Female ☐ Male ☐ My Gender Identity is _____	☐ Transgender ☐ Two-Spirit	☐ Non-Binary ☐ Questioning ☐ Prefer not to answer		
Pronoun: (tick all that apply)	☐ She ☐ He ☐ They ☐ My pronoun is _____				
Current Address:		City:			
Province:		Postal Code:		Ph:	Email:
Income Information: (tick all that apply)	☐ PPMB ☐ Hardship Assistance ☐ IA ☐ PWD ☐ Medical EI ☐ EI ☐ Employment ☐ No income ☐ Pension and/or CPP ☐ Old Age Security (OAS) ☐ Survivors Benefits ☐ Private Benefits				
Medical/Pharmacy Coverage					
Registered with BC MSP:	☐ Yes ☐ No				
Type of medical/ pharmacy coverage:		Third Party Insurer:			

Policy #:		ID #:	

Cultural Information

Does the participant identify as an Indigenous Person?	☐ Indigenous ☐ Participant declined, ask again later ☐ Non-Indigenous ☐ Participant declined, do not ask again ☐ Unknown ☐ Prefer not to answer
Predominantly lives:	☐ On reserve ☐ Off reserve ☐ Both on & off reserve
First Nations Status:	☐ Has status ☐ Non Status ☐ Pending Status

Status card #:		Band:	

Primary Language(s):		Interpreter needed?	☐ Yes ☐ No

Please provide details of language interpretation needs:	

We invite the participant let us know if there are any spiritual, religious practices or ceremonies that will support their wellness while in treatment: (please describe below)

Emergency Contact Person (Family/Friend/Support Person)

(Please note that the person below will be contacted should there be an emergent concern about safety, wellbeing, medical emergencies, etc.)

Name (first & last):		Relationship:	
Phone:		Email:	

Is there a power of attorney in place?	☐Yes	☐ No

If yes, name:		Ph:	

Family Involvement

Does the participant have children?	☐ Yes ☐ No	# of children:		Age of children:	

If child(ren), what is current living situation?	
If applicable, what visits are available for the participant with their child(ren)?	

Are there family members or friends that are important to the participant that they would like involved as part of their treatment planning or aftercare planning?	☐ Yes ☐ No

If yes, please provide details below:

Is there Ministry of Children and Family Development involvement?	☐ Yes ☐ No

Current Housing						
Housing Type:	☐ Own home/rental ☐ Shelter ☐ No fixed address ☐ With family/friends ☐ Subsidized housing ☐ Other: _____		Stable:	☐ Yes ☐ No	Safe:	☐ Yes ☐ No

Will housing be maintained for the duration of treatment?	☐ Yes ☐ No
If no, provide details:	

Is there a post-discharge housing plan?	☐ Yes ☐ No	Please describe actions taken to address post-discharge housing:

Participant Strengths

Treatment Goals

How can staff best support participants to achieve their treatment goals?

Is there any additional information that should be provided at this time?

Substance Use and other process issues/concerns

Participant has used/ a history with		Current Pattern	Date last used	# Days used in last 30 days	Route taken	Average amount used daily	Age at first use
☐	Alcohol						
☐	Non-beverage alcohol						
☐	Amphetamines						
☐	Ecstasy						
☐	GHB						
☐	Benzo						

☐	Cannabis						
☐	Cocaine						
☐	Crack cocaine						
☐	Crystal Meth						
☐	Fentanyl						
☐	Hallucinogens						
☐	Heroin						
☐	Inhalants						
☐	Other opioids						
☐	Tobacco/ Nicotine (incl. vaping/e-cigs)						
☐	Other (specify): _____						

Process Addictions

Participant has current/history with		Current Pattern	Date last active (D/M/Y)	# Days active last 30 days	Age at first use
☐	Gambling				
☐	Sexual activity				
☐	Pornography				
☐	Shopping				
☐	Shoplifting				
☐	Internet				
☐	Gaming				
☐	Social Media				
☐	Other (specify): _____				

Substance Use Treatment History

☐	Withdrawal Management/Detox/Stabilization	Dates:	

☐	Peer Support Groups (AA/NA/Smart Recovery/etc.)	Dates:	
☐	Community counsellor/social worker support	Dates:	
☐	Supportive Recovery	Dates:	

☐	Substance Use Treatment Programs (provide details below):

Program:		Date range:		Completed:	☐ Yes ☐ No
Program:		Date range:		Completed:	☐ Yes ☐ No
Program:		Date range:		Completed:	☐ Yes ☐ No

Other (please provide details below):
Why is this program being considered at this time?

Withdrawal History

Withdrawal management prior to admission needed?	☐ Yes ☐ No		
History of adverse events while in withdrawal (e.g. seizures):	☐ Yes ☐ No	Date of last seizure:	
Medically confirmed Delirium Tremens?	☐ Yes ☐ No	Hospital admissions for withdrawal?	☐ Yes ☐ No

Please provide any other information that the participant feels would be relevant to support them below:

Medical History

Environmental, food, medication allergies?	☐ Yes ☐ No
If yes, please provide a brief description, type of reaction(s) and treatment needed:	

Pregnant or post-partum?	☐ Yes ☐ No	Provide (estimated) date of delivery and other key details:	

Past overdose history?	☐ Yes ☐ No	If yes: ☐ Intentional ☐ Accidental	Date(s):	

History of disordered eating?	☐ Yes ☐ No	Is disordered eating still active?	☐ Yes ☐ No

If yes, provide details:	

Medical dietary concerns?	☐ Yes ☐ No	Does the participant have any dietary requirements?	☐ Yes ☐ No
Please note concerns and requirements here:			

Independent with Activities of Daily Living (ADLs)?	☐ Yes ☐ No	If no, provide details:	

Mobility issues?	☐ Yes ☐ No	If yes, please describe mobility challenge and what, if any, ability aids are being used and/or are needed below:

Fall risk:	☐ Yes ☐ No	HIV:	☐ Yes ☐ No ☐ Unknown	Hep C:	☐ Yes ☐ No ☐ Unknown

Visual impairment:	☐ Yes ☐ No	Prosthesis:	☐ Yes ☐ No	Head injury:	☐ Yes ☐ No ☐ Unknown
Hearing impairment:	☐ Yes ☐ No	Complex cognitive challenges:			☐ Yes ☐ No ☐ Unknown
Other:					

If yes to any of the above, please provide details:	
If yes to visual and or hearing impairment, please describe the challenge and what, if any, aids are being used and/or are needed below:	

DSM V Diagnosis/Mental Health History					
Psychiatric diagnoses (Axis I):					
Personality disorders & development disabilities (Axis II): Note: for head/brain injury/FASD or cognitive impairment provide a brief description of cognitive disabilities & attach any collateral assessments/reports.					
Medical Illness (Axis III):					
Psychosocial and environmental concerns (Axis IV):					
Is participant connected to Community Living BC?				☐ Yes ☐ No	
Contact Person:			Ph:		

Current Medication(s)

Please attach a list of medication such as a Pharmanet print-out, copy of prescriptions, Medication Administration Record (MAR) or write the information below

Medication & Dose	Date Started (D/M/Y)	Prescriber	Medication & Dose	Date Started (D/M/Y)	Prescriber

Currently on ARV treatment?	☐ Yes ☐ No	Have ARV medications been ordered for treatment?	☐ Yes ☐ No
Currently on long acting injectable antipsychotic medication?	☐ Yes ☐ No	Date of next required dose: (D/M/Y)	

Safety Concerns						
Self-harming behaviours?	☐ Yes ☐ No	Suicide ideation?	☐ Yes ☐ No	Flight risk?	☐ Yes ☐ No	
Sex work involvement?	☐ Yes ☐ No	Sexual offences involving minors?	☐ Yes ☐ No			
Arson/Fire setting?	☐ Yes ☐ No	Interpersonal/Domestic violence?	☐ Yes ☐ No			
If yes to any of the above, please provide detailed information about the safety concern and if possible, provide a copy of the safety plan. Please include the date and circumstances of the most recent incident for each concern.						
History of aggression?	☐ Yes ☐ No	If yes, ☐ Verbal ☐ Physical ☐ Sexual ☐ Other/Unknown				
Please provide a brief description of history of verbal and/or physical aggression incidents, outcomes and date of last occurrence (e.g. throwing objects, hitting someone, yelling, under the influence of substances).						
Please list effective interventions here, or attach a behaviour care plan/safety plan if there is one in place:						

Legal Information			
Is the participant supervised by a probation officer?	☐ Yes ☐ No	Is the participant currently out on bail?	☐ Yes ☐ No
Bail/Probation Officer's contact name:		Ph:	
Can the participant be supported in program in reference to recent/past charges?			☐ Yes ☐ No
Are there any conditions that we need to be aware of to support the participant's stay?			☐ Yes ☐ No
If yes, please provide details needed to support participant's stay:			
Upcoming court date(s) and location:			
Please provide details (e.g. transportation required, technological requirements, etc.):			
Status under the BC Mental Health Act:	☐ Certified ☐ Voluntary ☐ Extended Leave – Please attach all Forms 4, 6, & 20		

Safe Exit Plan				
A safe exit is when a participant leaves treatment prior to treatment completion. In this event, our goal is for the participant to have a safe place to go in their home community with appropriate supports. If the participant leaves on short notice, or an unplanned urgent discharge is required, the MHSU Community Care Team Contact and the Emergency Contact will be notified immediately and the participant will be discharged to the location listed below. **The plans below must be realistic and actionable within a short time-frame (e.g. 4-6 hours).**				
Participant Name:				
Key community contact for transition plan (name & relationship):				
Ph:		Email:		
Emergency contact and/or next of kin (name & relationship):				
Ph:		Email:		
MHSU Community Care Team Contact (name & organization/team)				
Ph:		Email:		
Safe Exit Discharge Plan – Plan A				
Safe exit location contact name:		Relationship:		
Safe exit location address:		Location Ph:		
If safe exit is home with family, are they aware?			☐ Yes ☐ No	
Safe exit transportation:				
If no, who will transport? (name, phone, relationship)				
Is this safe exit plan the same for the weekend?	☐ Yes ☐ No	If no, please provide alternative plan below:		
Safe Exit Discharge Plan – Plan B (Safe Exit due to Relapse)				
Safe exit location contact name:		Relationship:		
Safe exit location address:		Location Ph:		
If safe exit is home with family, are there aware?			☐ Yes ☐ No	
Safe exit transportation:				
If no, who will transport? (name, phone, relationship)				

Is this safe exit plan the same for the weekend?	☐ Yes ☐ No	If no, please provide alternative plan below:

Signatures

By signing below, I consent to the following:

- This referral is being submitted for consideration for an Island Health Regional Substance Use Treatment Program
- The information in this referral and any supporting documentation being released and shared between my community care team, regional health authority representatives, Island Health Regional Substance Use Treatment Program representatives is correct to the best of my knowledge
- Should I choose to leave the program early, my community care team, Island Health Regional Substance Use Treatment Program representatives and my emergency contact will be contacted and provided with an update
- My community team will be sent a discharge summary

Participant name (Print):			
Participant signature:		**Date: (D/M/Y)**	

Referral agent agrees to collaborate with the participant to ensure they reconnect with their community services upon discharge.

Referral agent name (Print):			
Referral agent signature:		**Date: (D/M/Y)**	

Release of Information Form

Consent to Sharing of Personal Information

- This consent is in regards to my referral to the treatment beds contracted by Island Health at Edgewood Treatment Centre, Cedars at Cobble Hill, and Homewood Ravensview (the “contracted service providers”).
- I consent to my care team, including Island Health representatives and the contracted service providers sharing my relevant health information to support quality and continuity of care.
- I confirm that the information in this referral and any supporting documentation being released and shared between my community care team, Island Health representative and the contracted service providers is correct to the best of my knowledge.
- Should I choose to leave the program early, my community care team and the Island Health liaison will be notified.

<table>
<tr><td>Client Name:</td><td rowspan="2">Referring Clinician agrees to collaborate with the client and service provider as required during and after participation in the contracted treatment program.</td></tr>
<tr><td>Client Date of Birth:</td></tr>
<tr><td>Date Signed:</td><td>Date Signed:</td></tr>
<tr><td>Client Signature:</td><td>Referring Clinician Signature:</td></tr>
</table>

Addendum for South Island Clients – Housing Overdose Prevention Services (HOPPS) Involvement

HOPPS are rooms in supportive housing facilities where residents of those buildings can go to use substances. The primary goal is to provide a space for people to inject previously obtained illicit drugs, with sterile equipment, in a setting where trained staff/resident responders can check-in, observe, and intervene in overdose situations as needed. The purpose of these questions is to enhance the understanding of HOPPS service usage, and to help plan for future service delivery.

Is the client living in a site where a HOPPS program is provided?	☐ Yes ☐ No ☐ Unsure	
If yes, which supportive housing site?	☐ Tally Ho Apartments ☐ Albina ☐ Muncey Place ☐ Le Soleil ☐ Juniper ☐ Tillicum Apartments ☐ Lighthouse ☐ Other _____	☐ Queens St. Apartments ☐ Tiny Town ☐ Capital City Centre (CCC) ☐ Mt. Tolmie ☐ Johnson St. Apartments ☐ Spaken House ☐ House of Courage (Catherine St.)
Is the client engaged in any HOPPS service provision either at their supportive housing site or another supportive housing site (i.e. use of safe injection space, use of safe inhalation space, and/or engagement with HOPPS staff and/or resident responder for witnessed consumption)?	☐ Yes ☐ No ☐ Unsure	
If known, which safe consumption contractor is being used?	☐ SOLID ☐ Peers ☐ Umbrella ☐ AVI ☐ Unknown	

Participant Selection Criteria

In order to help determine which program is most suitable for your client, the following table outlines the appropriateness criteria for each program.

Selection Criteria	Coastal Sage Healing House	Edgewood Health Centre	Cedars at Cobble Hill	Homewood Ravensview
Program Mandate	Moderate to severe substance use disorder. Participants may or may not have a stable co-occurring mild to moderate mental health disorder. Participants are voluntary. Participants require a woman-only environment.	Moderate to severe substance use disorder. Participants may or may not have a stable mild to moderate co-occurring mental health disorder. Participants are voluntary.	Moderate to severe substance use disorder. Participants may or may not have a stable mild to moderate co-occurring mental health disorder. Participants are voluntary.	Moderate to severe substance use disorder. Participants may or may not have a moderate to severe co-occurring mental health disorder. Some restrictions around mental health diagnoses exist, if you have questions about specific diagnoses please email treatmentcentres@islandhealth.ca. Participants are voluntary.
Specialization	People who identify as women & non-binary individuals	General substance use challenges	General substance use challenges	General substance use challenges and co-occurring mental health challenges
Length of stay	30-90 days with 9 month virtual after-care	50 days with 1-year after-care	50-90 days with 1-year after-care	42-63 days with 1-year after-care
Island Health Resident	✓	✓	✓	✓
Age	19+	19+	19+	19+
Gender Identity	People who identify as women & non-binary individuals	Individuals of all genders and orientations	Individuals of all genders and orientations	Individuals of all genders and orientations
Medically, Behaviourally and Psychiatrically Stable	✓	✓	✓	✓
Independent Activities of Daily Living:	✓ (Will provide set-up support)	✓	✓	✓
MHSU or Community Care Team Connection	✓	✓	✓	✓
Offers involuntary treatment (exceptions for Extended Leave or voluntary choice of treatment through Integrated Court or First Nations Court)	✗	✗	✗	✗

Offers on-site withdrawal management	✗	✓	✓	✓
Supports pregnant or immediately post-partum participants	✓	✓	✓	✓
Supports process addictions	✓	✓	✓	✗

Additional Considerations	**Exclusion Criteria**	**Program Discharge Criteria**
The following will also be considered when assessing participants for appropriate treatment match and timing:	*Please contact the site representatives noted on page 2 if unsure about exclusion criteria*	*Requests regarding early transitions/discharge from treatment program may include the following:*
Significant mobility challenges	Does not offer involuntary treatment.	Physical, sexual or verbal threats/ abuse/violence.
A recent and/or significant history of physical violence.	Sexual offences involving minors are considered on a case-by-case basis.	Participant's presentation or symptom severity requires care/ treatment in acute care/other tertiary facility.
Acute suicidality and ideation.	Arson/Fire setting are considered on a case-by-case basis.	Persistent pattern of alcohol or drug use and not engaging in safety or relapse prevention plans.
To ensure safety for all, participant mix and site milieu will be considered	Severe violence including sexual violence is considered on a case-by-case basis.	Attempted/recruitment of others into gangs or sex trade.
	Significant safety risk to themselves or others.	Recruiting others into illegal or harmful activities.
	Unable to support participants with neurocognitive disorders, dementia, and/or Alzheimer's diagnosis preventing their capacity to participate in programming.	Drug dealing/sharing.
		Persistent pattern of non-participation in programming.