Child, Youth and Family
Mental Health and Substance Use Services

YOUTH TIER 5 – MOBILE INTENSIVE CASE MANAGEMENT TEAM

PROGRAM & REFERRAL INFORMATION

YT5 Team

Youth Tier 5 (YT5) provides integrated service to youth primarily 13-18 years of age who have multiple and complex needs related to persistent and significant substance use and co-occurring mental health challenges. The YT5 Team is intended to reach both youth who have high needs for care but are not engaged with services; and youth who have a high need for care and frequently use available services, but whose needs have not been adequately met.

The YT5 Team utilizes a **wraparound team case management** approach offering **both brokerage and direct service**, to provide personalized care unique to each youth. The goals of the team are to improve health, social functioning, and access to care by offering a predominately intensive outreach approach providing comprehensive assessment, care planning, consultation, case management and systems navigation.

The YT5 Team is staffed by a transdisciplinary team of professionals who share the responsibility of care. The team includes specialists in psychiatry, mental health, primary care, addictions medicine, nursing, social work, substance use counselling, and family counselling.

Who We Serve

The target population is youth engaged in high levels of substance use with significant risk of negative health outcomes, and have not had their needs adequately met by existing systems. Priority will be given to youth who are experiencing these issues and identify as members of marginalized communities.

Our Core Services

- Community collaboration including referral, liaising, advocacy and collaboration
- Case management, including assessment and care planning
- Community outreach, support, and engagement with youth and families
- Crisis assessment, planning and intervention
- Individual, group and family skill building
- Psychosocial recovery supports, including life skills, school and employment
- Medication management (including Opioid Agonist/Replacement Treatment)
- Harm reduction supports
- Peer support
- Access to psychiatry and primary care

Our Goals of Service

- To improve coordination of services and enhance integration of services for youth and families
- To reduce avoidable hospitalizations
- To reduce harms of substance use for youth and their families
- To enhance access to health and psychosocial services

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Our Referral Process

Referrals for this target population are received from all sources, including self-referral and family referral. A YT5 team member will follow up to discuss in person the reason and goals of service.

Eligibility Criteria

A. Youth engaged in high levels of substance use with significant risk of negative health outcomes, with concurrent mental health concerns, leading to an inability to consistently perform the range of daily activities required for basic independence, family, school and community functioning. Youth require intensive outreach case management to help improve outcomes.

B. Youth with the aforementioned eligibility criteria may also be experiencing these factors:

- Additional vulnerabilities, including risk of homelessness and exploitation
- Neuro-divergence (developmental disabilities)
- Difficulties accessing services and/or have not been well served by traditional models of care (including emergency services)
- Limited or no professional supports
- High use of hospital and emergency services

Reminders

- **Fill out the Referral Form with the youth and obtain a signed Release of Information**
- **Fax to 250 519-3424**
- **Please include any relevant documents to support referral**
- **Completion of the referral form does not guarantee admission to this service**

PLEASE FAX THE FULLY COMPLETED FORMS TO:	PLEASE DIRECT ANY INQUIRIES TO:
250 519-6952	**250 519-5274**

island health

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YT5 REFERRAL FORM

DEMOGRAPHIC INFORMATION ABOUT YOUTH		
DATE OF REFERRAL:		**PERSONAL HEALTH NUMBER:**
LEGAL NAME:		**CHOSEN NAME:**
DOB:	**PRONOUN:**	**YOUTH'S PHONE:**
BEST WAY TO CONTACT YOUTH: ☐**PHONE** ☐**TEXT** ☐**IN PERSON** ☐**OTHER (i.e. EMAIL, FACEBOOK MESSENGER):**		
YOUTH'S ADDRESS:		
CAN WE LEAVE A MESSAGE?: ◯**YES** ◯**NO**		**WHERE YOUTH CAN BE FOUND IN COMMUNITY:**
PHYSICAL DESCRIPTION OF YOUTH:		
Does Youth identify as an Indigenous? ◯Indigenous ◯ Non-Indigenous ◯Unknown ◉No response **If yes, which First Nation or band?**		
What other cultural identities does the youth identify with?		
What languages does Youth speak?		
WHAT GRADE LEVEL HAS BEEN ACHIEVED_____ **SCHOOL NAME:** _____ **CURRENT STATUS:** ☐ **NOT IN SCHOOL** ☐ **PUBLIC SCHOOL** ☐ **PRIVATE SCHOOL** ☐ **ALTERNATIVE SCHOOL**		
Are there family members that are important to the client that they would like involved as part of their treatment planning or aftercare planning? ☐Yes ☐No Details:		
Legal Guardian Name:_____ Phone:_____ Email_____		

Housing Type:	☐**Own home/Rental** ☐**Homeless/Shelter/couch surfing** ☐**With Family/Friends** ▬**Foster Placement Name:** _____ ▬**Subsidized Housing** ☐**Other:** _____	**Is this Housing Secure/Stable** ▬**YES** ☐**NO**	**Is This Housing Safe?** ☐**YES** ▬**NO**
If Housing is not Safe/Secure, please provide details:			
REFERRED BY (NAME/AGENCY): _____			

PHONE: _____ **FAX:** _____ **EMAIL:** _____

FAMILY PHYSICIAN/NP _____ **PHONE** _____ **FAX:** _____

WHAT OTHER RESOURCES ARE THE YOUTH CONNECTED WITH? PLEASE INCLUDE IN THE "OTHER" SECTION OF THE RELEASE OF INFORMATION

CONTACT _____ **AGENCY** _____ **PHONE**_____

CONTACT _____ **AGENCY** _____ **PHONE**_____

CONTACT _____ **AGENCY** _____ **PHONE**_____

CURRENT CONCERNS

SUBSTANCE USE

HAS USED/HISTORY OF USE		CURRENT PATTERN	DATE LAST USED	# OF DAYS USED IN LAST 30 DAYS	ROUTE TAKEN (SMOKING, IV, SNORTING, ETC.)	AVERAGE AMOUNT DAILY	AGE AT 1ST USE
☐	Alcohol						
☐	Non-beverage Alcohol						
☐	Amphetamines/Speed						
☐	DXM (cold/cough meds)						
☐	Ecstasy						
☐	GHB						
☐	Benzo						
☐	Cannabis						
☐	Cocaine						
☐	Crack Cocaine						
☐	Crystal Meth						
☐	Fentanyl						
☐	Hallucinogens						
☐	Heroin						
☐	Inhalants						
☐	Other Opioids						
☐	Tobacco (incl. vaping / e-cigs)						
☐	Other (Specify):						

Substance Use Treatment History

Withdrawal Management/Detox/Stabilization	Dates:	Details:

Peer Support Groups (AA/NA/Smart Recovery)	Dates:	Details:
Community Counsellor/Social Worker Support	Dates:	Details:

Residential Treatment Programs *(provide details below)*

Program:		Date Range:		Completed Program: ■Yes ☐No
Program:		Date Range:		Completed Program: ☐Yes ■No
Program:		Date Range:		Completed Program: ☐Yes ☐No

HEALTH HISTORY

MEDICAL PROVIDER:	**CONTACT INFORMATION:**
PSYCHIATRY PROVIDER:	**CONTACT INFORMATION:**

PSYCHIATRIC DIAGNOSES/PRESENTATION:

PERSONALITY DISORDERS & DEVELOPMENTAL DISABILITIES:
Note: For head/brain injury/FASD or cognitive impairment: provide a brief description of cognitive disabilities & attach any collateral assessment/reports (e.g. most recent assessment(s) from psychiatry, O.T, psychology etc. if available)

MEDICAL ILLNESS:

PSYCHOSOCIAL AND ENVIRONMENTAL CONCERNS:

SAFETY CONCERNS

Self-harming behaviours?	☐ Yes	☐ No	Suicide ideation?	☐ Yes	☐ No	Flight Risk?	☐ Yes	☐ No	
Sex-trade work?	☐ Yes	☐ No	Sexual offences?		☐ Yes		☐ No		
Interpersonal/Domestic violence?	☐ Yes	☐ No	Arson/Fire Setting?		☐ Yes	☐ No			
Suicide attempt/s?	☐ Yes	☐ No	Dates of attempt/s: (please list all dates)						

If yes to any of the above, please provide detailed information about the safety concern and if possible, provide a copy of any previous safety plan.
Also please provide the date & circumstances of most recent incident for each one

History of aggression?	☐ Yes	☐ No	If Yes ☐ Verbal ☐ Physical

Please provide a brief description of history of verbal and/or physical aggression incidents, outcomes and last occurrence (e.g. throwing objects, yelling, under the influence of substances).

Effective Intervention(s):

Legal

Is the client supervised by a probation officer?	☐ Yes	☐ No	Is the client currently out on bail?	☐ Yes	☐ No

Bail/Probation Officer's name:		Contact Information:	

Are there any conditions that we need to be aware of to support the youth? ☐ Yes ☐ No

Upcoming court date/s:

Location:

Status under the BC Mental Health Act	☐	Certified - Please attach Forms 4 & 6	☐	Voluntary
	☐	Extended Leave – Please attach Forms 4,6 & 20		

STRENGTHS/ENGAGEMENT/GOALS

YOUTH STRENGTHS/INTERESTS:

ENGAGEMENT TOOLS:

GOALS FOR YT5 ICM TEAM:

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AUTHORIZATION FOR RELEASE OF INFORMATION

Our partnership with other services means that we will be:

- Sharing information/updates which includes exchanging important information with the staff at the resources you are utilizing
- Contacting resources you access to be able to follow-up and support you with care planning
- Sharing information with the health authorities where you are to best support your transition planning
- Discussing care plans that best suit your needs
- Supporting access to your personalized care plan with the rest of the members of your team
- Accessing your Island Health profile and history

I, _____ , am **aware of this referral** to YT5 and **give permission** for YT5 team members to contact the following agencies for more information, or to try and make contact with me:

☐ **Referral source** _____

☐ **Parent/Legal Guardian** _____

☐ **Primary Care Provider** _____

☐ **Foundry Victoria/Youth Clinic**
☐ **Youth Empowerment Services – Outreach, Alliance Club, KEYS, SYD**
☐ **Discovery Youth and Family Substance Use Services**
☐ **MCFD Child and Youth Mental Health**
☐ **MCFD Guardianship/Protection**
☐ **Probation (MCFD and/or Ministry of Public Safety and Solicitor General)**

☐ **Other:** Write in space below. Example - shelters, Victoria Native Friendship Centre, Outreach Worker

_____

_____

If I do not meet criteria for YT5 service, I consent to YT5 referring me to the following service(s) instead:

☐ Victoria Foundry

☐ Youth Empowerment Outreach Services

☐ Discovery Youth and Family Substance Use Services

☐ Other: _____

Consent is required for YT5 to connect with the youth or their supports for screening and program engagement. Consents can be updated or changed at any time by the youth.

_____ _____
Youth Signature **Date**

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