



NARSF
PROGRAMS LTD.

TRANSITIONS PROGRAM
REFERRAL PACKAGE FOR
DRUG & ALCOHOL COUNSELLORS

“Recognizing Strength, Building Capacity”

201-170 Wallace Street

Nanaimo, BC V9R 5B1

INTAKE PHONE: 250-714-8167

FAX: (250) 754-1605

REFERRAL AGENCY: _____

REFERRAL WORKER: _____

OFFICE: _____

PHONE: _____

FAX: _____ **EMAIL:** _____

TRANSITIONS PROGRAM

REFERRAL PACKAGE FOR ALCOHOL & DRUG COUNSELLORS

REFERRAL CRITERIA

Transitions is a voluntary program designed for females and males 13-19 years of age who have concerns related to personal or familial substance misuse and the contributing factors associated to substance misuse. **Referrals to the program are accepted only from Alcohol & Drug Counsellors with VIHA Discovery Youth and Family Addictions Services, or VIHA Alcohol & Drug contracted agencies. Referrals are accepted on an ongoing basis, Monday – Friday 9:00 am to 5:00 pm (excluding statutory holidays).**

PROGRAM INFORMATION

The Transitions Program offers two types of residential service. Youth who attend the Transitions Program will reside in one of our care homes for Withdrawal Management or Supportive Recovery in the Parksville / Qualicum or Ladysmith area while receiving weekly, day or evening support from the youth's assigned Care Coordinator and appointments with a Alcohol & Drug Counsellor. Our care homes serve 2 youth each.

Withdrawal Management (WDM)

Youth will stay up to ten days for acute WDM services. WDM is a voluntary and non medical program. Care providers carefully observe the youth for the first 72 hours and complete Withdrawal Symptoms records. Youth are carefully supervised during the stay in WDM. A specific set of rules and guidelines are followed to ensure youth are able to focus on health and wellbeing. A WDM Service Plan is created after the Program Coordinator completes the needs assessment with the youth and family. The service plan defines the goals and needs of youth while staying in the WDM care home. The plan also provides ideas for planning routine and programming activities for improved physical and psychological health. Family involvement is considered central to our approach and consistent efforts are made to engage family in communication to offer support to members as needed, as well as to encourage ways they can support their child, during a youth's seven to ten day stay.

Supportive Recovery (SR)

Youth will stay from one to three months for SR services. SR is a voluntary and non medical program. Care providers work with youth to continue to work on the stable routine and substance free environment established while in Withdrawal Management. Youth are slowly given more responsibility over their life functioning, and therefore experience a more typical amount of life stressors. The SR care home supports youth with accepting these daily stresses and encourages new ways of coping and behaving under life stress. A specific set of rules and guidelines are followed to ensure youth are able to continue to focus on physical and psychological health, as well as developing improved self talk, communication, relaxation and visualization skills. An Individual Service Plan (ISP) is created after the Team completes the Integrated Case Management meeting with the youth and family, and is reviewed monthly for progress,

emerging issues, and relevance. The ISP defines the needs and short term goals of youth while staying in SR care home. The plan also outlines the specific strategies that will be used to achieve the goals and the roles and responsibilities of the team members – including the youth`s job. Family involvement is considered central to our approach and consistent effort is made to engage family in communication to offer support to members as needed, as well as encourage ways they can support their child over the one to three month stay. Parents are offered additional counselling through NARSF`s Living In Families with Teens (LIFT) Program, and can access such services on request.

REFERRAL PROCEDURE

1. Contact the NARSF Transitions Program at **250-714-8167** to request a Referral Package or refer to Narsf Program website for updated referral package (www.narsf.org).
2. Fax the completed referral information to **250-754-1605**. A completed referral includes the following for:

Withdrawal Management:

- Intake and Initial Assessment or a Client Summary of Services
- Psychoactive Drug History Form (2 pages)
- NARSF Transitions Referral Form (5 pages)
- NARSF Transitions Medical Screen Form (1 page)

and for ***Supportive Recovery also include:***

- Tuberculosis Skin Test results
- Any Individual Service Plans, Safety Plans and or probation orders
- Previous assessments completed and services or programs attended.

3. Counsellors will provide the youth with a copy of the NARSF Medical Screen form (1 page) to be completed prior to Admission date. Youth / families or the Screening Physician can submit the Medical Screen form in person or by fax directly to the NARSF Transitions Program Care Coordinator.

After receiving the referral information a NARSF Transitions Care Coordinator proceeds by:

1. Contacting the referring Drug and Alcohol Counsellor to review the referral, and identify objectives and historical themes.
2. Completing an assessment with the youth and family to determine needs and goals, eligibility and placement priority of the referred youth. This assessment can be completed in person or by phone contact.
3. Notifying the referring youth, family and referring Drug and Alcohol Counsellor of the expected placement start date as well as pre schedule the discharge meeting.

PSYCHOACTIVE DRUG HISTORY FORM

Drug	Used in past 12 mos	# of days used in past 30 days*	Age of first use	How long since last use?**	Typical amount used each day in last 30 days***	Method of Use? +	Stage of Change ++	Clinical Comments (Drug name, dosage patterns, periods of abstinence, used only as prescribed, peer group usage, IV pattern, used prior to last 12 months etc).
Alcohol								
Cannabis								
Heroin								
Prescription Opiates (codeine, morphine)								
Cocaine								
Crack Cocaine								
LSD								
Mushrooms								
Crystal Meth								
Amphetamines /Ecstasy								

Drug	Used in past 12 mos	# of days used in past 30 days*	Age of first use	How long since last use?**	Typical amount used each day in last 30 days***	Method of Use? +	Stage of Change ++	Clinical Comments (Drug name, dosage patterns, periods of abstinence, used only as prescribed, peer group usage, IV pattern, used prior to last 12 months etc).
GHB								
Benzodiazepine (Valium, Sleeping pill)								
Dissociative Anesthetics (Ketamine)								
PCP								
Prescription Drugs								
Inhalants								
Other								
Tobacco								

Drug and Alcohol Counsellors Please review the Medical Screening Form and the Program Handout/ Brochure with your client and family, before submitting the referral to ensure that the youth and his / her family is fully informed of the program components and expectations.

Transitions Youth Withdrawal Management Referral Form

Date of Referral: _____ (Day/Month/Year)

Client Demographic

Name: _____ DOB: _____ Age: _____

Gender: M F T

Address: _____ Ethnicity: Caucasian Aboriginal

Other _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Information

Legal Guardian (1): _____

Address: _____

Phone: (H) _____ (C/W) _____

Relationship _____

Legal Guardian (2): _____

Address: _____

Phone: (H) _____ (C/W) _____

Relationship _____

Emergency Contact Phone _____

(If different from above)

Relationship to Emergency Contact _____

Is the youth in care of the Ministry of Children and Family Services? Yes No

Social Worker: _____

Office: _____

Phone: _____ Cell _____

Email: _____

Fax: _____

Foster Parent: _____

Address: _____

Phone: _____ Cell _____

Risk Factors/Related Issues

<input type="checkbox"/> Mental health Issues	<input type="checkbox"/> Self Harming/Cutting	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Fire setting
<input type="checkbox"/> Homelessness/Couch Surfing	<input type="checkbox"/> Disconnected from Family	<input type="checkbox"/> Cognitive Challenges	<input type="checkbox"/> Running away from home
<input type="checkbox"/> Criminal Behaviour/Youth Justice	<input type="checkbox"/> Suicide ideation	<input type="checkbox"/> School Drop out	<input type="checkbox"/> Anger/aggression
<input type="checkbox"/> Sexual inappropriateness	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Drug Trafficking	<input type="checkbox"/> Trauma

Does the youth agree to the referral? Yes No Does the youth want Detox? 7 days 10 days

Health

Education and Legal

1.	History of mental illness <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently attending school
2.	Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Grade:
3.	Significant Health Issues Pertinent to Detox?	Have you ever been in trouble with the law? <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Family history of substance use <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on Probation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Age of first use:	Family history of mental illness <input type="checkbox"/> Yes <input type="checkbox"/> No	Probation Officer

Have you experienced a complicated withdrawal, requiring medical intervention, previous to this? Yes No

Additional Information:

SUPPORTS AND COLLATERAL SERVICES

The purpose of this section is to identify significant relationships in the youth's life. Please list individuals important to the youths' bio-psycho-social system of support in order to assist Transitions staff implement a Service /discharge plan. (e.g. *Outreach Worker, Justice Worker, Significant Adult Mentor, Family Relative, Social Worker, etc*)

Name	_____	Phone	_____
Position/relationship to client	_____		
Organisation/Agency	_____		
Address	_____		
Postcode	_____	Fax	_____
		Email	_____
Name	_____	Phone	_____
Position/relationship to client	_____		
Organisation/Agency	_____		
Address	_____		
Postcode	_____	Fax	_____
		Email	_____
Name	_____	Phone	_____
Position/relationship to client	_____		
Organisation/Agency	_____		
Address	_____		
Postcode	_____	Fax	_____
		Email	_____
Name	_____	Phone	_____
Position/relationship to client	_____		
Organisation/Agency	_____		
Address	_____		
Postcode	_____	Fax	_____
		Email	_____



CLIENT CONFIDENTIALITY STATEMENT

I understand that my involvement is voluntary and confidential. The main exceptions to the confidentiality policy are:

In cases of suspected child abuse or neglect, and in cases of current or past sexual abuse in which the offender may have present access to minor aged children, staff are obligated to inform appropriate authorities at the Ministry of Children and Family Development;

When a client states that he/she intends to inflict bodily harm on self or another person, staff are obligated to notify the intended victim and/or the appropriate emergency services;

When staff are subpoenaed to testify in court at the direction of a judge or by the Workers Compensation Board;

When a person appears unfit to operate a vehicle and is known to intend to drive upon leaving the agency, police will be notified,

When specific referral sources request (eg. Probation Officer, Social Worker) attendance and completion requirements,

If staff participate in supervisory case consultation with qualified personnel at/through NARSF Programs Ltd.,

For the purpose of quality assurance by qualified personnel.

Any release of information outside the agency regarding a client shall otherwise be by the client's written and signed consent. Please sign to indicate that you have read and understand this statement.

Signature of Client/Guardian

Date



RELEASE OF INFORMATION AUTHORIZATION

NARSF Programs Ltd. (Transitions Program) is an agency/program that works within a community framework. This means that at times, it is important to share relevant information about you and your family with other professionals to assist NARSF staff to gain a better understanding to the clients' unique characteristics, strengths, needs and abilities.

The sharing of information will only be with persons directly concerned with your case and whenever possible, this will be discussed with you first.

I hereby authorize the staff of NARSF Programs Ltd. to request or release information regarding:

(Client name) Date (effective for one year from time of signing)

[in consultation with the professionals or individuals named below]

Content to include, but not be limited to:

It is further understood that, regarding a matter of professional safety such as child protection, or when a client is a danger to themselves or others, NARSF staff are legally obligated to bring this to the attention of the appropriate community resources.

If for any reason or at any time this Release of Information Authorization is to be revoked a request must be made verbally or in writing to the case coordinator.

Client Date

Staff Person Date



NARSF TRANSITIONS PROGRAM MEDICAL SCREENING FORM

Physician: PLEASE RETURN THIS FORM TO YOUTH / FAMILY

Youth/Family: PLEASE ensure this form is received by Transitions Program Staff prior to admission to detox

Date: _____ Youth Name: _____ Phone: _____ DOB: _____

PHN: _____ Legal Guardian: _____ Phone: _____

Address: _____ Postal Code: _____ Primary Care Physician: _____

Please highlight any medical concern that should be considered as the youth will be withdrawing from substances in a non-medical detox care home setting. Typical length of stay in the Transitions Withdrawal Management detox is 7-10 days. Please circle yes or no and give details as needed.

Confirm the drug(s) the client will be detoxing from:

Drug(s): _____ **Last Use:** _____ **Length/Method of Use:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Temperature:** _____ **Heart Rate:** _____ **bmp**

Any Known Allergies: _____

1) Do you believe the youth can safely withdrawal in a non-medical detox care home? Yes No
If not, please explain why? _____

2) Are you prescribing any withdrawal management medication? Yes No
If yes, please provide details: _____

3) Are you prescribing the use of any over the counter medication? Yes No
If yes what OTC medications are being prescribed and for which specific condition?

4) Does the youth have any presenting MEDICAL concerns that would intensify any health and/or safety issues while in a family care home/non-medical detox (such as: history of seizures, history of serious withdrawal symptoms, asthma, respiratory problems, diabetes, etc.)? Yes No
If yes, please provide details: _____

5) Does the youth have any presenting MENTAL HEALTH concerns that would intensify any health and/or safety issues while in a family care home/non-medical detox (such as: suicide ideation, previous suicide attempts, severe depression, etc.)? Yes No
If yes, please provide details: _____

6) Is youth taking medication for any of the above conditions mentioned in # 4 or #5? Yes No
What medications are being prescribed and for which specific condition:

7) Is the female youth pregnant or has she missed more than 1 period in the past 6 months? Yes No

8) If the youth is pregnant, can the mother and fetus withdrawal safely in a non-medical detox? Yes No

Physician: _____ Signature _____ Phone: _____ Address: _____



PRE INTAKE HANDOUT

What Youth and Families Can Expect

Transitions Youth Withdrawal Management & Supportive Recovery Program

Transitions is a program designed to help youth with problematic drug and alcohol use achieve their goal of abstinence or reduce harmful consequences of substance misuse. The program is voluntary and offers non-medical, multi-model services to youth between the ages of 13-19 years in a private, safe, chemical-free and supportive care-home setting.

Program Features

The **Youth Withdrawal Management** (detox) program provides a safe and supportive environment for voluntary withdrawal from alcohol and/or other drugs. Services are geared to youths under the influence of substances, in withdrawal, and/or otherwise in crisis directly related to substance use. The program provides support and supervised care as each youth goes through his/her unique withdrawal process. The length of stay ranges from seven to ten days. During this time the Program Care Coordinator and Discovery Youth and Family Addiction Services (DYFAS) counselors meet with the youth to develop a service plan to meet his/her individual needs. Additional support such as discharge planning and early recovery education is also provided.

Transition Supportive Recovery (Stabilization) Program provides youth an opportunity to stabilize from the physical, emotional, and educational consequences of substance use for a period of one to three months. Individual case planning addresses educational, vocational, life skills development, leisure and recreational opportunities, relapse prevention, harm reduction and personal development needs of each youth. Services and support to youth and their family in the program include: assessment, home visits, individual alcohol and drug counseling, education, support and assistance with post withdrawal treatment planning.

Supportive recovery offers a safe, supportive place where youth can experience new opportunities, overcome barriers, build positive relationships, return to school, attend support meeting, make significant life changes and develop confidence and skills for life.

What to Expect

Following acceptance into the program, a service plan is created with the youth in order to address his or her individual needs. These may include:

- Withdrawal management
- Substance misuse/harm reduction
- Supportive recovery
- Educational/vocational needs
- Life skills
- Safety planning
- Family relationships
- Nutrition
- Health needs
- Independent living skills
- Social/recreational needs
- Mental health concerns

Program Outcomes

- Withdrawal from drugs/alcohol
- Connection to school/employment
- Improved health
- Expanded social network
- Increased self-esteem
- Reconnection to family
- Exposure to positive recreational activities

Our Staff

Transitions is staffed by two Care Coordinators. Staff work closely with the Vancouver Island Health Authority Discovery and Contracted Agencies providing Youth and Family Addiction Services.

Fees for Service

The Transitions Program is free of charge and is funded by the Vancouver Island Health Authority.

Languages Spoken

English, or interpretive services, by arrangement.

Access to Program

Call a VIHA Discovery Youth and Family Addiction Services or a contracted VIHA Addictions Program to speak with a drug and alcohol counsellor at (250) 739-5790 and set up a meeting to complete:

Needs Assessment: A Drug and Alcohol Counsellor will conduct an initial assessment with the youth / family to determine their suitability for a referral to the Transitions Withdrawal Management or Supportive Recovery Care Home.

Medical Screening: Youth are required to attend a medical appointment with a medical physician who will determine the youth's appropriateness to stay in our non-medical Withdrawal Management or Supportive Recovery Care Home.

Admission: Prior to a youth's admission to a Transitions Care Home, an Intake meeting is held to sign pre admission forms, provide Program Orientation and set clear Withdrawal Management service goals.

If being admitted to Supportive Recovery Program, an initial integrated case management meeting is held. The ICM involves the entire team of relevant individuals to outline services, clarify roles, and set initial service goals.

Location

NARSF Transitions Program care-homes provide structured supervision and support within a family setting. The safe placement of youth emphasizes the protective and supportive elements of family living while encouraging and providing opportunities for independent growth and responsible community living. In addition, mutual self-help, assistance in economic, education, vocational and social adjustment, the integration of the life skills into daily life and a solid recovery plan is provided.

Transitions Office:

#2B-170 Wallace Street, Nanaimo, BC. Information Phone Lines: 250-754-2773 ext 218 or 221. If you have a referral please call the INTAKE LINE at 250-714-8167. Fax: 250-754-1605

Funding for this program is provided by the Vancouver Island Health Authority

PLEASE NOTE THE FOLLOWING:

Program participation may involve recreation and leisure activities in the community. It is understood that this program includes sports activities, where the risk of injury is always present. It is further understood that reasonable care and precautions for safety will be expected and implemented at all times by youth participants and professionals alike.