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Supportive Recovery Program
Referral Package 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 youth client. It is preferred that the referral package is completed digitally and submitted to intake@thresholdhousing.ca.

Date:	
Youth Name:	
Referring Agency:	

- ☐ Checklist
- ☐ Application Form
- ☐ Release of Information
- ☐ Guidelines and Standards
- ☐ Consent for Services
- ☐ Exemption Consent Form (For Minors Only)
- ☐ Early Exit Plan
- ☐ Childhood Immunization Status

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SUPPORTIVE RECOVERY PROGRAM APPLICATION

THIS SECTION MUST BE COMPLETED DIGITALLY

Referrer Information	
Name:	
Date:	
Agency:	
Email:	
Phone Number:	
Reason for Referral:	

Youth Applicant Information	
Name:	
Pronoun:	
Gender Identity:	
Cultural Identity:	
Languages spoken:	
Age:	
Birthday:	

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Applying from:	○ Westshore – Colwood/Langford/Sooke ○ Victoria/South Island ○ Mid-Island ○ North Island		
Enrolled in school:	○ Yes ○ No		
Employed:	○ Yes ○ No		
Describe the applicant's daily schedule:			
Current Address:			
Phone Number:			
Email:			
Legal Guardian:	Name:	Contact Information:	Relationship:
Emergency Contact:	Name:	Contact Information:	Relationship:

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Program Goals
What are the applicant's goals in a supportive recovery program?
How are they best supported with these goals?
What are the applicant's strengths?
What challenges does this applicant experience?

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Are there family members that are important to the applicant that they would like involved as part of treatment planning or aftercare planning?

Current Housing
Describe the applicant's current housing situation:
Is there a post-program housing plan?

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Medical History

List all medical diagnoses:

- ☐ Attention Deficit Disorder
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Reactive Attachment Disorder
- ☐ Fetal Alcohol Spectrum
- ☐ Psychosis
- ☐ Eating Disorder
- ☐ Mood Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Complex Post-Traumatic Stress Disorder
- ☐ Family History of Mental Health Diagnoses
- ☐ Family History of Substance Use
- ☐ Obsessive-Compulsive Disorder
- ☐ Oppositional Defiant Disorder
- ☐ Borderline Personality Disorder
- ☐ Bi-Polar Spectrum
- ☐ Depression
- ☐ Anxiety
- ☐ Learning Disability
- ☐ Developmental Disability
- ☐ Neurological Disability
- ☐ Autism Spectrum
- ☐ Other (Please specify)

List any allergies:

List all medications and dosages:

List all medical contacts:

Vaccinations and Immunizations:

- ☐ COVID-19 Vaccinations
- ☐ Childhood Immunizations
- ☐ Recent Flu Shot
- ☐ Recent Tuberculosis Screening

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Substance Use History								
Applicant has a History with:		**Age of 1st Use**	**Current Pattern of Use**	**Date of Last Use**	**# of Days Used in the last 30 Days**	**Route Taken (Intravenous, Smoke, etc.)**	**Average Amount Used Daily**	**Goals for this Substance**
☑	*Example: Cannabis*	*15*	*3x daily*	*Jan 1 2021*	*30*	*Smoke*	*1 gram*	*Only use on weekends*
☐	Alcohol							
☐	Non-beverage Alcohol (Listerine, rubbing alcohol, etc.)							
☐	Amphetamines (Dexedrine, Adderall, etc.)							
☐	Ecstasy (MDMA, MDA, etc.)							
☐	GHB							
☐	Benzodiazepines							
☐	Cannabis							
☐	Cocaine							
☐	Crack							
☐	Crystal Meth							
☐	Fentanyl							

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Applicant has a History with:		Age of 1st Use	Current Pattern of Use	Date of Last Use	# of Days Used in the last 30 Days	Route Taken (Intravenous, Smoke, etc.)	Average Amount Used Daily	Goals for this Substance
☐	Heroin							
☐	Oxycodone/ Oxycontin							
☐	Morphine/ Codeine							
☐	Kratom							
☐	Hydromorphone/ Dilaudid							
☐	O.A.T. (Suboxone, Methadone, Kadian)							
☐	Psilocybin							
☐	DMT							
☐	LSD							
☐	Inhalants (Gasoline, Nitrous Oxide, Poppers, etc.)							
☐	Prescriptions							
☐	Tobacco							
☐	Vaping							
☐	Other (Specify)							

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Process Addictions					
Applicant has a History with:		Current Pattern	Date Last Active	# of Days Active in the last 30 Days	Age of 1st Use
☐	Gambling				
☐	Sexual Activity				
☐	Pornography				
☐	Shopping				
☐	Shoplifting				
☐	Internet				
☐	Social Media				
☐	Video Games				
☐	Exercise				
☐	Other (Specify)				

Overdose History		
Has the applicant ever overdosed? If yes, complete the section below.	Yes ○	No ○
Was the overdose(s) accidental or intentional?		

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How many times have you overdosed?	
What substances were used?	
Where were you?	
Was naloxone administered?	
Was hospital admission required?	
Please provide any other information about the overdose event(s) that the applicant would feel is relevant to support them.	

Treatment History		
Withdrawal Management/Detox/Stabilization	Date/Details:	
Substance Use Community Groups (AA/NA/Smart Recovery)	Date/Details:	
Counsellor, Peer Support, Social Worker, Outreach Worker, etc.	Date/Details:	

Residential Treatment Programs *(provide details below)*		
Program Name:	Dates Attended:	Completed Program?
		Yes ○ No ○
		Yes ○ No ○
		Yes ○ No ○
		Yes ○ No ○
		Yes ○ No ○

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Any other substance-use related resources the applicant has engaged with:	
What are some things the applicant liked, found helpful or useful from previous substance use resources?	
What are some things the applicant did not like, did not find helpful or useful from previous substance use resources?	
Why is Threshold's Supportive Recovery Program being considered at this time?	

Safety Concerns	
List any cause for safety concerns:	
☐ Self-Harming Behaviour ☐ Suicidal Ideation ☐ Suicide Attempt ☐ Flight Risk ☐ Arson/Fire-setting ☐ Interpersonal Violence	☐ Sexual Offence Involving a Minor ☐ Physical Aggression ☐ Verbal Aggression ☐ None ☐ Other (please specify)
What form of intervention is most effective?	

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Community Supports		
Name:	Contact Info:	Relationship:

Is there any other information you would like to provide that would help us better support this applicant?

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Supportive Recovery Program
Release of Information

The following must be completed by youth applicant.

I, _____, consent to the Threshold Housing Society (THS) Supportive Recovery Program to contact, communicate and release information regarding myself to the authorized organizations and people listed below.

I consent to the release of information between the client support team at Threshold Housing Society.

I understand that I can withdraw my permission at anytime.

I understand that I do not have to sign this consent form.

This form will be valid until my file is closed at the THS Supportive Recovery Program.

People and Organizations	Goals	Progress Report	Legal Status	Substance Use	All	Other (Specify)
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☑	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

Participant Signature:	
Name:	
Date:	

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Guidelines and Standards for Supportive Recovery

Below are the expectations that SRP has for all youth. If these expectations are not followed, staff will speak with you about the behaviors. This could result in receiving a warning letter or being asked to leave the program. Please initial beside each one after reading through.

- ☐ I will treat staff and other participants with fairness, honesty and respect including keeping information about other participants confidential, avoid all activity that might harm other youth, staff or visitors and follow SRP guidelines.
- ☐ I will always use respectful communication. I will not yell, scream, or raise my voice when speaking with staff or other participants. I will not bully, make threats of violence, sexually harass, or become violent with other youth, staff, or visitors.
- ☐ I will not possess weapons such as blades, knives, brass knuckles, crow bars or anything else that could be used to harm someone. If you possess any weapons they will be removed immediately and stored until discharge. They will not be returned prior to discharge.
- ☐ I will meet with SRP staff for one-on-one meetings weekly and I will engage with staff to work on all goals set in my case plan.
- ☐ I will attend all recovery groups and programming. These activities are not optional. If you believe you need to miss a group or program, you must first speak with your case manager for that to be approved. Failure to participate in programs may result in being asked to leave the program.
- ☐ I will not share the address and location of the Supportive Recovery Program.
- ☐ I will not enter other participant bedrooms and private spaces; communal spaces are located on the main floor and backyard.
- ☐ **I will not share, sell, or distribute substances of any kind while in the program.**
- ☐ **I will not purchase substances near or on the program property.**
- ☐ **I will remain abstinent from alcohol &/or substances during groups and outings.**
- ☐ **I will not consume substances inside the program, residential spaces, or host family home. Including all tobacco, cannabis, or nicotine products.**
- ☐ **I will be honest with staff about my substance use.**
- ☐ I will use the designated smoking area.

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- [ ] I will complete a pass with staff prior to leaving the property. If you leave the property without a pass/staff permission, or you do not return when your pass expires, you will be considered AWOL and staff will complete a Missing Person's Report with the police.
- [ ] I will follow expectations around the program schedule, curfew, groups, and outings.
- [ ] I will allow all medications to be dispensed by staff.
- [ ] I will keep my living space, and communal space clean. Staff will remind/support around maintaining cleanliness if necessary.

Participant Signature:	
Name:	
Date:	

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CONSENT FOR SERVICES

Threshold Housing Society Supportive Recovery Program offers live in and host family accommodations, recovery and life skills programming and support as well as counselling services for up to 120 days. All services are voluntary, and you can stop programming at any time. We strive to be client-directed and encourage you to give us feedback and ask any questions you might have.

CONFIDENTIALITY

We wish to ensure you understand the limits of confidentiality we are bound by. Please know that your personal information is kept confidential and will not be shared without your consent, except when:

- If we obtain information which leads us to suspect that a child (18 and under) is at risk for, or has been, physically abused, sexually abused, emotionally abused, or neglected, we are legally obliged to make a report to the Ministry for Children & Family Development. We can make this call with you. This is about protecting children from harm.
- If you inform us about any intent to commit an act which could result in the injury or death of another/others, we are legally obliged to contact the police. This is about protecting others from harm.
- If we have concerns that you are a danger to yourself, she/he will discuss with you any plan that they may need to take on your behalf (e.g. call a family member or family physician). However, in situations where we are unable to discuss this with you, they may need to proceed without your consent in order to fulfill their obligation to ensure your safety.
- Subpoena.
- Knowledge of a crime that was or is about to be committed.
- All information gathered is subject to the *Freedom of Information and Protection of Privacy Act (FOIPPA)* as well as *Island Health's policy on confidentiality*.
- Some of the information you provide will be kept in your file electronically or paper format. You can make a formal request to see this information as per the *FOIPPA* requirements.
- Any information we use for statistical reporting purposes will be completely anonymous.
- If participating in online video counselling, you are aware of risks to privacy and confidentiality and have provided an alternative back up contact information (phone number and location).
- If you are participating in a group, we expect you to observe confidentiality regarding the information shared in the group sessions.
- I consent to participate in the services available through *Threshold Housing Society Supportive Recovery Program.*

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AMBULANCE TRANSFER AND MEDICAL ATTENTION

In the event of a medical emergency, emergency services will be dispatched. This may include, but is not limited to, being transported to hospital by an ambulance.

COMMUNICATIONS

I request and authorise *Threshold Housing Society Supportive Recovery Program* to communicate with me regarding the logistics of my care (such as meetings, contact when I am offsite) via my email address and/or mobile phone number.

I acknowledge email and text messaging is generally not secure and *Threshold Housing Society* does not recommend it for the transmission of personal or other confidential information. _____ (client initial).

My consent and agreement are valid for the duration of this program, but no longer than two years without renewal, following the date of signing below.

Signature:	
Name:	
Date:	

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Statement of Consent for Exemption Application

Threshold Housing Society's (THS) Supportive Recovery Program is an Island Health licensed facility. The license has been issued for participants over the age of 19, however, the program is available to participants between the ages of 15-21. This form only needs to be filled out if an applicant will be under 19 at the time of entering the Supportive Recovery Program.

In some cases, accommodations may be required to be double occupancy. As a safeguard, all participants below the age of 19 will have accommodations on the top floor of the program space, and all participants 19+ will have accommodations on the bottom floor of the program.

In order to accept participants under the age of 19 into the program, THS must submit an exemption request to Island Health on the participants behalf prior to their acceptance. The following statement of consent can be completed by a medical professional, parent, and/or a legal guardian and will be submitted with the exemption request.

○ I _____ consent to an exemption being submitted
(Name and Relation to Program Participant)

on the behalf of _____ and understand that other program
(Program Participant)

participant ages will vary between the ages of 15-21.

○ I _____ do not consent to an exemption being
(Name and Relation to Program Participant)

submitted on the behalf of _____.
(Program Participant)

Participant Name	Participant Signature	Date
Support/Guardian Name	Support/Guardian Signature	Date

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Early Exit Plan for Supportive Recovery Program

On occasion, a participant may choose to leave the program early or be asked to leave due to safety reasons. In the event of an early exit, participants and their families/supports are requested to have an early exit plan.

Provide instructions below to be followed in the event of an unexpected discharge from the Supportive Recovery Program. Include the name, relationship to participant, contact information, location youth will relocating to and who will provide transportation. If necessary, please provide a secondary contact, evening contact, weekend contact.

○ In the event of an unexpected discharge from the Supportive Recovery Program,

I, _____, understand the expectations of this form and I am
(Support/Guardian)
agreeable to the plan for _____ to discharge into my care.
(Participant Name)

○ In the event of an unexpected discharge from the Supportive Recovery program staff will make attempts to find a safe resource for the participant. I, _____,
(Participant/Support/Guardian)
understand that if no plan is provided _____ may be discharged
(Particpant)
to a community shelter.

Participant Name	Participant Signature	Date
Support/Guardian Name	Support/Guardian Signature	Date

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Childhood Immunization Status

The BC government recommends the following vaccinations to be completed during childhood:

- DTaP-HB-IPV-HIB (Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Haemophilus Influenza Type B)
- Pneumococcal Conjugate
- Rotavirus
- Meningococcal C Conjugate
- MMR (Measles, Mumps, Rubella)
- Influenza

I, _____, declare that to best of my knowledge most or all of
(Doctor, Parent, Participant)

_____ vaccinations included in BC's immunization schedule
(Participant)

☐ HAVE, ☐ HAVE NOT, ☐ UNSURE IF been completed.

Signature: _____ Date: _____