BC MENTAL HEALTH
& SUBSTANCE USE SERVICES
Provincial Health Services Authority

ENHANCED CARE UNIT

RED FISH HEALING CENTRE FOR MENTAL HEALTH AND ADDICTION

REFERRAL PACKAGE INFORMATION

The Enhanced Care Unit (ECU) is a high acuity, locked unit for clients requiring contained stabilization and treatment for mental health and substance use. Clients referred to the ECU may be eligible to continue on into the ASU and then Treatment Unit as indicated by their desire for treatment and suitability to continue in the Red Fish Healing Centre (RFHC) program.

Fraser Health Authority	Beds=6
Vancouver Coastal Health Authority	Beds=6
Flex Beds	Beds=3

Admission criteria for ECU

- Certified under the BC Mental Health Act
- History of significant risk or ongoing physical aggression
- Hx of, or ongoing problematic behavioural challenges
- Concurrent disorder (severe substance abuse and mental illness)
- Require treatment and containment in a secure, locked facility; and
- Cannot presently be treated safely or contained in acute, tertiary mental health settings or the Red Fish Healing Centre Assessment and Stabilization Unit (ASU)
- Age 19 and above
- Independent in Activities of Daily Living (including transferring, toileting, and mobilizing)

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Exclusion criteria for ECU

- Requires acute medical care or is medically unstable
- Diagnosis of moderate to severe developmental disability or severe cognitive impairment

We welcome pre-referral consultations with our Intake Committee and Access team for all complex cases. Please contact us directly (604-524-7100 extension 336424) to discuss potential referrals to the Enhanced Care Unit.

Referral process for ECU

Clients admitted to the ECU will be identified by FHA, VCH, and other Health Authority staff and the Most Responsible Physician/Psychiatrist. The psychiatrist is responsible for certifying the client under the Mental Health Act.

Staff caring for the client referred to ECU are responsible for:

- Completing the Enhanced Care Unit Referral Package and sending to their local Health Authority Liaison
- Communicating with the Health Authority Liaison potential upcoming referrals

Bed offers and admission dates will be coordinated between the Red Fish Healing Centre Access and Discharge Coordinator, the Health Authority Liaison and referral agent and/or community case manager.

Continuity of care for ECU

ECU is up to a 90-day program with expected repatriation to the referring health authority upon completion. If clinically suitable and referral requirements are met, the client may transition to another level of care at Red Fish Healing Centre.

In preparation for discharge planning and as a prerequisite for continuing in the Red Fish program streams (ASU Units and Treatment Units), connection to a community team is required. If not already connected to a community team, a referral must be initiated by the referring health authority within two weeks of admission to ECU to a local mental health or substance use team.

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ECU REFERRAL PACKAGE

☐ Completed ECU referral form

☐ Hospital admission sheet (if applicable)

☐ Initial or recent Psychiatric Consultation/Assessment

☐ Involuntary status – send forms 4, 5, 6, 13, 15

☐ Review panel pending ☐No ☐Yes – Scheduled date:_________________

Note: If the review panel is scheduled to take place within 4 days of transfer to ECU, an accompanying letter with clinical background information is required from the referring psychiatrist.

☐ Repatriation agreement

☐ Current psychiatric progress notes (over past week)

☐ Medical history including allergy status, chronic conditions etc.

☐ List of current medications (Medication Administration Record x 1 week)

☐ Specialist consultations, second opinions

☐ Current lab work, results of CT/MRI scans, other diagnostic imaging, EEGs, X-rays or indicate if results are pending (if applicable)

☐ Interdisciplinary notes or summary of current or a recent hospital admission

☐ Available recent and most relevant psychiatric history (i.e. Mental Health team notes)

☐ ECT records of current treatment (if applicable)

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Referral information

Referral Date (day/month/year):	Health Authority:		Is this a FNHA Referral?	☐ Yes ☐ No
Client's Legal Name (First, Last):			Preferred Name(s):	

Referring Agent Name:		
Referring Organization (name of hospital and unit):		
Telephone:	Fax:	Email:

MH&SUS Community Team Name:		
MH&SUS Case Manager Name:	Ph:	Fax:
Email Address:		
Community Physician Name:	Ph:	Fax:
Community Psychiatrist Name:	Ph:	Fax:
Community Pharmacy:	Ph:	Fax:

Client information

Date of Birth:	Age:	PHN:
☐ Female ☐ Male ☐ Self-identification:		
Current Address:		
City:	Province:	Postal Code:
Telephone:	Email:	

Cultural information

Does the client identify as an Indigenous person?	☐ Indigenous ☐ Non-Indigenous ☐ Client Declined, Ask again later ☐ Client Declined, Do not ask again ☐ Unknown
Indigenous Identity Group:	☐ First Nations ☐ First Nations & Inuit ☐ First Nations & Métis ☐ First Nations & Métis & Inuit ☐ Inuit ☐ Métis ☐ Métis & Inuit ☐ Unknown ☐ Outside of Canada ☐ No response
Predominantly lives:	☐ Both on & off reserve ☐ Off reserve ☐ On reserve ☐ No response
First Nations Status:	☐ Has Status ☐ Non Status ☐ Pending Status ☐ No response
Metis Citizenship:	☐ Has citizenship. Métis Citizenship #:_______________________

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	☐ Non citizenship ☐ Pending citizenship ☐ No response
Would you use Indigenous Patient Services?	☐ Yes ☐ No ☐ Maybe
Status #:	Band:
Ethnicity (German, Spanish, etc.):	Primary Language:
Is there a need for an Interpreter?	☐ Yes ☐ No
Provide details of language interpretation needs:	
Are there any spiritual or religious practices or ceremonies that would support the client's wellness while in treatment:	

Emergency contact person (family/friend)

(Please note that the person below will be contacted should there be an emergent safety or medical concern)

Name (first & last):	Relationship:
Telephone:	Email:
Is there an identified Substitute Decision Maker (SDM)?	☐ Yes ☐ No

Name:	Telephone:	Email:

Power of attorney/trustee

Is there a Power of Attorney in Place?	☐Yes ☐ No
If yes, provide a brief description: (e.g. finances, treatment decisions, etc.)	

Is there a Trustee?	☐ Yes ☐ No	Name:
Telephone:		Email:

Current housing

☐Independent ☐Partner/Family ☐Supportive Housing ☐Treatment/Detox Program ☐SRO ☐No fixed address	
Will the client be able to return to the current living situation?	☐Yes ☐ No
If no, please explain:	
Is there a post-discharge housing plan?	☐Yes ☐No
Details:	

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DSM V diagnosis/Mental health history

Psychiatric Diagnoses (Axis I):

Personality Disorders and Developmental Disabilities (Axis II).
Note: For head/brain injury/FASD or cognitive impairment: provide a brief description of cognitive disabilities and attach any collateral assessment/reports (e.g. most recent assessment(s) from psychiatry, O.T, psychology etc.)

Medical Illness (Axis III)

Psychosocial and Environmental Concerns (Axis IV):

Is the client connected to Community Living BC or other support services?	☐ Yes ☐ No	Contact Person:

If yes, provide a brief description of required supports including number of support hours received per week:

Medical history

Environmental, Food, Medication Allergies?	☐ Yes ☐ No

If yes, provide a brief description and type of reaction(s) and interventions required:

Pregnant?	☐ Yes ☐ No	Number of weeks pregnant:
Independent with ADLs?	☐ Yes ☐ No	Details:
Mobility Issues?	☐ Yes ☐ No	
Mobility Aids?	☐ Yes ☐ No	Details:

Medical Dietary Concerns?	☐Yes ☐ No	Does the client have any dietary requirements?	☐Yes ☐ No
Details of dietary concerns/requirements:			

Fall Risk:	☐ Yes ☐ No	Hearing Impairment:	☐ Yes ☐ No	Visual Impairment	☐ Yes ☐ No
HIV:	☐ Yes ☐ No	Hep C:	☐ Yes ☐ No	Cognitive Impairment	☐ Yes ☐ No
Other:					
If yes to any of the above, please provide details below:					

Does the client have any scheduled surgeries, dental appointments or specialist appointments?	☐ Yes ☐ No
If yes, provide a brief description:	

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History of aggression

History of Verbal Aggression?	☐ Yes ☐ No

Date of Last Incident(s):

Context of Incident(s):

Effective Intervention(s):

History of Physical Aggression?	☐ Yes ☐ No

Date of Last Incident(s):

Context of Incident(s):

Who was the physical aggression directed towards?

Degree of harm to victim:

Effective Intervention(s):

Current safety concerns

Self-harming behaviours?	☐Yes ☐ No	Suicidal ideation?	☐ Yes ☐ No	Flight Risk?	☐ Yes ☐ No
Sex work?	☐Yes ☐ No	Sexual offences involving minors?	☐ Yes ☐ No	Arson/Fire setting?	☐ Yes ☐ No
Suicide attempt(s)?	☐Yes ☐ No	Dates of suicide attempts: (please list all dates and methods of attempts)			

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If there are concerns noted above, please provide detailed information about the safety concern and if possible, provide a copy of the care plan.

Legal		
Is the client supervised by a probation officer?	☐ Yes ☐ No	
Probation Officer's contact name:		Phone:
Current charges? ☐ Yes ☐ No	Details of Current Charges:	
Upcoming court dates:		
Location:		
Please provide details (e.g. transportation required, technological requirements, etc.):		

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Substance use and activities of addictive concern

Please indicate which of the following the client has used and has a history of using	Select top 3 Drugs of Choice	Current Pattern (i.e. binge, daily, occasional)	Date last used	# Days used in last 30 days	Route	Typical amount used daily	Age at 1st use
☐ Alcohol							
☐ Non-beverage alcohol							
☐ Amphetamines							
☐ Ecstasy (XTC)							
☐ GHB							
☐ Benzo							
☐ Cannabis							
☐ Cocaine							
☐ Crack Cocaine							
☐ Crystal Meth							
☐ Fentanyl							
☐ Hallucinogens							
☐ Heroin							
☐ Inhalants							
☐ Nicotine							
☐ Opioids							
☐ Other (Specify):							
☐ Gambling							
☐ Sexual activity							
☐ Pornography							
☐ Shopping							
☐ Shoplifting							
☐ Internet/Gaming/Social Media							

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Substance use treatment history

Please provide details on the types of substance use treatment the client has previously engaging with including treatment programs, counselling, and/or detox. Please list approximate dates of engaging in the service:

Why is the Enhanced Care Unit at Red Fish Healing Centre being considered at this time for the client's care?

The Community Team/Case Manager agrees to collaborate with the Red Fish Healing Centre team to develop and implement a safe discharge plan for the client or support the repatriation process.

Case manager name (PRINT):	
Case manager signature:	**Date (D/M/Y):**