BCMHA

The Burnaby Centre for Mental Health and Addiction

Referral Information Package

The Burnaby Centre for Mental Health & Addiction (BCMHA) is a 100 bed residential treatment program for BC residents with concurrent disorders. The vision of the program is to provide leadership in interdisciplinary Complex Concurrent Disorders treatment, training, education, treatment development, and interventional research.

The centre is a provincial, tertiary concurrent treatment resource and all referrals must be made through a designated referral agent within one of the provincial health authorities. **Program length: 6-9 months**

Admission criteria

Clients need to have the following items to be considered for the program at BCMHA:

- Substance addiction and complex mental health disorders;
- May have complex medical and/or behavioural issues;
- BC resident age 19 and older; and
- Independence in Activities of Daily Living.

Mandate

The BCMHA mandate is to provide service to clients who present with severe and complex concurrent disorders. The clients who are typically referred for treatment at the center often have:

- Serious impairment in functioning (employment, personal safety, housing, etc.) due to complex mental health and addiction issues.
- High use patterns of specialty hospital, tertiary, or psychiatric emergency services (MHES).
- High involvement with the Criminal Justice system.
- Do not access (or unable to maintain) involvement with traditional, Mental Health and Addiction services.

Additional Considerations

The following will also be considered when assessing clients for appropriateness for admission:

- Current Client Mix: To ensure a therapeutic environment for all clients the client mix will be balanced with each admission: i.e. Number of clients with high medical needs, number of clients with severe behavioural issues (Axis II), number of clients with severe psychotic/affective disorders.

- Health Authority resources have been exhausted: The referring health authority must demonstrate they have exhausted the resources and in their Health Authority region.

- Mental Health and Addiction Team Connection: Clients must be connected to a Mental Health and Addiction Team for continuity of care and discharge planning

- Activity of Daily Living: Clients should have the ability to be independent in their activities of daily living including eating, toileting, and mobilizing.

Exclusion criteria

- Arson/Fire Setting
- Sexual Activities Involving Minors
- Severe Violence

Please contact the Access Coordinator if your client has experienced Severe Violence and/or Arson/Fire Setting as these criteria can be discussed based on history and severity, but due to the location of the BCMHA any sexual Activities Involving Minors will not be accepted.

If the client's history with respect to these factors is not known to you, please investigate to the best of your ability.

If a client is admitted to BCMHA, and it is subsequently found there is a current issue with respect to the factors above, the client will be discharged and responsibility for community care plan will be developed with the referring Health Authority.

Program

BCMHA provides specialized services for the assessment, stabilization and treatment of their clients while providing an integrated clinical approach. The care model is aligned with evidenced-based practice that treats mental health and addiction clients. A full range of pharmacological management including methadone maintenance is provided. An interdisciplinary team including psychiatrists, physicians, nurses, occupational therapists, social workers, a pharmacist, a dietician, recreational therapists, a psychologist, mental health & addiction support workers, art therapists, music therapists, an acupuncturist, and a physiotherapist will collaborate with the clients to meet treatment goals.

The program is divided into two phases: Assessment/Stabilization, Treatment/Psychosocial rehabilitation. Continuing consultation/liaison with the referring source throughout the stay BCMHA will be part of the treatment goal.

Note: Recommendations will be made in consultation with the referral source at the end of the assessment/stabilization period (4-6 weeks). Recommendations may include further treatment at the BCMHA or referral to other program/services. For some clients the assessment/stabilization period may demonstrate that continued treatment at BCMHA would not provide benefit and/or be counter-therapeutic for the client given their unique presentation.

Care Planning

Each client will be assigned a care team that will work with the client on care planning. The care plan will be client-centred and based on the best available scientific evidence and the Recovery Model of care, "Recovery, a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential". Embedded in the care plan will be the discharge goals and discharge plans as initiated by the referring health authority.

Transition Planning

Transition plans will begin prior to admission by the client's mental health addiction team at their home Health Authority. This plan will be updated by the BCMHA care team with the client's home Health Authority mental health and addiction team as soon as the client completes the stabilization and assessment phase with appropriate recommendations and treatment goals are identified. The social worker will work with the client and the BCMHA care team, and the client's designated Health Authority referral source to determine a "best fit" for aftercare ensuring a continuum of treatment whenever possible. The social worker will regularly liaise with the referring Health Authority in the home community and collaborate on transition planning throughout the client's treatment.

Each client will need to come with an "early exit" transition plan in case of an early unplanned exit from the program. An unplanned early exit could result from one of the following risk behaviours: continued threats, physical or verbal abuse, intentional physical assault or continued active drug/alcohol using/dealing on site where the client is unwilling to curtail behaviour despite active care and treatment planning. Early exits could also be determined after the assessment/stabilization phase; the clinical team along with the client may determine that the BCMHA is not appropriate or therapeutic for treatment for the client.

BCMHA values understanding if clients have been able to maintain improvements in functioning when they return to their home community. At 2-3 months post transition back to home community BCMHA will work with referring Health Authorities to complete assessments of clients to understand where their functioning is at. The feedback received will help us as we continue to develop the programming at BCMHA to ensure best results for clients while at the centre and upon re-integrating back to their home community.

Process

The Referring Health Authority Liaison starts by receiving the referral package, screening the information to ensure the client fits the mandate of BCMHA, and ensuring completion of referral package. If accepted the Liaison presents the client to their Health Authority screening committee for approval. If Health Authority Screening Committee approves client, the Health Authority Liaison sends the referral via email to the BCMHA Access Coordinator who reviews the referral package. Once all required information is received by BCMHA, the clinical team reviews the referral within two business days and make a decision. Once the client is accepted, if a bed is not immediately available, their Referring Health Authority will place the client on a waitlist.

Once a bed is available, the BCMHA Access Coordinator informs the Referring Health Authority Liaison and starts the admission process, meaning that the Health Authority Liaison contacts the referral source and arranges for the client to safely travel to the BCMHA, while the BCMHA Access Coordinator helps coordinate with the Health Authority liaison with the arrival date and time.

Checklist:

- Referral form (page 9 - 16)
- Early Exit Transition Plan (page 17)
- Participation Agreement (page 18)

Thank you for referring your client to our program.

If you have further questions please contact the Access Coordinator who can assist you in completing the form and provide you with further information.

Access Coordinator: 604-675-3950 local 69948   EMAIL: BCMHAReferrals@vch.ca