Youth Substance Use Treatment Program
Client Participation Agreement

As part of my treatment application, I have reviewed the program services and I understand that this is an abstinence-based program. Upon arrival and admission to the Provincial Substance Use Treatment Program, I agree with the following:

- A physical examination with physician and nurses and participating in medical review/assessments
- Will provide all prescription and non-prescription medications to the nurse
- If recommended, meeting with the Program Psychiatrist
- Participating with the bed-bug protocol, which includes showering and washing my clothing

On an ongoing basis I understand and agree the following:

- Participating in group and individual counselling programs
- Working with the Treatment Team to plan my successful return home after treatment
- Treating others with respect, dignity and without discrimination
- Participating in assessment and development of a treatment plan and committing to following this plan
- Following program guidelines,
- Working towards abstinence from smoking by participating in cessation programs
- Abstaining from all drugs, alcohol and over-the-counter and pharmaceuticals (with the exception of prescribed medications)
- Recognizing that the Program is scent-free
- Will only leave the Program area when planned and with staff
- Will visit with family and supports during visiting hours
- Understand that for reasons of confidentiality, I will need to leave my cell phones, cameras, Ipods or personal data devices at home
- Will keep all information about other program participants confidential
- Understand that I may be required to share a room with another client
- Understand that I will need to keep food items in designated areas and not in my room
- Understand that for safety and comfort, I will keep my room clean and clutter-free
- Understand that for safety, comfort and respect of my roommates, I will not invite others to my room
- Understand that for safety, staff may conduct random room searches
- Understand that I need to take all my belongings with me when I leave the Program and that anything I do not take with me will be donated to charity
- Understand that aggressive behaviours and recruiting others into gangs or sex-trade may result in being asked to leave the program

Consent for Release of Information

I, ___________, understand that all information gathered on this form will remain confidential and will only be shared with the Admission and Aftercare Committee.

Confidentiality is an extremely important matter in the Program. In serving you, the Program will work to appreciate your situation and how we can best support you. Just as with any health service, some of what we learn about you will be recorded in electronic/paper files. We record these details for the following three main reasons:

1. To support good planning and delivery of service to you. This involves sharing information between program staff and key professionals involved in helping you.
2. To provide necessary information for activity reports (e.g., how many people we serve, ages, needs). Activity reports information is important for service planning and is used by the Program and shared with health authorities. Activity reports do not contain the names of people we serve.
3. Audits, service reviews, follow-ups or quality assurance surveys require access to contact and other personal information. These audits, reviews, follow-ups and surveys are conducted by the Program, an accrediting body or the funder. This helps ensure that we are doing a good job and it provides opportunities to learn from the people we serve towards improving services.

Apart from the four basic exceptions (below), this information will not be shared with anyone outside of PSUTP unless you give us written permission to do so.

These **four basic exceptions** are:

1. If there is a concern related to the safety and wellbeing of any one currently less than 19 years of age (e.g., neglect or abuse of a child), Ministry of Children and Family Development and/or the police may need to be contacted. This is about protecting children.
2. If there is a concern that you may harm yourself, another person or the public.
3. If you are experiencing a medical emergency.
4. If there is a **legally authorized** request, enquiry, investigation or duty to report. For **example**,
    - A subpoena, warrant or other type of court order
    - Required report related to Communicable Disease Regulations
    - An investigation by Worker's Compensation Bureau
    - An investigation conducted by the Coroners Service of British Columbia.

If you have any questions or concerns about the limits of confidentiality, you are encouraged to speak with your counsellor / health care practitioner. PSUTP is committed to being as open as possible about our responsibilities to both you and the community.

Please indicate below your consent for PSUTP to share your personal information.

Name	Phone #/Email	Specify limitations to the information you consent to
Counsellor		
Physician		
Psychiatrist		
Social Worker		
Probation Officer		
MCFD Worker		
Other		

I, ______________________________, (full name of youth) agree to both the client participation agreement and the consent to release of information as specified above.

I have carefully reviewed the above information and any questions or concerns have been addressed to my complete satisfaction.

x	
(Youth signature)	Date (**D/M/Y**):
Parent / Guardian Name:	
x	
(Parent / Guardian signature)	Date (**D/M/Y**):
Community counsellor / health care practitioner's Name:	
x	
(Staff signature)	Date (**D/M/Y**):

Signatures

By signing below, I consent to my referral liaison and emergency contact being contacted. I also understand that if I leave PSUTP early, my physician will be sent an early discharge summary.

Client:	Date (**D/M/Y**):
Referral Agent agrees to the repatriation of the client upon discharge from the treatment program.	
Referral Agent:	
Case Manager:	Date (**D/M/Y**):