

Syl Apps Youth Centre Secure Treatment Application



**475 Iroquois Shore Rd.
Oakville, ON L6H 1M3**



Youth's Name:

Date Submitted:
(mm/dd/yyyy)

**Application
Syl Apps Youth Centre (SAYC)
Secure Treatment Program**

Please send the full application and all required documentation by mail, fax or email to:

Syl Apps Youth Centre
475 Iroquois Shore Road
Oakville, Ontario
L6H 1M3

Fax: (905) 844-9197

Email: SAYCIntake@kinark.on.ca

Inquiries

Intake

905 844-4110 x 2210

Lu-Ann Middleton

905 844-4110 x 2202

OVERVIEW

The therapeutic milieu is clinically intensive, focusing on those elements of the youth and family's personality and life patterns that cause the youth to be behaviourally and emotionally dysregulated. The multidisciplinary treatment team designs individualized treatment plans based on the mental health needs of each of youth. The program relies heavily on the active participation of the youth, family, guardian and supporting agencies in the formulation and implementation of the treatment plan, including placement and discharge planning.

The focus of the secure treatment program is twofold:

1. To stabilize the youth and clarify their mental health needs within the secure setting and
2. To allow the youth to make sufficient gains that they may continue their treatment in a less secure setting.

REFERRAL PROCESS

Admission into the Secure Treatment Program goes through the Family Courts and is subject to the criteria set out in section 114 of the Child, Youth and Family Services Act. It is critical that all information be filled out clearly and completely in order for the referral to be reviewed and considered for the secure treatment program. The completed package is to be returned to the attention of the Program Assistant. The program will only process referrals when it is in receipt of the **complete** referral package.

Once we receive a completed referral package we will schedule a screening interview with the applicant, community supports, and if appropriate the youth. The purpose of the screening interview is to provide information about Syl Apps and to explore the suitability of pursuing an admission to a secure treatment program.

If the youth is appropriate they will be placed on the waiting list and prioritized by need. Prioritization is a dynamic process and may change over time. When a bed becomes available the youth in the most assessed need will receive the documents required for a Secure Treatment Application Hearing including a signed consent by the Administrator of the Program, an Application Form and the Secure Treatment Order, which the Judge will be required to complete for admission.

Note: Youth with matters in process related to the Youth Criminal Justice Act (YCJA) which would negatively impact their ability to participate in our program, may not be admitted to the program until those matters are dealt with.

SECURE TREATMENT ADMISSION CRITERIA

The Court may order that a child be committed to a Secure Treatment Program only where the Court is satisfied that,

- (a) the child has a mental disorder
- (b) the child has, as a result of the mental disorder, within forty-five days immediately preceding,
 - (i) the application under subsection 114(1)
 - (ii) the child's detention or custody under the Young Offenders Act (Canada) or under the Provincial Offences Act, or
 - (iii) the child's admission to a psychiatric facility under the Mental Health Act as an involuntary patient,
caused or attempted to cause serious bodily harm to himself, herself or another person.
- (c) the child has,
 - (i) within the twelve months immediately preceding the application, but on another occasion than referred to in clause (b), caused, attempted to cause or by words or conduct made a substantial threat to cause serious bodily harm to himself, herself or another person, or
 - (ii) in committing the act or attempt referred to in clause (b), caused or attempted to cause a person's death;
- (d) the Secure Treatment Program would be effective to prevent the child from causing or attempting to cause serious bodily harm to himself, herself or another person;
- (e) treatment appropriate for the child's mental disorder is available at the place of Secure Treatment to which the application relates; and
- (f) no less restrictive method of providing treatment appropriate for the child's mental disorder is appropriate in the circumstances.

NOTE: WHERE THE CHILD IS LESS THAN TWELVE YEARS OLD, THE CONSENT OF THE MINISTER OF HEALTH IS REQUIRED.

APPLICATION FOR ADMISSION

Admission to the Secure Treatment Program requires that an application be made to the Provincial Court under Section 114(1) of the Child, Youth and Family Services Act.

Any one of the following persons may, with the administrator's written consent, apply to the court for an order for the child's commitment to a Secure Treatment Program:

Where the child is **less than sixteen years** of age;

1. The child's parent,
2. A person other than an administrator who is caring for the child, if the child's parent consents to the application, or
3. A society that has custody of the child under an order made under Part III (Child Protection)

Where the child is **sixteen years of age or more**;

1. The child,
2. The child's parent if the child consents to the application
3. A society that has custody of the child under and order made under Part III (Child Protection), if the child consents to the application, or
4. A physician

On the basis of this application, the Court may order the child into Secure Treatment for a period up to 180 days if the criteria for admission are met. In no case shall the child be committed to the Secure Treatment Program for longer than the period specified under subsection (1). R.S.O. 1990, c. C.11,s 118 (1, 2).

ADMISSION CRITERIA (b)

Provide details that the child has, as a result of the mental disorder, **within forty-five days** immediately preceding,

- the application under subsection 161(1), **OR**
- the child’s detention or custody under the Youth Criminal Justice Act or under the Provincial Offences Act, **OR**
- the child’s admission to a psychiatric facility under the Mental Health Act as an involuntary patient, **OR**
- has caused or attempted to cause **serious bodily harm to himself, herself or another person.**

Incident	Date (mm/dd/yyyy)	Outcome

Please attach supporting documentation i.e., summary of Serious Occurrence Reports (SORs), incident reports, police reports, psychosocial assessments, psychological assessments, psychiatric assessments, hospital discharge reports, etc.



ADMISSION CRITERIA (c)

Provide details that the child has, as a result of the mental disorder, in the **twelve months** immediately preceding the application, but on another occasion than referred to in criteria (b),

- caused, attempted to cause or by words or conduct made a **substantial threat to cause serious bodily harm to himself, herself or another person, OR**
- in committing the act or attempt referred to in criteria (b), **caused or attempted to cause a person's death;**

Incident	Date	Outcome

ADMISSION CRITERIA (c) - continued

Incident	Date	Outcome

CLIENT INFORMATION SHEET

Applicant Name:					
Organization/Relationship to Youth:					
Mailing Address:					
Email:					
Telephone:	Cell:	Business:			
Is the youth consenting to this treatment application? Yes <input type="checkbox"/>		No <input type="checkbox"/>			
Youth's name					
Current address					
Home Telephone					
Sex assigned at birth		Identifying Gender			
Date of birth (mm/dd/yyyy)				Age:	
Primary language		<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Other	
Youth's school name				Grade:	
Legal guardian					
Address					
Telephone		Home/Main	Work/Other		
		Email			
Parent's name					
Address					
Telephone		Home	Work/Other		
		Email			
Parent's name					
Address					
Telephone		Home	Work/Other		
		Email			
Siblings		Name	Relationship to youth	Date of Birth	
CAS Involvement Yes <input type="checkbox"/> No <input type="checkbox"/>		Name	Phone	Email	
Nature of CAS Involvement					
Other significant support people		Name	Relationship to youth	Telephone/Email	

DEMOGRAPHIC INFORMATION

GUARDIANSHIP STATUS (LEGAL CUSTODY)

- Parental
- Parental Joint Custody
- Parental (Single Parent); identify parent name:
- Parental- CAS (Temporary Care Agreement)
- Children's Aid Society – Crown Ward
- Children's Aid Society – Society or Temporary Ward
- Children's Aid Society – Interim Care and Custody
- Customary Care Agreement
- Independent
- Other:

YOUTH'S CURRENT LIVING SETTING:

- Family Adopted Kin
- Children's Aid Society
 - Foster Home
 - Group Home
 - Collaborative Group
 - Care Kinship in Care
- Friend's Home
- Group Home (Treatment Home – Non Medical) Homeless, Hostel
- Hospital, Treatment Facility – Medical Independent
- Currently in detention
- Other: _____

HISTORY OF FAMILY/ CAREGIVER INVOLVEMENT:

Please provide a brief synopsis of the youth's family relationships and their history, including guardianship history if status has changed over time.

YOUTH'S RACE (A set of values that best represents a group of people who possess similar and distinct physical characteristics.) Please choose all that apply:

- Arab
- Black
- Chinese
- Filipino
- Indigenous
- Japanese
- Korean
- Latin American
- South Asian (i.e., East Indian, Pakistani, Sri Lankan, etc.)
- Southeast Asian (i.e., Vietnamese, Cambodian, Thai. etc.)
- West Asian (i.e., Iranian, Afghan, etc.)
- White
- Prefer not to answer
- Other

If Other, please specify:

YOUTH'S PLACE OF BIRTH:

- Canada
- Born Outside of Canada

Specify country of birth:

Current legal status in Canada:

- Prefer not to answer

YOUTH'S ETHNIC/CULTURAL IDENTIFICATION:

(The information provided will help us better serve and meet the needs of various ethno cultural groups)

- Indigenous
specify:
- North American
specify:
- British Isles (i.e., Irish, Scottish, English)
specify:
- French (i.e., Acadian, French)
specify:
- Western European (i.e., Austrian, Belgian, Dutch, German, Swiss)
specify:
- Northern European (i.e., Danish, Finnish, Icelandic, Norwegian, Swedish)
specify:
- Eastern European (i.e., Czech, Hungarian, Latvian, Polish, etc.)
specify:
- Southern European (i.e., Bulgarian, Croatian, Greek, Italian, Portuguese, etc.)
specify:
- Other European (Jewish)
specify:
- Caribbean (i.e., Guyanese, Jamaican, Haitian, Puerto Rican, etc.)
specify:
- Latin, Central and South American (i.e., Mexican, Columbian, Peruvian, etc.)
specify:
- African (i.e., Congolese, Somali, Nigerian, South African, etc.)
specify:
- West Asian (i.e., Afghan, Armenian, Iranian, etc.)
specify:
- South Asian (i.e., Bangladeshi, East Indian, Pakistani, Sri Lankan, etc.)
specify:
- East/Southeast Asian (i.e., Cambodian, Chinese, Filipino, Japanese, etc.)
specify:
- Oceania (i.e., Australian, New Zealander, Pacific Islander)
specify:
- Unknown
- Prefer not to answer
- Other - specify:



ADDITIONAL DIVERSITY IDENTIFICATION AND NEEDS:

Please identify, if applicable, any other diversity identification. Indicate any special needs or accommodations the youth may require with respect to their religious/spiritual needs, their gender identification and/or their ethnic/cultural identification (food preferences for meals and snacks, cultural activities, celebration of religious holidays, or other cultural traditions or practices):

CURRENT & HISTORICAL DIAGNOSES:

Youth's Mental Health and Neuro-Developmental Diagnoses	Diagnosing professional	Date mm/dd/yyyy

Please add any additional explanation or comments regarding the information provided above for the youth's diagnoses, if applicable:

CURRENT PRIMARY PRESENTING PROBLEM AREAS:

Check category that apply; choose as many as apply.

<p>School and Learning</p> <ul style="list-style-type: none"> <input type="checkbox"/> Truancy <input type="checkbox"/> School Phobia <input type="checkbox"/> Academic under Achievement <input type="checkbox"/> Learning Problems <input type="checkbox"/> Specific Learning Disability <input type="checkbox"/> Not in School/Other Specify: 	<p>Victimization</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sexual Abuse (Suspected) <input type="checkbox"/> Physical Abuse (Suspected) <input type="checkbox"/> Emotional Abuse/Bullying <input type="checkbox"/> Sexual Abuse (Verified): Age of Abuse: By whom: <input type="checkbox"/> Physical Abuse (Verified): Age of Abuse: By whom: <input type="checkbox"/> Witness of abuse <input type="checkbox"/> Neglect
<p>Disruptive Behavior</p> <ul style="list-style-type: none"> <input type="checkbox"/> Aggression (Verbal) <input type="checkbox"/> Aggression (Physical) <input type="checkbox"/> Running <input type="checkbox"/> Fire Setting <input type="checkbox"/> Stealing <input type="checkbox"/> Destruction of Property <input type="checkbox"/> Sexual Acting Out <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Defiance <input type="checkbox"/> Problems with Self Control <input type="checkbox"/> Bullying 	<p>Thought, Perception and Mood Disturbances</p> <ul style="list-style-type: none"> <input type="checkbox"/> Disturbances in Thought Process <input type="checkbox"/> Anxiety /Depression <input type="checkbox"/> Continued Excited Mood <input type="checkbox"/> Self Harm <input type="checkbox"/> Severe Mood Swings/Reactivity <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> Suicidal Gestures/Attempts
<p>Intellectual/Adaptive/Functional</p> <ul style="list-style-type: none"> <input type="checkbox"/> Deficits in Intellectual Function <input type="checkbox"/> Deficits in Life Skills <input type="checkbox"/> Development Delay 	<p>Social Withdraw</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Peer Friendships <input type="checkbox"/> Lack of Adult Relationships <input type="checkbox"/> Social Isolation
<p>Family Issues/Concerns/Dynamics</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Family Support to Provide Care <input type="checkbox"/> Family Conflict/Distress <input type="checkbox"/> Parent/Child Conflict <input type="checkbox"/> Family Break-up <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Physical or Mental Health Issues <input type="checkbox"/> Other Specify: 	<p>Physical/Sensory Status</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neurological or Severe Brain Damage <input type="checkbox"/> Enuresis <input type="checkbox"/> Encopresis <input type="checkbox"/> Sensory Deficits/Disorders <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Psycho-Physiological <input type="checkbox"/> Physical Disability

SERVICE HISTORY (Please list current and historical service involvement, <i>other than placements</i>)			
Organization/Service Provider Name	Service Sector (i.e., Addictions, Day Treatment, Respite, Counselling, Groups, Youth)	Start Date mm/dd/yyyy	End Date mm/dd/yyyy

EDUCATION (Current & Historical):

(If more space is required due to educational complexity, please provide details in the summary)

School, School Board, and Program	Start Date mm/dd/yyyy	End Date mm/dd/yyyy	Grade Completed

Location of OSR (Ontario Student Record):

Identify any additional student services or professional support services accessed, including special accommodations made to youth's attendance requirements:



YOUTH'S/FAMILY STRENGTHS:

Please include:

- Character strengths
- Talents, interests, skills, assets
- Relationship supports, connections
- Strengths identified in formal assessments, reports, and/or other professional consultations

YOUTH'S/FAMILY'S NEEDS:

For effective treatment planning, please identify:

- Immediate goals/needs to be addressed in the initial phase of treatment
- What the youth and/or family/caregiver need in order to sustain achievements from previous services received
- What they will need from the SAYC treatment team within the SAYC program
- What needs they may have that can only be met outside the SAYC and how those needs can be best accommodated for while the youth reside at the SAYC program



ANTICIPATED OR RECOMMENDED DISCHARGE PLAN:

Please provide as many details as possible regarding the anticipated/recommended plan for the youth's discharge from SAYC upon completion of their treatment AND the estimated timeline, expected outcomes, and needs for this plan to be successful.

ADDITIONAL INFORMATION, if applicable:

Please include:

- Upcoming appointments that would need to be maintained
- Ongoing medical treatments the youth requires
- Anything relevant for the health and safety of the youth and the members of the treatment team: communicable diseases, significant triggers, safety protocols, imminent risks, etc.

FINANCIAL RESPONSIBILITY

While food, shelter and program costs are the responsibility of the centre other costs are the responsibility of the resident's Parent/Guardian unless negotiated otherwise.

Costs covered by the Secure Treatment Program	Costs covered by the Parent/Guardian
Basic clothing maintenance	Clothing suitable for the resident's age, sex, weather and program
Personal care supplies	Any extraordinary costs such as special therapy
Basic school supplies	Long distance transportation, beyond 100 km round trip from Syl Apps, including the staffing costs
Allowance of up to \$20 per week	Medical, including prescription medication, optometrist
	Dental, beyond regular check ups
Contact person's name and phone number for medical and dental billing:	
If there are any concerns in regard to any of the financial responsibilities please indicate them with potential solutions.	

SIGNIFICANT OTHERS

Name	Relationship	Address/Telephone