

Gya' Wa' Tlaab Healing Centre Society



Referral Package



To: All Referral Agents

The Early Recovery/Stabilization Program at Gya' Wa' Tlaab Healing Centre is based upon a Holistic Model approach and incorporates the Harm Reduction Principles into all of its programming. Following are the details:

- The holistic model is consistent with the public health approach.
- It recognizes the complex set of factors that impact addictive behaviour.
- It also recognizes the complex relationship between addictive behaviour and harmful consequences for both the individual and community.
- It accepts and works with individual differences in client characteristics in both preventing and responding to harms. These include risks associated with gender, age, cultural identity and concurrent mental health issues.
- This approach incorporates the strengths of the various models of the past and present, and uses these various insights to effect change with clients.
- The goal is to reduce the impact of problem consequences.

The Gya' Wa' Tlaab Healing Centre is honoured to offer this holistic healing model approach to all First Nations, Inuit and other people of Canada who choose to attend our program that alternates between eight (8) and seven (7) week programs. This program can be defined as an assessment, orientation, and readiness phase to treatment for clients. The program utilizes the following correlated program resources to assist clients: Acu-Detox, Equine Therapy, Physical Fitness Instruction, Psycho-educational group facilitation, Mental Health Counselling, Methadone Prescribing Physician, Primary Care Physician, and Culturally Appropriate Ceremonies.

In relation to the continuum of care for Addictions and Mental Health, our program is designed to meet the needs of Early Recovery; Pre-Contemplation, Contemplation, to Early Recovery... as described in the (*Prochaska and DiClemente's Model*) also utilizing the Developmental Model of Recovery; Transition, Stabilization, and Early Recovery stages... (*Gorski*)

We are confident that the program clearly demonstrates our commitment to wellness.

All my relations,

Patricia Starr
Executive Director



Philosophy

Our vision of Service is one of a Holistic Model as an evidenced-based residential treatment programme that is supported by a number of well defined beliefs, which include:

- It is consistent with the public health approach.
- There is an understanding that no single treatment is appropriate for all individuals.
- It is recognized that effective treatment attends to multiple needs of the individual, not just his or her substance misuse.
- It acknowledges that counselling (individual and/or group) and other behavioural therapies are critical components of effective treatment for addiction.

Service Goals

To teach clients that chemical dependency is a disease, and this disease causes physical, psychological, social and spiritual problems. And the total person is affected.

Program Objectives

The Holistic Model of Recovery will inform and teach the clients to:

- Be fully informed of the exact nature of the disease of addiction.
- Have accurate information to recover from substance abuse and addiction.
- Objectively evaluate their own alcohol and drug use to see if they have a substance abuse or addiction problem.
- Take ownership of the information; they'll need to apply it to themselves, and then they'll need to put what they've learned into action.
- Recognize that relapse is not an accident and some people fail to recover because they do not understand their addiction and, therefore, fail to do what is necessary to avoid relapse.



Program Description

Developmental Model of Recovery (*Gorski-CENAPS Model*)

The 7-week and 8-week programs are designed to move the individuals through the *progressive stages of recovery*. The developmental model of recovery is based upon a series of beliefs: recovery is a long-term process, recovery requires total abstinence from alcohol and other drug use, plus active efforts toward personal growth, there are underlying principles that govern the recovery process, the better we understand these principles, the easier it will be for them to recover, and understanding alone will not promote recovery. (*Gorski and Miller, 1989*)

Recovery is a developmental process and means “*to grow in stages or in steps.*” The following briefly describes the 3 stages clients will move through:

RECOVERY STAGE

MAJOR THEME

1. Transition

Giving up the need to control alcohol and other drug use.

We need to accomplish three major goals during transition:

- Recognize that we have lost control over our alcohol and other drug use.
- Recognize that we can't control our use because we are addicted.
- Make a commitment to a program of recovery that includes the help of others.

2. Stabilization

Recuperating from the damage caused by addictive use.

Four important things to happen during the stabilization stage of recovery:

- We physically recover from withdrawal from substance use.
- We stop being preoccupied with our primary drug of choice.
- We learn to solve problems without using alcohol or other drugs.
- We develop hope and motivation.

3. Early Recovery

Internal change (change of thinking, feeling, and acting related to alcohol and drug use).

The major goals of early recovery are:

- To change the attitudes and beliefs about alcohol and other drug use that sets us up for relapse.
- Change our understanding of addiction and the role it plays in our lives.
- To explore the meaning and purpose of substance use and learn to cope with life without it.



Holistic Model

Our approach with the holistic model is consistent with a public health approach. We recognize that there is a complex set of determinants that impact addictive behaviour. And we accept and work with individual differences in the client characteristics in both preventing and responding to problems. We believe that within the chronic disease management, active participation by clients is essential in self-management, treatment, and recovery activities. We have implemented a wide range of best practices to assist in client wellness:

- Acu-Detox
- Meditation, and physical fitness
- Motivational techniques
- Brief intervention
- Daily Psycho-educational groups
- Cognitive-behavioural techniques
- Access to Mental Health Counselling
- Equine Therapy
- Incorporating Culturally Appropriate Activities wherever possible



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Principles of Drug Addiction Research-Based Guide
1999



**ATTENTION REFERRAL WORKERS: IMPORTANT ITEMS REQUIRED
CLIENT PREADMISSIONS CHECKLIST**

Please go over this list with your client, and ensure he receives a copy of this list.

| | |
|--|---|
| | All information must be up-to-date. If your client is mandated by the courts, probation or MCFD, <u>ALL INFORMATION MUST BE DISCLOSED.</u> |
| | TB Test Results (CDCs Form #939) and page 7 (signed) of referral package must be received by the Gya' Wa' Tlaab Healing Centre before client can be admitted into program. |
| | Fifty dollars (\$50.00) to cover the cost of the self-help books and program manuals. Please make cheque out to the Gya' Wa' Tlaab Healing Centre. |
| | If your client is receiving money from the Band, Ministry of Social Development & Housing, or elsewhere, all cheques must be made out to the Gya' Wa' Tlaab Healing Centre to ensure cheque can be cashed. |
| | Client to have Provincial Health Care Card, Status Card, and/ or photo ID. |

ATTENTION CLIENTS—THINGS TO NOTE

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| | Incidental Items: postage, toiletries, etc., are for sale at the Centre. |
| | Valuables: Safekeeping for money and airline/bus tickets is available. For the Client to bring cash and/or bank card to use for their personal comforts. |
| | Laundry Facilities: Washing machines and dryers are available at no charge. |
| | Client Chores: Clients will be assigned chores for the duration of the program. |
| | Mail: The mailing address for letters and packages is: Client's Name c/o Gya' Wa' Tlaab Healing Centre, PO Box 1018, Haisla, BC, V0T 2B0. As a safety precaution, all mail must be opened in front of Gya' Wa' Tlaab Healing Centre staff by the client it is addressed to. |
| | Clients will be in a 1-week isolation period at the beginning of the program. |
| | Telephone: clients can be reached on the client phone starting at the end of the 3 rd week. Clients are responsible for providing the number of this phone to family and friends. |
| | Clients will receive day passes starting on the 3 rd weekend. |
| | Visitors: Family members are welcome to visit on the 3 rd weekend from 12:00 to 5:00 pm. |

WHAT TO PACK

| | |
|--|---|
| | Comfortable clothing sufficient for 7 days and Swimwear |
| | Toiletries: i.e. shampoo, toothpaste, shaving kit. |
| | Carvers may bring their tools. |
| | Sleepwear (slippers, t-shirt and shorts or pajamas). |
| | Fitness Wear (t-shirts, shorts or track pants and runners) for use in the fitness centre. |
| | Seasonal - Weather-appropriate clothing, i.e. winter jacket, rain gear. |
| | Indoor and outdoor runners, shoes, boots. |

WHAT NOT TO PACK

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| | Clothing suggestive of alcohol or drug use (including names of bars or taverns), or clothing that promotes sexism, racism or homophobia. |
| | Drug paraphernalia |
| | Electronic equipment (laptops, palm pilots, pagers, amplifiers for musical instruments, portable DVD players). |
| | Weapons, including pocket knives. |
| | Mouthwash or other toiletries containing alcohol. |



CLIENT ASSESSMENT/REFERRAL PACKAGE

| | |
|-----------------------|--------------|
| Referral Worker Name: | Band/Agency: |
| Address: | Email: |
| Town/Province: | Postal Code: |
| Phone Number: | Fax Number: |

CLIENT INFORMATION

| | | | |
|---|-----------------|---------------------|--------------|
| Legal Name: | Also Known As: | | |
| Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male | Date of Birth | <i>(dd/mm/yyyy)</i> | |
| Care Card #: | SIN: | | |
| Status Indian, Metis, Recognized Inuit, or Other Indigenous Group? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Status Number: | Band Name: | | |
| Mailing Address | Street/Box No.: | | |
| | City: | Province: | Postal Code: |
| Phone: | Email: | | |

CONTACT PERSON IN CASE OF EMERGENCY

| | |
|--------|---------------|
| Name: | Relationship: |
| Phone: | Alternate: |

Program Fee (\$50.00) (who will be paying?)



LEGAL STATUS

MARITAL STATUS

| | | | |
|---|--|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Bail | <input type="checkbox"/> Charges Pending | <input type="checkbox"/> Common-law | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Parole | <input type="checkbox"/> Probation | <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Temporary Absence | <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Single | <input type="checkbox"/> Widowed |

PRESENTING ISSUES: (why is the client here?)

Include client's view of the problems, the causes, and previous attempts at dealing with the issues.

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PRESENTING STRENGTHS:

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RELEVANT HISTORY WITHIN THE LAST 24 MONTHS:

(family, marriage, support system, legal status, ministry of child and family, child custody)

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TREATMENT SERVICES ACCESSED IN PREVIOUS 24 MONTHS

| | | | |
|--|---|---|--|
| <input type="checkbox"/> Addictions Counselling | <input type="checkbox"/> Family Counselling | <input type="checkbox"/> Mental Health Counselling | <input type="checkbox"/> Survivors of Sexual Abuse |
| <input type="checkbox"/> Addictions Treatment for self | <input type="checkbox"/> Hospitalized | <input type="checkbox"/> Religious Counselling | <input type="checkbox"/> Traditional Ceremonies |
| <input type="checkbox"/> Addictions Treatment for family | <input type="checkbox"/> Indian Residential School Survivor | <input type="checkbox"/> Self Help Group for Self | <input type="checkbox"/> Traditional Healer |
| <input type="checkbox"/> Anti-poverty Rights Group | <input type="checkbox"/> Legal Services | <input type="checkbox"/> Self Help Group for Spouse | <input type="checkbox"/> Treatment from a Psychiatrist |
| | <input type="checkbox"/> Medical | <input type="checkbox"/> Sexual Assault Services | <input type="checkbox"/> Treatment from a Psychologist |
| | <input type="checkbox"/> Men's Group | | <input type="checkbox"/> Women's Group |
| Details: | | | |
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TRAUMATIC EXPERIENCES WITHIN THE LAST 24 MONTHS:

(disruption of family relationships; medical, psychiatric, or substance abuse problems within the family; emotional, physical, mental or sexual abuse; suicidal ideation/behaviour within the family)

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DEVELOPMENTAL / EDUCATIONAL HISTORY

| | | | |
|--|--|--|--|
| <input type="checkbox"/> No Formal Education | <input type="checkbox"/> Elementary School | <input type="checkbox"/> Some College | <input type="checkbox"/> Bachelor's Degree |
| <input type="checkbox"/> Indian Residential School | <input type="checkbox"/> Grade 8 – 10 | <input type="checkbox"/> College Certificate | <input type="checkbox"/> Master's Degree |
| | <input type="checkbox"/> Grade 11 – 12 | <input type="checkbox"/> College Diploma | <input type="checkbox"/> PhD |
| | | <input type="checkbox"/> Some University | |



RESIDENTIAL SCHOOL

LITERACY/SPECIAL REQUIREMENTS

| | |
|--|---|
| <input type="checkbox"/> Client Attended Indian Residential School <input type="checkbox"/> Client Did Not Attend Indian Residential School <input type="checkbox"/> Inter-generational Survivor | <input type="checkbox"/> Illiterate <input type="checkbox"/> Legally Blind <input type="checkbox"/> Has trouble reading <input type="checkbox"/> Has trouble writing <input type="checkbox"/> Can read but struggles with Comprehension <input type="checkbox"/> Needs Audio Books/Resources |
| Details: | |
| | |
| | |

WORK HISTORY

| | |
|---|--|
| <input type="checkbox"/> Contract Work <input type="checkbox"/> Disability <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time | <input type="checkbox"/> Primary Care-taker of young children <input type="checkbox"/> Seasonal Work <input type="checkbox"/> Student (full or part-time) <input type="checkbox"/> Unemployed |
| Usual Occupation: | |

SPIRITUAL INVOLVEMENT

| | |
|--|--|
| <p>Traditional/Indigenous</p> <input type="checkbox"/> West Coast <input type="checkbox"/> Plains/Prairie <input type="checkbox"/> East Coast <input type="checkbox"/> South American <input type="checkbox"/> Sun Dance <input type="checkbox"/> Long House <input type="checkbox"/> Other | <p>Church Affiliation</p> <input type="checkbox"/> Anglican <input type="checkbox"/> Catholic <input type="checkbox"/> Shaker <input type="checkbox"/> Salvation Army <input type="checkbox"/> Pentecostal <input type="checkbox"/> United <input type="checkbox"/> Other |
|--|--|



STATEMENT OF COMMITMENT:

(to be signed by the Client and the Referral Agent)

- I understand that my participation in all areas of the Gya' Wa' Tlaab Healing Centre Program is part of the commitment that I make to myself and the Program Staff.
- I understand that by entering the Program, I agree to a one (1) week graduated isolation period that includes no phone calls, emails, or faxes. Week 2 will be a semi-supervised outing and meetings. Week 3 weekend day passes (earned only) will begin.
- I agree that I will fully participate in all aspects of the program, attend on time, and be respectful of all program participants.
- I agree that I will not request any medication from any Staff Member that has not been prescribed by Physician.
- I understand that the Gya' Wa' Tlaab Healing Centre has a ZERO tolerance policy in place for Violence. I agree that I will abide by this policy and find respectful ways of dealing with Rage and Anger issues.
- I understand that I will not be permitted to walk unescorted in the Community of Kitamaat Village and will only be permitted to go on scheduled outings with the Staff of the Gya' Wa' Tlaab Healing Centre.

| | |
|----------------------------------|--------------|
| Client Signature: | Date: |
| Referral Agent Signature: | Date: |



REFERRAL AGENT SUMMARY

| | | |
|---|-----------------------------|---|
| 1. Would you describe your client as being free of Crisis at the time of this referral? | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 2. Is this client in a therapeutic relationship with you? | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, how much contact have you had in the last 6 months? |
| | | <input type="checkbox"/> Initial A&D assessment |
| | | <input type="checkbox"/> 1 – 6 Counselling Sessions |
| | | <input type="checkbox"/> 7 – 20 Counselling Sessions |
| 3. Has this client attended a Treatment Program in the past? | | |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. List Programs that client successfully completed in the past 10 years: | | |
| 4.1 Please list reasons for non-completion of any programs (looking for patterns): | | |
| 5. Are you, in any way, related to this client? | | |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5.1 If yes, please describe how: | | |
| 5.2 If yes, please describe below, how it will affect the client/counsellor relationship and confidentiality issues regarding the Consent for the Release of Information: | | |



PRE-ADMISSION MEDICAL EVALUATION

Physician Name and Address:



Pre-Admission Medical Evaluation Form

Notes to the Physician

- The client is to be medically assessed as a potential participant in our 7- or 8-week Early Recovery/Stabilization Residential Treatment Program.
- **As the signing physician, you will remain the primary caregiver for this client .**
- Upon receipt of 'Client Prescription Letter', as primary caregiver for this client, you **must fax all prescriptions** for chronic medical conditions to our local Pharmacist, Eva at Shoppers Drug Mart, fax # 250-632-6023, **prior** to intake date for the full 7 or 8 week period.
- Please have all prescriptions faxed prior to entry. Client cannot bring medications into the Centre.
- **Methadone** clients must have full 7 or 8 week prescription faxed to our local Pharmacist, Eva at Shoppers Drug Mart at (250) 632-6023.
- If there is any acute care needed it will be provided by our current attending Physician.
- The client must be physically and mentally ready to participate in the program that operates from 06:00 – 22:30 every day for seven or eight weeks.

CLIENT INFORMATION

| | |
|--------------------------------|-----------------------|
| Client Name: | Date of Birth: |
| Personal Health Number: | Status Number: |

CLIENT RELEASE

| | |
|--|--------------|
| <p>I, _____, hereby permit the Gya' Wa' Tlaab Healing Centre Society's attending physician to release medical facts and assessments about me to the Gya' Wa' Tlaab Healing Centre Treatment Team for the purpose of continuum of care. The photocopy of my signature on this form is as valid as the original.</p> | |
| Client's Signature: | Date: |



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ALLERGIES

| | |
|--|------------------------------|
| 1. Does Client have any allergies? <input type="checkbox"/> Yes, <i>please list</i> <input type="checkbox"/> No | |
| Dietary Allergies: | Dietary Intolerances: |
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| Medication Allergies: | Any other Allergies: |
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TB SCREENING STATUS

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|---|
| <p>The TB test must be completed and results (including a copy of the CDC's Form 939) faxed to Gya' Wa' Tlaab Healing Centre prior to acceptance.</p> |
| <p>2. A TB Test has been administered in the last 12 months. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2.1 Date of Test: _____</p> <p>2.2 Results of Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>Please Note: If there is a positive result, a chest x-ray is mandatory with a copy of the results faxed to Gya' Wa' Tlaab Healing Centre.</p> |



COMMUNICABLE DISEASE STATUS:

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|---|
| <p>3. Does your client have any communicable diseases? (Sexually Transmitted Diseases, scabies, lice, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3.1 Has the client tested positive for any of the following:</p> <p>Hepatitis A: <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis B: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis C: <input type="checkbox"/> Yes <input type="checkbox"/> No HIV / AIDS: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3.2 Please list all related medications.</p> <p>3.3 Current Medical Concerns/Problems due to above diagnosis.</p> |
|---|



SUICIDAL IDEATION

| | | | |
|---|--|------------------------------|-----------------------------|
| 4. Does Client have a history of suicide attempts? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4.1 Has Client attempted suicide in the last 12 months? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4.2 If Yes, please note the date: _____ | | | |
| 4.3 If Yes, was Client hospitalized due to this attempt? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4.4 Is there adequate Clinical Support to deal with suicide issues? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Please list the Clinical Support Team involved. | | | |
| Counsellor: | | Therapist: | |
| Attending Physician: | | Other: | |

HISTORY OF PSYCHIATRIC CARE / DIAGNOSIS

| | | | |
|---|--|--------------------------------|--|
| 5. Does client have a psychiatric history? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5.1 If Yes, please check all applicable diagnosed illnesses: | | | |
| Anxiety Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bi-polar Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Clinical Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Post Traumatic Stress Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleep Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Schizophrenia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5.2 Is Client currently receiving mental health care? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5.3 Last date Rx was reviewed? _____ | | | |
| 5.4 Length of time on anti-psychotic medications: _____ | | | |
| 5.5 Is Client receiving Clinical Mental Health Support from any of the following: | | | |
| Clinical Counsellor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health Therapist | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Psychiatrist | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychologist | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other _____ | | | |



MEDICATION QUERY

| 6. Is the Client currently on any prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
|--|------------------------|-------------------------|----------------------------------|
| 6.1 If Yes, please list all current medications below: | | | |
| Rx Medications/Dosage Including PRN & OTC | Most Recent Rx Date | Length of Time on Rx | Name of Prescribing Physician |
| | | | |
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| | | | |
| 6.2 Is the client fully informed about all medication? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 6.3 Is the client agreeable to taking all medications as prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 6.4 If unsupervised, does the client forget to take medications? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 6.5 Is client known to hide or feign taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

METHADONE MAINTENANCE CLIENTS

| | |
|---|------------------------|
| 7. Please provide information on the Prescribing Physician. | |
| Physician Name: _____ | City Located in: _____ |
| Phone Number: _____ | Fax Number: _____ |
| 7.1 History of Methadone use: | |
| Year in which it was first prescribed: _____ | Initial Dose: _____ |
| Date of most recent prescription: _____ | Current Dose: _____ |
| Carrying Privileges: <input type="checkbox"/> Yes <input type="checkbox"/> No | |



MOST RECENT URINE RESULT: PLEASE ✓ FOR POSITIVE RESULTS

| Test Dates | Amphetamines | Benzodiazepines | Cannabis | Cocaine | Crystal Meth | Opiates |
|------------|--------------|-----------------|----------|---------|--------------|---------|
| | | | | | | |
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CONTINUUM OF CARE: DECLARATION BY CLIENT

For the purpose of supporting the “Continuum of Care” and to ensure safe prescribing practices, I consent to allow the ATTENDING PHYSICIAN, ATTENDING DENTIST, and the ATTENDING PHARMACIST of the GYA’ WA’ TLAAB HEALING CENTRE to:

- contact my primary physician to discuss my medical status
- access my PharmaNet profile
- contact NIHB benefits, if applicable.

Furthermore, I assert that:

- I have been fully informed about this consent issue, and that I voluntarily give my consent to the sharing of this information.
- I understand that I can revoke my consent at any time.
- The photocopy of my signature on this form is as valid as the original.

Client Signature:

Date:



DECLARATION BY PHYSICIAN

- I conclude that my patient **IS** physically and mentally fit and able to fully participate in all aspects of the treatment program at the Gya' Wa' Tlaab Healing Centre.
- I conclude that my patient **IS NOT** physically and mentally fit and is unable to attend treatment at the Gya' Wa' Tlaab Healing Centre at this time.

Physician's Signature:

Date:

ANY OTHER INFORMATION FROM PHYSICIAN

Please provide any other information regarding this client that you believe is relevant.

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