REFERRAL PROCESS: Please read attentively

To the referral person: thank you for supporting this applicant

We appreciate your cooperation in expediting the referral and admission process. If we can be of assistance, please call us at **Isuarsivik Recovery Center** at **1-866-964-9994**, or correspond by e-mail to: clinicalsupervisor@isuarsivik.ca.

As the referral person, when would like highlight the following for you to consider:

1. Read the sections called *Admission criteria* and *Guidelines for applicants on parole or probation* to determine if the program is fitting for this applicant.
2. Fill out and return the forms in this package to Isuarsivik Recovery Center. It is preferable to send the application by email to clinicalsupervisor@isuarsivik.ca. However it is possible to send it by fax at 819-964-2041.
3. Ensure that the following forms are submitted as part of the application package. Use this list as a checklist:

- ☐ Read and understand referral process
- ☐ Completion of PARTS I, II, III, IV, V, VI
- ☐ Signed consent form
- ☐ Review and signature of guidelines (How things work at Isuarsivik)
- ☐ Pre-admission Medical Evaluation
- ☐ Copy of court orders or DYP measures if applicable during program cycle
- ☐ Psycho-social information, family and social background, and current behaviors for applicants referred from the legal or penal system
- ☐ Copy of health care and status card

4. Upon receipt of all the forms, the referring person and/or client will be notified of a **pre-admission telephone interview date**.

Note: No admission date will be considered until the WHOLE application process has been completed.

Referral: Please read this with applicant, as this will help the applicant better understand the program

Welcome to the Isuarsivik Recovery Center. Together we can make a difference through shared commitment to deliver a high quality of service to clients who are seeking help for their recovery from trauma and substance abuse.

Overview of the Program

The Isuarsivik Recovery Center is located in Kuujjuaq and offers a 42-day on-site recovery program for trauma and substance abuse. A Board of Directors consisting of seven members from various community services governs the Centre. The program commenced in February 1995.

VISION

Isuarsivik is a rich resource that promotes Inuit pride, self-empowerment, spirituality and healing through loving, healthy, protective lifestyles in safe, addiction free communities.

Mission Statement

To provide a culturally based wellness program, as a means for Inuit to achieve a healthy, addiction free lifestyle.

Philosophy

The foundation of our program is based on using traditional values in partnership with modern accepted treatment models reflecting mental, physical, spiritual and emotional well-being.

Recovery Program Specifics

The program consists of:

- Individual and group trauma and substance abuse counselling sessions.
- Individualized care plans based on client goals.
- Education on trauma and substance abuse, and the related behaviors.
    - Intergenerational trauma, physical, emotional, sexual abuse, etc.
- Healing from unresolved trauma and grief.
    - Loss by accidental death, suicide, etc.
- Spiritual and cultural awareness.
- Land-based and community activities.

Program Resources

- Elder guided activities
- Presentations by community partners
- In-house Alcoholics Anonymous / Inuit Steps Meetings
- Self-help support groups

Application and Referral Process

- The complete application (including the consent and pre-admission medical exam and TB test or chest x-ray) must be submitted and received prior to review of application.
- Isuarsivik reviews all documents.
- A short pre-admission phone call between the counsellor and the applicant is scheduled.
- A letter confirming the acceptance or non-acceptance to the program is sent directly to the referring agent.
- The applicant or the referring agent, must arrange travel, spending monies, etc. prior to admission.

Admission Criteria

1. Beneficiaries of the James Bay and Northern Quebec Agreement and their spouses over 18 years of age who can benefit from a therapy based on Inuit culture are invited to complete an application. There is no cost for to beneficiaries of the JBNQA
2. Clients MUST abstain from ALCOHOL and/or MIND ALTERING DRUGS for a minimum of 72 hours prior to entering treatment. Longer is better.
3. Clients must be mentally and physically able to participate in a recovery program experience.
4. Clients must recognize that alcohol/drug abuse or addictive behaviors is/are a problem in their lives.
5. Clients must express a need and desire to change, by exploring the role of trauma in their present life-style.
6. Clients must have no outside interference during the six week treatment program such as court appearances, doctors, dentist or other medical appointments, child care concerns etc.

Guidelines for applicants on parole or probation

- The applicant is expected to cooperatively participate and follow the guidelines and the program with the understanding that the center is under no obligation to keep a client who does not participate.
- Isuarsivik Recovery Center is not under any obligation to accept a person who has been legally ordered to attend the program. Therefore, unless there are specific conditions mentioning that the client must stay the complete 42 days, Isuarsivik is not responsible for informing the probation officers.
- If there are specific attendance orders upon acceptance to the Isuarsivik program, the probation officer will be informed if the client is asked to leave the center, or leaves voluntarily before program completion. Documents provided in the application package must be provided indicating the conditions applicable during the entire program cycle.
- The parole or probation officer must confirm agreement that the applicant will be required to go to communities activities, shopping, day passes, etc. during the program.
- Information the psycho-social, family, social background as well as current applicant behavior must be provided with the application package.

Application Package

In this package, ***Referral*** is the social worker, lawyer, or probation officer or whoever is referring someone, and ***applicant*** refers to the person going for therapy)

PART I: INFORMATION TO BE COMPLETED BY APPLICANT (please print)

First name: _____ Last name: _____

Date of Birth: Month:_____ Day: _____ Year: _____

Mailing address (client): _____

Community: _____ Province: _____

Postal code: _____ Email: _____

Home Tel #: _____ Work Tel #: _____

Marital Status: _____ Number of children: _____ Ancestry: _____

Education: _____ Occupation: _____

Employer: _____

Beneficiary Card Number: _____

If not working, source of income to support yourself/family: _____

Next of kin to be notified in case of emergency: _____

Telephone number: _____ Relationship to Applicant: _____

** ***As part of the application process and before an application will be considered, all applicants MUST agree to provide a "Contact Telephone Number" for our Pre-Treatment Assessment & After-Care Counsellor contact them.***

INFORMATION TO BE COMPLETED BY REFERRAL (please print)

Name of Referral Agency: _____

Name of Referral: _____ Title: _____

Agency Telephone: _____ Fax: _____

Email: _____

Agency Address to send the treatment summary to:

_____

_____

1. Is the client seeing the referral regularly? Yes ___ No ___
2. If yes, how much contact in the past six months? _____

3. Will client continue working with referral person or agency for follow up after treatment? Yes___ No___

If not, who will the client be seeing to get more support after treatment:

Name: _____ Title: _____

Telephone: _____ Fax: _____

Email: _____

PART II: INFORMATION TO BE COMPLETED BY REFFERAL AND APPLICANT

Was client coerced (forced) (includes attendance required by law) into coming or did he/she decide voluntarily? Circle the ones that apply to you.

Parole/Probation		Court order	Choice of (going to jail or treatment)
Charges	Court cases	Outstanding warrants	Department of Youth Protection
Outstanding custody issues		Employment reasons	

Give details if there are specific conditions we should be aware of at Isuarsivik and join legal document(s) to support this:

_____

_____

_____

Probation/Parole officer's Name/Location/Phone and Fax No's

_____

ADDICTIVE SUBSTANCES (used)

Does the client perceive himself/herself as having other addictive behaviors? If yes, please name:

(Bingo, card games, casino, sex, food, work, shopping, relationships, television, X-box games, etc.)

_____

1. Have you ever tried to cut down on your use? Yes___No___
2. Has anyone every expressed concern about your alcohol or drug use? Yes___No___
3. Have you ever felt bad or guilty about your alcohol or drug use? Yes___No___
4. Have you ever used to get over a hangover/after-effects of using? Yes___No___

Withdrawal reaction to substance abuse – indicate all effects of experience.

Hangovers	Shakes	Seizures	DT's	Ulcers
Cirrhosis	Heart Problems	Blackouts	Vomiting	

History/Actual use

What is/are your drug(s) of choice ? _____

Date of last use: _____

PART III: PRESENTING PROBLEM

1. What event(s) took place that caused the client to seek help at this time?

_____

Client's perception of the problem

1. Does client feel he/she has an addiction problem? Yes ___ No ___

   1.2 How does the client feel of his/her alcohol/and or drug use:

   Does client express a need to change? Yes ___ No ___

Medical/Psychological Factors/Mental Health Issues/Special needs

1. Significant past and present medical issues (i.e. cancer, diabetes, impairment – hearing loss, illiteracy, loss of limb): _____
2. Significant past and present psychological issues.
   Do you have a history of depression? ___ Yes ___No If yes, for how long? _____

PART IV: SUICIDAL RISK ASSESSMENT

In the past month:

1. Have you wished you were dead or wished you could go to sleep and not wake up? Yes___No___
2. Have you actually had any thoughts about ending your life? Yes___No___

If YES to 2, answer questions 3, 4, 5,6, and 7. **If NO** to 2, go directly to PART V.

3. Have you thought about how you might do this? Yes___No___
4. Have you had any intention of acting on these thoughts of ending your life, though you definitely would not act on them? Yes___No___
5. Have you started to work out or worked out the details of how you would end your life ? Yes___No___
6. Do you intend to carry out this plan? Yes___No___
7. **In the past three months**: Have you done anything, started to do anything, or prepared to do anything to end your life?
   Yes___No___

PART V: HISTORY OF SUPPORT

A.A/N.A When? _____ How long? _____

Psychologist/Psychiatrist When? _____ How long? Social Services

When? _____ How long? _____

Other Support Groups When? _____ How long? _____

Please give details of the outcome of the above involvement. _____

Have you ever attended treatment at Isuarsivik? Yes___No___ if so, when? _____

PART VI: REFERRAL'S PERCEPTION OF THE CLIENT

1. How is the client's emotional state:

_____

_____

2. Does the client understand that this is a voluntary program? Yes___No___
3. How is the level of client's motivation, on a scale of 1 to 5 (with 1 being slightly motivated, and 5 being highly motivated): 1__2__3__4__5__
4. Is the client aware that many of the activities at Isuarsivik take place in the community, with people who are not involved in the treatment program? Yes___No___ (Example: wood working shop, community feasts, celebrations, church services, etc.)
5. Does the client understand that with the activities that take place in the community, people who are not associated to Isuarsivik have not signed agreements for client confidentiality? Yes___No___

CLIENT RELEASE

I, _____ (Please print client's name), request and permit Isuarsivik to forward my discharge/treatment summary to the person referring me. I understand that this is not mandatory to be accepted in the program.

Referral agency, title and name (i.e. social worker, intake office, probation officer):

_____

_____

After-Care Counsellor contact them.

Dated: _____ day of _____, 20____

_____ _____

Client's name (please print) **Signature**

_____ _____

Referral (please print) **Signature**

Client's signature: _____Date: _____

How things work at Isuarsivik

(Review with and give a copy to applicant)

TO ALL PARTICIPANTS

The following will help you in contributing to a positive environment for your program and healing. Please read these guidelines carefully—and for the welfare of all the participants, be prepared to follow them.

1. ALCOHOL AND DRUGS

Isuarsivik is a trauma and addiction recovery center where all participants are required to abstain of using alcohol and drugs while being resident of Isuarsivik. There is a **zero tolerance** to alcohol and or drug (mind altering drugs) use while being in Isuarsivik program. Participants using mind altering substances **will be required to leave the center immediately.**

2. BEHAVIOR GUIDELINES

a. You are to remain with the boundaries of Isuarsivik at all times, except when accompanied by staff or on pass.
b. Do not visit anyone else's bedroom without an invitation. Visiting and chatting takes place in the living room, outside deck and dining room, not in bedroom.
c. All valuables and monies in excess of $20.00 should be turned to the administration for safekeeping. They will be returned to you upon request. If you decide to keep all your money, you will sign an agreement that Isuarsivik is not responsible for any losses.
d. You are responsible for all your personal belongings and effects. Any items left behind when you leave will be disposed of (normally after 30 days). Isuarsivik accepts no liability or responsibility for the personal belongings and effects of residents or visitors.
e. Gambling is not allowed.
f. Running or soft-soled shoes are to be worn in the gymnasium and shoes should be worn all the time.
g. Appropriate clothing is mandatory and reflects respect—no halter tops, bare midriffs, muscle shirts, short shorts (inseam 3" above knees), see through or ripped clothing, logos promoting alcohol or drugs etc. Spandex shorts or pants must be worn with a long shirt. No sleepwear outside of your bedroom.
h. Absolutely NO videos are to be brought in from outside without approval by the counsellors.

3. TELEPHONE CALLS

a. You are permitted one phone call to your family the day you arrive, to let them know you have arrived safely. Phone calls are permitted every day for 15 minutes per client. Telephone schedule is from **7-8 am, 4:15 pm to 10:00pm** (not during dinner) and **as soon as everyone finishes chores during the week-ends.**
b. **Calling cards must be used for long distance calls.**
c. Messages will be taken during the day and staff will distribute them after program each day.

Note: telephone time schedules are subject to changes.

4. SCHEDULE

a. You are to be up by **7: 00am** in the morning during the week and by **8:30am** on the weekends.
b. **TV will be turned off by 10:30pm** and bedtime is **11:00pm** from Sundays to Thursdays.
c. On Fridays and Saturdays **TV will be turned off by 12:30am** and bedtime is **1:00am**.
d. You are accountable and responsible for attending **all** program sessions and activities **on time**—on weekdays and weekends.
e. Radios, TV, etc. are not to be turned on until **after 6:00pm,** or until all chores are completed on weekends. Volume to be moderate at all times. IPods or any personal music devices will be handed over to clients and can be used **only after 6:00pm.** iPods and personal music devices are to be in administration safe from **10:00pm**.

5. HEALTHY AND SAFETY

a. Smoking is not allowed in the building. Smoking is allowed outside at the back of the Centre. Ashtrays are supplied and it is expected that you will use them. Cigarette butts are not to be thrown on the ground. Smokers are responsible to keep ashtrays clean **(We strongly discourage pregnant women smoking).**
b. All medication will be turned over to the administration office upon entrance
c. You are assigned regular daily chores, which must be completed before supper.
d. There will be no horseplay, running, or swearing.
e. Due to high incidences of communicable diseases please do not share cigarettes, pop or anything that can pass along germs from your mouth.
f. Money and valuables can be safeguarded by handing them in to the administration office.
g. If we have concerns regarding client's health we may refer to our consulting physician or dietician.

6. CHORES

a. Participants are required to do their assigned chores every day. You are responsible for your assigned chores.
b. It is strongly recommended participants can help someone else if they complete their chores early.
c. It is everyone's responsibility to wash your own dishes in the mornings, evenings, and weekends.

7. VISITORS

a. Visitors will be asked to show a staff member anything they are bringing to the Center for clients. Bags will be searched, and unauthorized items will be removed.
b. Visitors are allowed only in the designated visiting areas (living room, dining area and outside deck) and are prohibited from entering the bedroom area.
c. Visitors under influence of alcohol or drugs are prohibited.
d. Sexual relations between residents and visitors are prohibited.
e. You are responsible for your visitors and letting them know of the House Rules.

8. PASSES

a. Passes are not time off, they are part of the program, an opportunity to try out, explore, and experience healthier choices in the community. You can share your successes of your day pass when you get back to the Centre.

b. Passes are not automatic RIGHT**. Passes are a PRIVILEDGE and will only be issued if you attend all sessions, do your chores on a timely basis**, and demonstrate progress in your treatment.
c. All residents are required to remain on the grounds unless on pass or on an approved walk.
d. Your Program Counsellor and Clinical Supervisor approve passes.
e. Clients out on a pass must return by **9:00pm**
f. If you fail to return by the time designated on your pass, you will be held accountable and responsible.
g. We strongly recommend that you do not attend places that use and promote the use of drinking, drugs, or gambling.

10. TRANSPORTATION

a. Clients will be picked up at the airport by Isuarsivik staff.
b. If granted a weekend pass, you are welcome to stay at the Centre. However, you will be required to follow day pass regulations. If you decide to go out, you will be on your own, arrange for your own rides etc. Clients are urged to call the Centre if they feel they are in trouble, they will be picked up.
c. Special needs will be addressed by your counsellor and your group.

WHAT TO BRING:

Ensure your client is aware of clothing and personal needs including items on the list below –

Minimum 4 complete changes of clothing (laundry facilities are limited)

- White soled/non-marking soled runners (for gym)
- Slippers, pajamas, and a bathrobe for use going back and forth to the washrooms
- Indoor shoes
- Appropriate outdoor seasonal wear:
  - summer wear – sweater, swimsuit, mosquito repellent, sunscreen, hats;
  - winter wear – pants, boots, jackets, mitts, hats.
- Toilettries (shampoo, toothpaste, razors, feminine needs, etc.),
- Writing paper, envelopes, stamps,
- **Calling cards**
- Comfort/spending money for 40 days,
- Arts and crafts projects, if on hand, and

Note that intake arrival time is **before 7 pm** on the scheduled date. If arriving by plane, someone from Isuarsivik will be at the airport to welcome the client.

GENERAL GUIDELINES FOR RESIDENTS AGREEMENT

I understand the General Guideline and agree to follow them. I agree to participate fully in the program, and I understand that some activities take place in the community, with people who are not part of the Isuarsivik team.

***Client's name:** (please print): _____
***Client's signature**: _____
Date: _____

PRE-ADMISSION MEDICAL EVALUATION

*Client's Name: _____ Medical Number: _____

Date: Month_____, Day: _____, Year: _____

CLIENT RELEASE

I,_____ (name of client) hereby request and permit my physician to release medical facts and assessments about me to _____and **Isuarsivik**. The photocopy of my signature on this form is as valid as the original.

***Client's signature**:_____

TO THE PHYSICIAN or NURSE

The above named client is to be medically assessed as a potential participant in our six week addiction program. Our program is designed to help people who acknowledge that their drinking or drug use has interfered with their effective functioning and who are physically and mentally ready to participate in a program of intense counseling activity. **Isuarsivik** requires a client to have had a complete physical examination prior to admission. In order for a client to be successful in our program, the client has to be free of any psychoactive/mood altering drugs, painkillers, sleeping pills, or tranquilizers that are being used addictively for a period of three months prior to admission.

MANDATORY
MEDICAL EXAMINATION
IMPORTANT: TO BE DONE BY DOCTOR OR NURSE, NOT BY THE CLIENT

Name: _____

Date of last alcohol/drug use: _____

Date of last psycho-active drug use: _____

Current Diagnosis: _____

Medical problems to be followed while in treatment (MD is available for follow-up)

_____

Does patient have any allergies? _____ If so, to what? _____

Is patient pregnant? _____

Past history of Tuberculosis (TB) **___Yes ___No**

Date of latest chest x-ray, if known and results: _____

Has the client the following symptoms?

- Unusual cough ___Yes __No
- Sputum production ___ Yes __No
- Unexplained fever ___ Yes __No
- Night sweats ___ Yes __No
- Recent weight loss ___ Yes __No

If any combination of these symptoms is compatible with active tuberculosis it is mandatory for client to have a chest x-ray before coming to treatment.

(Revised by Nunavik Regional Health Board Public Health department: March 2010)

Functional inquiry – is there any disorder of the following?

Hair, skin, nails (especially current or recent infestations or infections)	___ Yes	___ No
Ear, nose, throat	___ Yes	___ No
Muscular-skeletal system	___ Yes	___ No
Blood, lymphatic system	___ yes	___ No
Cardio-vascular system	___ Yes	___ No
Respiratory system	___ Yes	___ No
GI system	___ Yes	___ No
GU system	___ Yes	___ No
CNS – especially hex of seizures	___ Yes	___ No
Past history of TB	___ Yes	___ No

Family History

Alcohol/drug problem	___ Yes	___ No
Psychiatric history	___ Yes	___ No
Adopted	___ Yes	___ No

Physical Examination

Height _____ Weight _____ BP/PR _____

	Normal	Abnormal
Appearance	___	___
ENT	___	___
Hair, skin, nails	___	___
Reticuloendothelial system	___	___
Muscular-skeletal system	___	___
Thyroid	___	___
Cardio-vascular system	___	___
Respiratory system	___	___
Abdomen	___	___
Central nervous system	___	___
Evidence of sexually transmitted disease	___	___

Please comment on any abnormalities noted above.

_____

_____

Present Medications:

_____

_____

Have you any comments, suggestions or insights that might be helpful in terms of client's being physically and mentally able to participate in group, one-to-one counseling and living in residence for six weeks?

_____

_____

Clients attending treatment should be as free as possible from all drug abuse and should not be on any sedative-hypnotics. The client is not in need of acute hospital care; diseases are to be under control as much as possible – ESPECIALLY contagious diseases.
Clients should be checked for STDs before entering treatment.

I have examined this client and find him/her to be fit to attend treatment.

Physician or Nurse's Signature and stamp_____

Date _____

Address _____

_____

Telephone _____