Kackaamin
FAMILY DEVELOPMENT CENTRE

Restoring Balance: Growth, Health and Wellness

We are pleased to be a part of your healing journey.

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"Restoring Balance"

This specialized program will offer group therapy, individual counselling, cultural support, and 12 Step program supports.

Restoring Balance draws upon Western and Indigenous approaches to healing through a trauma informed lens. The Four Indigenous Values of Belonging, Kindness, Cooperation and Respect are interwoven into the program. This program offers crisis intervention for individuals and couples who may be experiencing increased stress during COVID-19. Participants will be supported through addiction recovery and learn stress management skills.

The program will explore:

- **Identifying feelings**
- **Self-regulation**
- **How to identify triggers**
- **Resilience**

Participants are asked to refrain from any and all drug and alcohol use during programming. Healing will be based on Traditional culture and ceremony- participants' need to have a clear mind and spirit to connect with the Creator and Ancestors.

Accommodation at Kackaamin Family Development Center will be provided

Please connect with Intake Coordinator, Julie Fontaine, at 250-723-7789 or julie.f@kackaamin.org for appropriate applications and for any questions or concerns related to programming application requirements.

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Thank you for choosing our program! We are looking forward to seeing you soon. Below is some information that you may be helpful in your preparations. Please call or email if you have any questions (250-723-7789 or julie.f@kackaamin.org)

How to get to our centre:

Use Google Maps and enter "Kackaamin Family Development Centre" in the search bar-this will bring up a map to our Centre.

From Hwy 19 to Parksville, then west on Hwy 4 (Exit 61) through to Port Alberni. Keep right, (past Walmart) automatically becomes Johnston Road, continue down Johnston to the bottom and turn right at the lights on River Road, go over the bridge and the first right is Beaver Creek Road, go 9.2 km up Beaver Creek Road, Kackaamin is on the left. If you are bring your own car, there is ample parking available at the Centre.

What to Bring:

- Shampoo, soap, tooth brush other personal items
- Care Card, Status card
- Comfortable modest clothing is required
- Snacks
- Alarm clock/Radio
- Water bottle and travel coffee mug with lid
- Small blanket for cooler weather, in group and for outside activities as needed
- Towels for your unit
- Two week's groceries for your unit. Please note: You need to bring all spices, condiments and baking supplies as they are not provided. Shopping will be arranged weekly.
- Medications to be blister packed for easy dispensing and to limit staff/client physical contact
- Bedding is provided and laundry facilities are onsite.

Note:

CELL PHONE USE DURING PROGRAMMING WILL NOT BE TOLERATED. WE HAVE LANDLINE AVAILABLE FOR COMMUNICATION PURPOSES.

Guidelines

- No alcohol or drugs are allowed at the Centre
- Smoking is permitted in designated areas
- Please leave all valuables at home
- Participation is a requirement in all aspects of the program
- Attached medical MUST be completed and submitted to KFDC by a physician or nurse practitioner for consideration of admittance to program.
- Participants MUST be socially isolating 14 days before program start date for acceptance/ admission to center.
- Applicants MUST be available for pre-treatment screening phone call by KFDC clinical/ team prior to program start date.

Check out our website at www.kackaamin.org for photos of our centre.

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RESTORING BALANCE: Growth, Health and Wellness Application

PLEASE PRINT CLEARLY

IDENTIFYING INFORMATION

LAST NAME	FIRST NAME	KNOWN AS
DATE OF BIRTH (YYYY MON DD) ❑ MALE ❑ FEMALE	TELEPHONE	EMAIL
ADDRESS	CITY	PROVINCE / POSTAL CODE
ABORIGINAL ANCESTRY ❑ YES ❑ NO	BAND NAME	ON RESERVE ❑ YES ❑ NO
CARE CARD NUMBER	STATUS NUMBER (10 DIGIT NUMBER)	
RESIDENTIAL SCHOOL - YES/ NO DAYSCHOOL YES/ NO	INTERGENERATIONAL : PARENTS YES/NO GRANDPARENTS YES/NO	

PERSONAL HISTORY

EMPLOYMENT STATUS ❑ WORKING ❑ S.A. ❑ E.I.C. ❑ OTHER	CHEMICAL USE HISTORY: i) Substance Used (1ist):		
❑ ALCOHOL	❑ STREET DRUGS	❑ PRESCRIPTION DRUGS	❑ INHALANTS
ii) Abuse Pattern	❑ DAILY ❑ MOSTLY WEEK-ENDS ❑ BINGE		

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT SURNAME	EMERGENCY CONTACT FIRST NAME	RELATIONSHIP
TELEPHONE	EMAIL	CITY OF RESIDENCE

INFORMATION

Do you have physical limitations that prevent you from doing recreational or cultural activities	❑ YES ❑ NO	Do you require a wheel chair accessible unit?	❑ YES ❑ NO
Do you have any allergies (food, insect, medications) we need to be aware of		Please explain	
I understand and accept I will be placed in shared accommodation	❑ YES ❑ NO	I am committed to complete a structured program process focused on my wellness	❑ YES ❑ NO
I am willing to be involved in all types of intensive activities	❑ YES ❑ NO	I am willing to participate in First Nations Treatment program components such as daily smudge, pipe and other cultural ceremonies?	❑ YES ❑ NO
I am willing to put aside all external distractions while in the journey to the wellness program	❑ YES ❑ NO	I have received COVID 19 Vaccinations: 1 – 2 - 3	

Kackaamin Family Development Centre Program Guidelines

- Clients must have a minimum 2 weeks of abstinence from any previously misuse substance.
- Smoking is allowed in the designated smoking areas

- Clients must have travel arrangements confirmed to and from the center
- Arrival time will be designated time on intake day- **ARRIVALS MUST OCCUR AT THE SPECIFIC TIME INDICATED UPON CONFIRMATION LETTER RECEIVED.**

TREATMENT NEEDS

Have you engaged in healing programs (healing circle, cultural practice, support groups or workshops)?
Trauma Please note any recent or past traumatic events you feel comfortable disclosing at this time.
Specific Treatment Please note any specific goals or needs (i.e. spiritual, mental, emotional, physical) that you have for treatment.
Specific Needs Please note any special needs, physical limitations, or other concerns you may have at our centre.

_____ _____

Client Signature Date

_____ _____

Referral Worker Signature Date

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MEDICAL ASSESSMENT	
Must be completed by medical personnel (e.g., Physician, Nurse Practitioner, Registered Nurse) Please print clearly.	
Date of Assessment/ Referral:	Are you the applicant's regular Physician/ Nurse? Yes ❑ No ❑
Applicants Name:	Date of Birth:
Personal Health Care Number:	Status Number:

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (applicants name), hereby request and authorize _____ (Physician, Nurse Practitioner or Registered Nurse's name) to release medical information pertaining to myself to Kackaamin Family Development Center and to my referral worker acting on my behalf (listed above).

_____ _____

Applicant's Signature Date

_____ _____

Medical Personnel's Position/Title Date

_____ _____

Physician, Nurse Practitioner or RN's Signature Date

Informed Consent must be completed with the Patient.

*****Note: This form is applicable for one year after signed and dated. The Applicant may change or revoke this release at any time by giving notice to the treatment center in writing. *****

Specify any dietary requirements) allergies, intolerances, diabetes, etc.):

Current Medications (Names)	**Dose (ml/ng)**	**Reason for Taking:**	**How long has patient been taking?**

1) Have you reviewed client's medications personally? Yes ❑ No ❑
2) Does the applicant take prescribed narcotics or opioid medications? Yes ❑ No ❑

If yes- what for, what type and how often?

3) Does the applicant take prescribed medical marijuana in any form or oils containing CBD or THC? Yes ❑ No ❑

If yes- what for, what type and how often?

4) Is client taking all medications as prescribed? Yes ❑ No ❑

Medical History	**Comments**
Does the applicant have any communicable diseases? Yes ❑ No ❑	Please Specify:

Does the applicant have any head trauma or cognitive impairment? Yes ❑ No ❑	Please Specify:
Does the applicant have a history of seizures? Yes ❑ No ❑	Type of Seizures- Please Specify: Date of last seizure:
Does the applicant have any chronic illnesses or conditions? Yes ❑ No ❑	Please Specify:
Does the applicant have any cardiovascular disorders or conditions? Yes ❑ No ❑	Please Specify:
Does the applicant have any allergies? Yes ❑ No ❑ Please Specify:	Does applicant require an Epi-Pen or Ana-Kit? Yes ❑ No ❑ ***NOTE- clients are responsible for their own epi-pens and Ana-Kit's- Kackaamin DOES NOT supply***
Is the applicant pregnant? Yes ❑ No ❑ N/A ❑	If yes, how many weeks.
Is client currently receiving specialized medical care? E.g. injections, dialysis, wound care, physio, chiropractor, etc.	Please specify condition being treated and the type and frequency of treatment being accessed.

Please provide blood pressure for applicant.	
Please provide resting heart rate for applicant.	

ANY CONCERNS WITH COVID-19 EXPOSURE?

Any recent travel off of Vancouver Island?	Yes ❑ No ❑
Any family members tested positive/ being treated for COVID-19?	Yes ❑ No ❑
Any community members tested positive or being treated for COVID-19?	Yes ❑ No ❑
Displaying any signs or symptoms of COVID-19?	Yes ❑ No ❑

Guidance Re: Tuberculosis Screening for Entry into Treatment Centres

Background:
Tuberculosis (TB) screening for entry into detox or treatment centres has been a barrier for some clients because of the perceived need to include a Tuberculin Skin Testing (TST) and/or chest x-ray as part of that screening process. Consequently, FNHA TB Services has worked with the FNHA Mental Wellness Clinical Team to simplify the TB screening process by incorporating it directly into the medical assessment part of the treatment centre application. This assessment may be completed by any qualified practitioner (MD, NP, RN).
The purpose of TB screening for entry into treatment programs is to rule out active TB. Thus, the only requirement for entry into a treatment centre is a negative symptom assessment. A TST or chest x-ray is not required unless the client is having symptoms suggestive of active TB.
Despite this, **screening for latent TB infection (LTBI) with a TST may be of benefit to the client** since people who use substances are often at higher risk for exposure to TB and at higher risk for progression to TB disease if they have LTBI. Those with known LTBI may also benefit from treatment to prevent active TB disease. As such, we continue to encourage Community Health Nurses to offer screening to these clients as part of their Priority Screening for TB program.

Process if using the new TB screener contained within the Medical Assessment section of the FNHA Treatment Centre Referral Package

1. Complete TB screening pages in medical assessment portion of the application.
2. If the client has symptoms suggestive of active TB (productive cough for > 3 weeks, unintentional weight loss, drenching night sweats, etc.), collect 3 sputum for AFB and send client for CXR. Notify FNHA TB services by phone (604-693-6998) or email (FNHATB@fnha.ca) and complete the regular BCCDC TB screening form for submission.
3. If client has no concerning symptoms, complete the remainder of the TB screening part of the medical assessment. Provide education to the clients regarding their individual risks and, if appropriate, the benefit of treating LTBI.
4. Obtain consent from the client to share the information with FNHA TB services.
5. Fax only that section of the medical assessment to FNHA TB Services at 604-689-3302.
6. No additional clearance letter is required.
7. If there is a significant time lapse between when the assessment is done and when the client enters treatment program (i.e. 6 months), advise client to report the development of any symptoms to their health care provider or yourself.
8. If another practitioner is completing the medical assessment you may advise them on this process (e.g. they do not need to refer the client to you for TST).
9. If the client is interested and available at this time for latent TB screening (e.g. TST), or for a discussion regarding the benefits of the treatment of LTBI, you are encouraged to go ahead and do that. Otherwise make arrangements to have the client return at another time for this screening. Add client details to your Priority Screening list to ensure you remember to follow-up.

Process if using the BCCDC TB Screening Form
Non-FNHA Treatment Centres may not have incorporated TB screening into their medical assessment package.

1. Complete the BCCDC TB Screening Form as you normally would.
2. If the client has no symptoms of active TB, you can provide clearance for entry (sample clearance letter attached). You do not need to wait to receive a clearance letter from FNHA.
3. No TST or referral for CXR is required unless the client is having symptoms. Check off "TST not done". Provide education to the client regarding their individual risks and, if appropriate, the benefit of treating of LTBI.
4. If the client is available for latent TB screening and a TST is appropriate, go ahead and do that now or have them return at a later date.
5. Fax completed screening form to FNHA TB Services at 604-689-3302 or, if entering into Panorama yourself, notify us that a screening has been done.

Guidance Re: Tuberculosis Screening for Entry into Treatment Centres cont…

Documentation in Panorama:
If you have access to Panorama, enter the screening using these steps:

1. Open a TB Investigation (Case - Person Under Investigation)
2. Ensure client demographics are updated, especially the "Address on Reserve Administered By" section. Be sure to mark current address as the "preferred address".
3. In Treatment and Interventions>TB Skin Test Summary, update TB History Summary.
4. Create TB Follow-Up Only (unless skin test is done). Enter 06 as reason for screening if client is going for substance use program or enter 12 if going for trauma/ family program. Under follow-up, select No Follow-Up Required". Under Follow-up Details enter "Client denies signs and symptoms of active TB at present. Cleared for program entry." You can also add other details, such as "Asked client to return next month for TST", etc.
5. Complete the Signs and Symptoms and Risk Factor sections.
6. You may complete allergies and external source information if this is available to you.
7. You can generate a clearance letter directly from Panorama. To do this, ensure you have the Investigation in context. Go to Reporting and Analysis>Reports>Investigations, scroll down to Tuberculosis Disease section. Select the hyperlink RBCY TB005 Client No Active TB Letter. In the top navigation banner, select Generate Report Now. Select Open in Adobe and print for the letter for client.

For additional information or support, please refer to the BCCDC Decision Support Tool or contact FNHA TB Services.

Section 13: Tuberculosis (TB) Screening

The purpose of TB screening for entry into treatment programs is to **rule out active TB**. *Screening for latent TB is not required, and should never delay program entry*, but might be of benefit to the client and can always be done at a later date.

People who use substances are an important group to consider for regular TB screening and this screening continues to be an essential part of TB prevention and overall wellness.

For follow-up purposes, does client reside in a First Nations community: No Yes (>50% of the time)
Community Name: _____

TB Symptom Assessment

☐None	☐Fever	☐Short of Breath
☐Chest Pain	☐Haemoptysis	☐Sputum Production
☐Cough (for >3weeks)	☐Lymphadenopathy	☐Unintentional Weight Loss
☐Fatigure	☐Drenching Night Sweats	☐Other:

*** If client has a cough, or other symptoms consistent with active TB, collect 3 sputum for AFB, send client for CXR, and complete TB Screening Form (Appendix A) for review by TB Services prior to program entry. ***
For clients who live in a First Nations community fax form to FNHA TB Services at 604-689-3302.
For clients who reside within VIHA fax to Island TB Services at 250-519-1505.
For all other clients fax form to BCCDC at 604-707-2690.

TB History (check all that apply)

☐ Has the client ever had a positive TST and/ or IGRA result?

☐Has the client ever been in contact with someone with active TB?

☐Has the client ever been treated for TB?

If TB history is unclear, please contact FNHA TB Services at 1-844-364-2232. FNHA Clinical Nurse Advisors can provide practitioners with the client's TB history.

TB Risk Factors

Certain risk factors pose a higher risk for progression to active TB in the presence of latent TB or increase the risk of exposure to TB (check all that apply):

☐None	☐HIV
☐Transplant (specify):	☐Diabetes
☐Chronic Kidney Disease/Dialysis	☐Cancer (specify):
☐Substance Use (alcohol or other)	☐Tobacco Use
☐Immune Suppressing Meds (name, dose, duration):	☐Homelessness/Underhoused (past or current)
☐Work or live in a congregate setting (past or current)	☐Work or live in a Correctional Facility (past or current)

If client lives in a First Nations community, please discuss sharing this information with FNHA TB Services for follow-up purposes.

☐I, _____, consent to sharing the above information with FNHA TB Services.
(print name)

Client's Signature: _____ Date: _____

Client's Date of Birth:_____

If consent provided, please fax this page to FNHA TB Services at 604-689-3302.

ANY ADDITIONAL COMMENTS OR CONCERNS:

Please return completed medical to:

Julie Fontaine
Intake Coordinator
Kackaamin Family Development Center
PH: 250-723-7789 FAX: 250-723-5926
Email: julie.f@kackaamin.org