NATIVE ADDICTIONS COUNCIL OF MANITOBA
Pritchard House Criteria for Residential Treatment

BE ADVISED THAT THE FOLLOWING IS THE CRITERIA FOR ACCEPTANCE INTO PRITCHARD HOUSE RESIDENTIAL TREATMENT PROGRAM.

IF YOUR CLIENT DOES NOT MEET OR IS NOT WILLING TO MEET THE FOLLOWING CRITERIA, HE/SHE WILL NOT BE ADMITTED INTO OUR PROGRAM.

IF YOU HAVE ANY QUESTIONS ABOUT THE FOLLOWING, YOU MAY CONTACT THE NATIVE ADDICTIONS COUNCIL OF MANITOBA AND SPEAK TO A RESIDENTIAL INTAKE WORKER.

1. **All applicants must be 18 years of age or older.**
2. **Previous Clients who have either left the program early or completed the program and wish to re-enter residential treatment must wait 2 years before re-applying.**
3. **Couples WILL NOT attend residential treatment together.**
4. **Women who are 7 months pregnant or more may not enter residential treatment.**
5. **All applicants who are admitted into residential treatment must participate in all assigned chores, group sessions and all program activities.**
6. **Applicants must meet with the referral agent at least 5 times following the initial referral to ensure suitability for the program.**
7. **ALL TRACES OF THC (marijuana) WILL DELAY TREATMENT.**
8. **All applicants must be drug and alcohol free 7 to 10 days PRIOR to admittance into residential treatment and any suspicion of recent alcohol or drug use may result in client not being admitted. (Note: This is not only IMPORTANT for the staff but for the well being of the client as well. Clients will be Drug and Alcohol screened upon arrival at Pritchard House).**
9. **Applicants must not currently be in a methadone program or on the waiting list for a methadone program.**
10. **Applicants who are attempting to stop the use of crystal meth may not enter residential treatment.**
11. **Applicants must not be using OxyContin or oxycodene, either by prescription or without prescription.**

12. **Applicants must have completed a medically supervised step-down program for use of benzodiazepines (e.g. Valium, Lorazepam, Diazepam, Triazepam, etc.) Prior to acceptance into residential treatment. (Note: A Note will be required from the Doctor For completion of step-down program).**

13. **No active gang members or gang associates will be permitted to enter residential treatment.**

14. **Applicants must not be currently in a correctional facility, applicants who are on parole or probation will be considered, depending on the nature of the offence.**

15. **Applicants MUST NOT have a history of arson, sexual offences or violence-related charges or pending charges of arson, sexual offence or violent nature.**

16. **All applicants must have medical conditions or injuries treated prior to admission to residential treatment.**

17. **Applicants who have been diagnosed with or are suspected of having serious mental health issues (e.g. Schizophrenia, bi-polar disorder, borderline personality disorder, etc.) will not be admitted into residential treatment.**

18. **NNADAP workers who are filling out referrals MUST send a SASSI form along with the referral package.**

19. **ALL medications MUST be packaged in Bubble Packs upon entry of program.**

Criteria subject to change

NATIVE ADDICTIONS COUNCIL OF MANITOBA

PRITCHARD HOUSE

Referral Agent Checklist

Please note that the following information must be completed by referral agent in order for clients to be accepted into Pritchard House Treatment Program.

1. Has the client been alcohol and drug free for 7-10 days since the referral was sent?
Yes____ No ____

NOTE: BECAUSE OF THE CONTROVERSY REGARDING DRUG SCREENING RESULTS, NAMELY THC, NACM HAS INTRODUCED A POLICY REQUIRING ALL CLIENTS TO BE DRUG SCREENED AND SHOW A NEGATIVE RESULT FOR THC PRIOR TO ADMITTANCE TO ALL PROGRAMS.

2. Is the client aware that specific prescription drugs will not be allowed during treatment?
Yes ____ No ____

3. Does the client have a physical injury that requires medical attention prior to entering treatment? Yes ____ No ____

If yes, please explain:

_____

_____

_____

_____

4. Are you aware of any diagnosed or undiagnosed mental health conditions or issues?

Yes ____ No ____

If yes, please explain:

_____

_____

_____

5. Have you met with the client at least five times since the initial referral was made?

Please state dates of follow-up meetings: _____

_____

_____

_____

_____

6. Has referral package been fully completed (including answering all questions and a completed medical assessment) Yes ____ No ____

Referral Agent Signature: _____ Date: _____

***Please note that if referral package is not complete, including medical assessment and checklist, the client will not be accepted into the Pritchard House Treatment Program.**

Native Addictions Council of Manitoba
Pritchard House
Traditional, Family and Community

Application for Admission to Treatment
REFERRAL PACKAGE

- **Due to health concerns, women beyond their seventh month of pregnancy will not be considered for admission.**
- **All participants must abide by the house rules-failure to do so will result in immediate discharge.**
- **All participants must be detoxified for at least SEVEN TO TEN DAYS PRIOR to treatment; all participants must be screened for drug use.**

- **ALL PARTICIPANTS MUST PROVIDE IDENTIFICATION**

- **PLEASE COMPLETE ALL QUESTIONS ON THE REFERRAL PACKAGE FOR YOUR CLIENT TO BE CONSIDERED FOR TREATMENT**

BEFORE MAKING A REFERRAL TO OUR PROGRAM, HAVE YOUR CLIENT ANSWER THE FOLLOWING QUESTIONS.

1. **Is your client willing to learn about and participate in Native Cultural Activities?**
   [ ] Yes [ ] No

2. **Is your client sincerely interested in working to change his/her current behaviors?**
   [ ] Yes [ ] No

3. **Is your client willing to commit to participating actively in five weeks of treatment?**
   [ ] Yes [ ] No

Transportation: All referral agents are expected to arrange for travel prior to admission and for return. Admissions will not be accepted without travel arrangements in place.

If the answer to either question is No, then please refer to another program.
Thank-You

Native Addictions Council of Manitoba
160 Salter Street
Winnipeg, Manitoba
R2W 4K1
Telephone: (204) 586-8395
Fax: (204) 589-3921

The mission of the Native Addictions Council of Manitoba is to provide traditional healing services to our own people through wholistic treatment of addictions. The belief of NACM is that each person has the right to wellness, success and self-determination.

Native Addictions Council of Manitoba
PRITCHARD HOUSE TREATMENT CENTRE

Items that should be required by clients:

-Towels (2)

-face cloths (2)

-Tooth brush & tooth paste

-Brush or comb

-Robe

-Nightwear

-Slippers

-Track shoes

-Facial soap

-Shampoo/conditioner

-Phone cards-long distance

-money (change) for local calls

NATIVE ADDICTONS COUNCIL OF MANITOBA

Pritchard House Program Rules

1. BAG SEARCH- All bags will be searched upon entry into building or stored. All luggage will be searched upon admission and upon discharge.

2. PARTICIPTION – Residents are to participate in all activities in and away from the building. Failure or refusal to do so may result in discharge.

3. NO CELL PHONE/ELECTRONICS allowed in the program, **NO EXCEPTIONS.**

4. MEETING – Residents are to be on time and attend all meetings. (Including all exercise sessions) Ensure you ask staff on duty about meeting times before leaving building. You must show up 5 minutes prior to meeting time.

5. COUNSELLING- All residents will be expected to seek a counselor for counselling, minimum of 3 sessions a week or more if necessary.

6. HEALTH – All residents must be in good health. All medication is to be turned in and staff will monitor prescriptions. All medical forms must be also be turned in prior to programming.

7. APPOINTMENTS – All residents must not have any outside appointments throughout the program. All other appointments will be left up to the discretion of counselor/s. Clients must provide notes for all appointments they attend (i.e., CFS, medical, lawyers, etc.) Only 3 accountability forms allowed per program.

8. PHONE CALLS AND VISITS – No phone calls or visits for the first seven (7) days from the Intake date. All seven (7) days, telephone calls are permitted. Saturday and Sunday visits are from 1:00 p.m. to 4:00 p.m. No visitors including children will be allowed anywhere in the building, except in designated areas.

9. RANDOM DRUG SCREENING – Random drug screening will be done during your stay. Refusal to undergo screening or failing the screening will result in immediate discharge. Further admission to any other NACM program will be reviewed and discussed by NACM staff at a further date. Any discharged clients will be banned from the premises indefinitely.

10. ALCOHOL/ILLICIT DRUGS – Residents who abuse any banned substances (alcohol/drugs) or who brings contraband into the centre will be discharged immediately. This also includes any abuse of prescribed drugs (pain killers or mood altering drugs NOT permitted in program).

11. SMOKING – Smoking is only allowed in the designated area outside the building. No smoking within 25 feet of the front doorway.

12. PERSONAL INVOLVEMENT – Residents will not engage in romantic or sexual relationships with visitors, clients or staff, Residents are not allowed in each other's rooms. Anyone involved in sexual misconduct will be discharged.

13. PROBATION/PAROLE- Residents on probation who violate their respective agreements will be reported to the proper authorities if they leave the program before completion.

14. THEFT- All thefts will be reported to the police. Any incidents of theft will be accountable to the client and/or referral source.

15. VIOLENCE- Physical, verbal or emotional abuse of residents, staff or visitors will result in immediate discharge. Existing restraining orders need to be brought to the attention of counselors prior to treatment. No foul language.

16. VANDALISM- Any acts of vandalism will not be tolerated and will result in immediate discharge. NOTE: Any resident who commits vandalism will be held directly responsible and their referral source will be notified and held accountable. No removing or writing on posters, no moving furniture from room to room. No damaging the building or vehicles in any way. Police will be called to investigate any incidents of vandalism.

17. CURFEW- Curfew is 11:00pm, Monday to Sunday. Bedtime is at 11:00pm Sunday to Thursday, seven (7) nights a week. The front door will remain locked at all times. NO overnight or weekend passes.

18. ELEVATOR- Do not use the elevator during a fire or emergency evacuation. Do not misuse the elevator (e.g. jumping on or jumping in the elevator). The elevator should be used only for clients with disabilities or any health conditions.

19. ALARM SYSTEM – Alarm is armed at all times so please use the front door only. Use of any other door will set off the alarm system. **Please use only in emergency.**

20. MONEY – Cash on hand must be limited to the amount needed during your stay. Large amounts of money are to be given to designated staff for safekeeping. **NOTE: NACM will not be responsible for lost or stolen money. Clients are not allowed to borrow money from counselors or staff.**

21. WAKE UP CALL – Wake up calls will be done at 7:00 a.m. (weekdays) and 9:00 a.m. (weekends and holidays).

22. NACM BUILDING – Do not move furniture. Do not mark on the walls. Do not tie up the curtains in the rooms. Keep the same room assigned to you when you entered the program.

23. KITCHEN – Do not remove food from the kitchen. Please see guidelines in kitchen area.

24. MONITORS – Two (2) residents will be assigned to attend to the store when clients need supplies (i.e. cigarettes, oral hygiene, feminine products, etc.)

25. SIGN IN/OUT BOOK – Residents must mark their absences in the sign in/out book clearly. Residents please indicate the time you leave; mark your destination and when you return to the center.

26. CHORES – All residents are expected to do their assigned chores (i.e. washing bed, clean walls, etc.). Rooms should be kept clean as well.

27. LAUNDRY- Washers and the lint traps on the dryers must be cleaned after each use. Doing laundry during group sessions is not permitted. Laundry hours are Monday to Friday 3:00 p.m. – 10:30 p.m.; Saturday and Sunday 8:00 a.m. – 10:30 p.m. Bedding should be done once per week, preferably on weekends. (Last wash at 9:30 p.m.)

28. WEIGHT ROOM – Hours of use will be; Monday to Friday 3:00 p.m. to 10:00 p.m., Saturday and Sunday, 8:00 a.m. to 10:30 p.m. Exercise equipment should not be used unless another client or staff is present. Available between sessions.

29. REGULAR ROOM CHECK/RANDOM ROOM SEARCH- Room searches will be made at staff discretion. All luggage will be searched upon admission and upon discharge. Rooms will be inspected for cleanliness. Please keep your bedroom clean at all times.

30. PERSONAL TIME – This is considered constructive time to be used for: meditation, journaling, chores, arts and crafts, etc. NO gambling in any form while in treatment i.e. bingo or scratch tickets. Clients will not be allowed in any bar or lounges while in treatment on their personal time.

31. CLOTHING – Residents are required to wear footwear at all times. Residents are to wear clean, non-revealing clothing. No exchanging or lending of clothing. All belongings left behind will be held for seven (7) days and then will be donated**.**

32. NON-COMPLETION – Leaving the program early will result in a non-completion of program. Clients who do so are responsible for their own fare home.

33. COMPLETION DATE- On the last day of the program, maintenance staff will clean the building. All bedding must be turned in. Residents are responsible for cleaning out their room. Letters of completion will not be given until all responsibilities are complete.

34. ALL RESIDENTS ARE REQUIRED TO DEPART ON DISCHARGE DAY.

_____
Signature of Client

_____
Signature of Witness

Dated on this_____ day of _____, 20__.

PHOTO REQUIRED

Native Addictions Council of Manitoba

Date: _____ Date of Birth: _____

IDENTIFYING INFORMATION:

Full Name: _____

Address: _____

Phone: _____ Contact: _____

Marital Status: Single, Separated, Divorced, Common-Law, Married, Widow/er

Living situation: Live alone, Common-law, Immediate/extended family, Friends, Shelter
Other: _____

Health#:_____ PHIN#:_____

Band: _____ Band #:_____

Education: _____ Did you attend School On or Off Reserve?

Preferred Language: Cree, Ojibway, Dene, Oji-Cree, English, French, Saulteaux, Sioux.

Source of Income: Employed, Social Assistance, UI, Other _____

Nickname or other Name you are known by: _____

Next of Kin: _____ Ph: _____

Address: _____ Relationship: _____

Substance(s) used in order of preference: _____

Or specific behavior involved (Gambling, Eating Disorder): _____

Ever admitted to Detox:_____ Name of Detox: _____

Date last in Detox:_____ Counsellor assigned: _____

Client Dry Date: _____ Completed by: _____

Date of previous registration (if any): _____

Native Addictions Council of Manitoba

Pritchard House

Traditional, Family, and Community

Referral Source Information

Name of Referring Person: **Position:**
Agency Name and Address:
Phone#: **Fax#:**
What is the nature of your relationship with the client (counselor, advocate, family, doctor)?
How long have you known the client?
Reason for involvement with referring person/agency?
Give a brief description of client's problem as you see it?
What is your assessment of the client's level of motivation at this time?
To your knowledge, has the client ever experienced episodes of depression, anxiety, or any recent suicide attempts?
What steps have been taken to prepare this individual for treatment?
Please list the program and/or services available in your community for aftercare or follow-up for this client?
Is there family support for this client?

****PLEASE provide a brief history of why you feel the client would benefit from Pritchard House. (Use another sheet for documentation)**

TO BE COMPLETED

BRIEF DRINKING / DRUG HISTORY:

How old were you when you started using alcohol?
What age did a regular use begin?
What were the consequences / difficulties as a result of your using.
How old were you when your drug use began (Prescription or non-prescription)
What age did your regular use begin?
What were the consequences as the result of your drug use?
Have you ever experienced any of the following? Indicate yes with a check mark.
□ Hangovers □ Vomiting □ Shakes □ Paranoia □ Blackouts □ Seizures
□ Headaches □ Hallucinations □ Any serious Health Problems

TREATMENT HISTORY:

Place:	**Date:**	**Completed / Uncompleted**
How long were you sober after treatment and how is this time going to be different?		
What do you identify as the reasons for returning to drinking / drug use?		
Did you ever attend a halfway house or supportive housing after completing treatment?		
Have you or your family ever attended Residential School? [ ] YES [ ] NO		

MENTAL HEALTH HISTORY

Do any of the following apply to you? (Indicate Yes by using a check mark).	
□ Tension, Anxiety, Nervousness	**□ Depression**
□ Eating Disorder (binging, starving, comfort eating	**□ Fears, Phobias / Excessive Worry**
□ Sexual Abuse / Assault	**□ Sexuality Concerns**
□ Physical / Emotional / Mental Abuse	**□ Anger / Aggression Problems**
□ Low Self-Esteem / Lack of confidence	**□ Difficulty Expressing Emotions**
□ Grief Issues / Excessive Sadness	**□ Sleeping Disorders / Problems**
□ Suicidal Thoughts / Ideation	**□ Self Harm Behavior / Harm from others**

Have you ever been hospitalized for suicidal thoughts and / or suicidal attempts? If so when?
Have you ever made a plan? When? What was it?

Have you had suicidal thoughts in the past:

□ Two Weeks □ Three Months □ Six Months □ 1 year

Have you ever had counseling for any of the above concerns? Give name below.

Name: **Agency:**

Date: **How long:**

Please indicate briefly what issues were addressed:

Would you be willing to sign a release of information for N.A.C.M. to access reports from the above agency(s)? If not, why?

Is counseling / therapy ongoing?

What is your view of life at this present time?

LEGAL HISTORY:

Are you currently on probation? If so, for how long and what are the conditions?			
Are you on parole? If so, for how long and what are the conditions.			
Do you have to attend court? If so, when and for what?			
Do you belong to or were you associated with a gang?			
Please indicate if you have had any of the offences listed below (past/current/pending) Check all that apply.			
□ Theft/Possession property	**□ Probation/Parole Violation**	**□ Willful damage / mischief**	**□ Murder / Manslaughter**
□ Drug Charges	**□ Weapon Offenses**	**□ Robbery**	**□ Assault**
□ Sexual Assault	**□ Burglary / B&E**	**□ Forgery**	**□ Arson**
□ Impaired Driving	**□ Prostitution**	**□ Sexual Abuse to a child**	**□ Other**

Please Note: Depending on past/current/pending charges will determine eligibility for Treatment.

DEPENDANT CHILD/REN INFORMATION:

Please list the names and ages of your children below:

Full Name:	Date of Birth/age:	Where is she/he now:

If your child/ren is now in care, who will care for your child/ren while you are in treatment?

Name:	Address:
Relationship to the child/ren:	Phone #:

Do you struggle with parenting?

Has C.F.S. ever been involved in the care of your child/ren? If yes, how many times?

If C.F.S. or any other Child Welfare Agency is currently involved with your children, please fill in the information below.

Name of Worker:	Phone No:
Name of Agency:	Fax No:

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____ hereby authorize Native Addictions Council of
(client's name)
Manitoba to give/receive any and all information pertinent to the assessment and treatment of myself, to/from any agency that I am involved with as the Native Addictions Council of Manitoba may require for said purpose.

The document(s) and/or information requested is described on the line below:

_____

_____

_____

_____

_____

I understand that I may revoke this consent at any time (with such revocation to be in writing). Except to the extent that action has been taken in reliance upon it.

I further understand that this consent will automatically expire one (1) year after the date signed.

_____
Signature of Client

_____
Signature of Referral Source Representative

Signed this _____ day of _____ 20____.

Native Addictions Council of Manitoba
Pritchard House / Outreach Program

Drug Screening Tool Policy

We are a **TOTAL ABSTINENCE TREATMENT CENTER**. Our goal is to help the client live a sober healthy, clean lifestyle. Our programs will require each individual, applying for either one of these programs, be free from drugs and alcohol for **SEVEN (7) FULL DAYS**.

***THERE WILL BE NO EXCEPTIONS**.

If you are coming in from out of town for treatment, please keep in mind, this agreement, **under no circumstances** will one be allowed to enter any of N.A.C.M's treatment programs until one shows a negative result with N.A.C.M.'s drug screening tools.

We at N.A.C.M. will be using drug screening tools to monitor any substance use before entering and during your program stay.

***We will go by N.A.C.M.'s screening results and make our decisions based on these findings.**

I, _____, hereby agree and understand to this policy.
(Client print name)

Signed on _____ day of _____, 20_____.

_____
Client signature

_____
Referral/Counselor Name (print)

_____
Referral/Counselor Signature

Native Addictions Council of Manitoba

Pritchard House

Phone: 204.586.8395 / Fax: 204.589.3921

MEDICAL ASSESSMENT

(To be completed by MD, NP or RN)

Client Personal Identification:

First Name: _____ Last Name: _____

Birthday: Year _____ Month _____ Day _____ Age _____

Gender: Male _____ Female _____ Transgender _____

Provincial Health Number: _____ PHIN: _____

Treaty Number: _____

Informed Consent Must Be Completed With Client:

I, (client's name) _____ do hereby request and give permission to _____to release medical facts and assessment about myself to Native Addictions Council of Manitoba/Pritchard House. The photocopy of my signature on this form is as valid as the original.

Client's Signature: _____ Date: _____

To the Health Care Provider:

Please ensure the medical assessment form is completed legibly and in layman's terms.

Native Addictions Council of Manitoba requires a client to have a complete medical assessment prior to admission.

The client should not require acute medical care at the time of admission to Native Addictions Council of Manitoba/Pritchard House. Diseases are to be under control, especially communicable diseases.

The drug and alcohol treatment programs require a client to be physically and mentally capable of intense group and individual counseling. Participation is expected in all aspects of the program.

Medical History:

Vital Signs:

BP: _____ P: _____ R.R: _____ Sp02: _____ RBS: _____

Please indicate whether the client has or had any history of the following:

	Medication	Duration	Prescribing Doctor
Allergies Reaction:			
High Blood Pressure			
High Cholesterol			
Diabetes			
Asthma			
Heart disease/stroke			
Epilepsy/seizure			
Head Injury			
Skin condition			
Scabies, lice, impetigo			
Sexual transmitted infections			
Hepatitis			
HIV			
Pregnancy (EDC)			
Methadone			
Sleeping Disorders			
Other conditions, explain:			

Mental Health/Illness:

Anxiety/panic attacks			
Bipolar Disorder			
Depression			
Schizophrenia			
Suicidal Ideation			
Other conditions, explain:			

Tuberculosis Screening:

Recent contacts to TB: yes ___ no ___

Tuberculin skin test: yes ___ no ___ Documented: yes ___ no ___

Signs and Symptoms of active TB:

Coughing	Yes ___	No ___	Blood in sputum:	Yes ___	No ___
Night sweats:	Yes ___	No ___	Fever:	Yes ___	No ___
Loss of appetite:	Yes ___	No ___	Unexplained weight loss:	Yes ___	No ___

Are you aware of current or recent medical problems which may require follow-up while client is in treatment?
If yes, please explain:

_____
_____
_____

Follow-up appointment date & time:

_____

Name: _____
(Health Care Provider)

Address: _____

City: _____ Province: _____

Postal Code: _____

Telephone: _____

Fax: _____

Office Stamp

_____ _____
(Health Care Provider-Signature) **(Date)**