Native Horizons Treatment Centre

130 New Credit Road
Hagersville, ON
N0A 1H0
T: 905-768-5144
Toll Free: 1-877-330-8467
F: 905-768-5564
E-mail: office@nhtc.ca

REFERRAL AND CLIENT INFORMATION

Native Horizons Treatment Centre is a fifteen (15) bed, co-ed six (6) week residential treatment program. This package will provide the information necessary to apply for our program. For facsimile purposes, please keep the application one-sided and only return pages four to fourteen (4 – 14), the Drug Use Screening Inventory (DUSI-R) and the Native Wellness Assessment (NWA) tools.

Enclosed are the following documents:

Adult Intake/Referral Form:

- All areas must be completed.
- Court documents must be attached.
- Client and referral signatures are required.

Medical Forms:

- An **updated** medication list is required.
- TB skin test and results are required (can be completed by a Registered Nurse, Nurse Practitioner and/or Physicians) every twelve (12) months.

Release of Information:

- Client must specify referral worker and/or any other person(s) authorized to receive information.
- Client and referral worker signatures are required.

Drug Use Screening Inventory Revised Questionnaire (DUSI-R):

- This assessment requires one answer only (yes or no) for each question.
- If the question does not apply to you, please answer no.

Native Wellness Assessment (NWA):

- This assessment requires one answer only for each question.

Personal Items Checklist:

- This document is for client information only.

Please read the following information before completing and sending an application:

Native Horizons requires and accepts referrals from the following sources **only**:

- Community-based frontline workers (NNADAP, Mental Health Workers, Counsellors, etc.).
- Indigenous/Non-Indigenous Service Agencies.

Our re-admission policy stipulates that:

- Priority will be given to the clients who have not attended residential treatment within the past six (6) months.
- Clients re-applying must establish proof of continuing care since discharged from any previous treatment program.
- Re-admission to Native Horizons cannot be guaranteed and will be assessed on an individual basis.

Criteria for Native Horizons to refer an applicant to another facility/agency includes:

- We are not a medically equipped facility; therefore, we currently do not accept clients on Methadone, Suboxone, Narcotics (including Tylenol-3), Ativan, or any antipsychotic medications.
- Applicants who have been diagnosed with Bi-Polar Disorders, Personality Disorders, Major Depressive Disorders, FAS/FASD, brain injury and/or severe physically dependent persons.
- Clients being referred by medical professionals or from medical facilities (including withdrawal management).
- Clients that are pregnant.
- Clients currently incarcerated and/or have not been out of custody for a minimum of thirty (30) days.
- Only two (2) clients with legal involvement will be accepted per program cycle.
- Clients who have not maintained fourteen (14) days free of alcohol and/or drugs.
- Couples and relatives cannot be accepted into the same program cycle; one may be considered for the following program cycle.

The following is the application process into Native Horizons program cycle:

- Referral worker and client must complete four (4) pre-treatment sessions to determine if residential treatment is appropriate for the client (excluding filling out the application).
- Referral worker and client must complete Native Horizons intake application together.
- Incomplete applications will be held for thirty (30) days before being discarded.

1. Client application is received and entered into our Addiction Management Information System (AMIS).
2. Intake worker reviews and screens application to determine eligibility for the potential client.
3. A telephone interview is scheduled with the client and/or the referral worker.
4. Application is forwarded to the treatment team for decision of acceptance or alternative resources.
5. After treatment team's decision is made, a letter is sent stating approval or denial to the referral worker and/or client.

6. Referral worker and client continue to prepare for treatment and/or alternative resources.

Additional Information:

- Please bring identification documents on intake day (Health card, Status card, Social Insurance card).
- All medication must be in blister packs for six (6) weeks.
- Medication must be prescribed by a physician.
- Vitamins and/or any other supplements not prescribed by a physician, must be in unopened containers and may be approved.
- All medications (prescribed and non-prescribed) are secured and monitored by staff.
- Clients must bring sufficient supplies of personal items – toiletries, cigarettes, money, etc.
- Starting the fourth (4th) Sunday of the program client's privilege of television and telephone calls begin.
- Week four (4) Saturday and week five (5) Saturday clients earn weekend day passes from 12:00 p.m. – 10:00 p.m.
- Clients are allowed visitors starting on the fifth (5th) Sunday and sixth (6th) Sunday of the program from 1:00 p.m. – 4:00 p.m.
- Incoming client mail begins after 5:00 p.m. on the fourth (4th) Friday of treatment. Outgoing mail is sent on a weekly basis.
- All money and valuables of the client may be secured until privileges are granted.
- Transportation to and from Native Horizons for any reason is the sole responsibility of the client and/or the client's First Nation.
- Laundry machines and supplies are provided. If you require special or preferred supplies, please bring your own as Native Horizons cannot provide additional supplies.
- All food (and other) allergies must be documented in the application package with supporting medical documents. Native Horizons tries to accommodate food allergies as much as we can, however, this is not always possible. We will not cater to food preferences and/or dislikes.
- Native Horizons Treatment Centre is equipped and monitored by security cameras at all times.

Native Horizons Treatment Centre is committed to the continued healing of our communities!

Native Horizons Treatment Centre

INCOMPLETE APPLICATIONS WILL DELAY THE INTAKE PROCESS

Form to be completed by Referral Agent **and** Client
If information is not applicable, indicate as **NA**, unknown as **UNK** and unavailable as **UNA**. Attach a separate sheet of paper if more space is needed.
PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED

ADULT INTAKE/REFERRAL APPLICATION

A. General Information			
Date Application Received by Community Worker:		Date Application Received by Treatment Centre:	
Surname:	First Name:		Preferred Pronouns:
Date of Birth: (DD/MM/YYYY)	Age:	Sex:	Provincial Health Card Number:
Full Mailing Address:			Telephone Number:
Personal E-mail Address:	Reside On or Off Reserve:		Social Insurance Number:
Status Native/Metis/Non-Status:	Status Number:		Band Name:
Education: (Incomplete/Completed High School, College, University)			Employment Status:
Emergency Contact Name:	Emergency Contact Telephone Number:		Relationship to Emergency Contact:

Family/Relationships		
Marital Status: ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Widowed		
Does the client have dependent children?	☐ Yes ☐ No	
If yes, do they have access to adequate childcare while client is in treatment?	☐ Yes ☐ No ☐ Not Applicable	
Are the children in care of Child Protection Services?	☐ Yes ☐ No ☐ Not Applicable	
Does the client have other dependents?	☐ Yes ☐ No	
Provide information on client's children or other dependents: (continued on next page if more space is needed)		
Name	**Age**	**Relationship**

Please list the client's family support system and their relationship to the client:		
Please list the strengths of the client's familial support system:		

Legal Status:	
Has the client been court ordered to attend treatment?	☐ Yes ☐ No
If yes, provide details (include copy of legal order):	
Is the client under any of the following legal conditions?	☐ Bail ☐ Parole ☐ Temporary Absence Order ☐ Charges Pending ☐ Restorative Justice ☐ Probation ☐ Other
Has the client ever been charged with a criminal offence? If yes, please list charge(s) and date(s) of offence(s):	

Treatment History:	
Has the client participated in a non-residential/community-based substance abuse program?	☐ Yes ☐ No
Has the client participated in a non-residential/community based mental health program?	☐ Yes ☐ No
Has the client participated in a residential treatment program before?	☐ Yes ☐ No
If yes, please provide information on previous treatment experience: (continued on next page)	

Year	Treatment Centre	Type of Addiction	Completed	Comments

			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Reason(s) for currently requesting treatment:

B. Withdrawal Symptoms

Has the client experienced any of the following symptoms while withdrawing from substances <u>in the last six (6) months?</u>

Symptom		Describe
Blackouts	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Hallucinations	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Nausea/Vomiting	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Seizures	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Shakes	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Delirium Tremens (DT's)	☐ Yes ☐ No ☐ Not Applicable	

Ever experienced DT's?	☐ Yes ☐ No	

C. Mental Health		
Provide the following information about the client's mental health status:		
Mental Illness		**Describe**
Has the client been diagnosed with a mental illness?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Is the client currently being treated for any mental health issues?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, is the client taking medication consistently and as prescribed?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Previous suicide attempts?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, when?		
Hospitalized for suicide attempts?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
If yes, when?		
Currently suicidal?	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Name of Psychiatrist and/or Psychologist, telephone number and address (if applicable):	Name: Title:	Telephone: Address:

D. Process/Behavioural Addictions		
Has the client experienced problems with any of the following?		
Process/Behavioural Addictions		**Describe**
Gambling (slots, cards, bingo, etc.)	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Eating (obesity, anorexia, bulimia, etc.):	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Sex (promiscuity, pornography, etc.):	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Internet/Texting:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Video Games:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Shopping:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Not Applicable ☐ Unknown	

E. Other Issues/Needs	
Does the client have cultural and/or spiritual beliefs and practices we should be aware of? If yes, please describe:	☐ Yes ☐ No
Does the client have any literacy or learning needs or issues we should be aware of? If yes, please describe:	☐ Yes ☐ No
Are there any other significant issues we should be aware of? If yes, please describe:	☐ Yes ☐ No
Does the client understand there is an expectation of completion of a minimum of four counselling sessions prior to applying to residential treatment?	☐ Yes ☐ No

Does the client understand there is an expectation they have been alcohol and drug free for at least fourteen (14) days prior to admission to residential treatment? They have been out of incarceration for a minimum of thirty (30) days prior to admission? (Clients with less than the required days must notify the treatment centre prior to admission)	☐ Yes ☐ No
Please list your personal strengths:	

Client's Stage of Readiness: Please choose one of the following:
☐ Pre-contemplation – Not considering change; resistant to change. ☐ Contemplation – Unsure of whether to change, chronic indecision. ☐ Determination – Preparation; committed to changing behaviour within one month. ☐ Action – Begin changing behaviour. ☐ Maintenance – Behaviour change has persisted for six (6) months or more

Please identify all concerns/issues you're currently experiencing:

☐ Child Welfare Involvement	☐ Replacement of Identification	☐ Food Security
☐ Ontario Works Assistance	☐ Report-in to Authorities	☐ Job Security
☐ Disability Assistance	☐ Reliable/Safe Housing	☐ Re-entering the community
☐ Continuing Education	☐ Relocating	☐ Homelessness
☐ Dental Needs	☐ Sexual Health Concerns	☐ Adverse Effects of Medication
☐ Sleep-Wake Disorders	☐ Eating Disorders	☐ Other:
☐ Financial Crisis	☐ Family Court	

What areas might need to be addressed in treatment?

☐ Low Self-Esteem	☐ Physical Abuse	☐ Inability to Express Emotions
☐ Grief and Loss	☐ Sexual Abuse	☐ Depression
☐ Hatred of Self	☐ Verbal Abuse	☐ Anxiety
☐ Hatred of Others	☐ Emotional Abuse	☐ Sexual Identity
☐ Mistrust of Others	☐ Spiritual Abuse	☐ Criminal Activity
☐ Boundaries	☐ Foster Care/Adoption	☐ Gang Affiliation
☐ Rejection	☐ Residential/Boarding Schools	☐ Anger
☐ Abandonment	☐ Parenting Skills	☐ Mental Health
☐ Suicide	☐ Cultural Oppression	☐ Other:

F. Application Checklist

Has transportation **to** Native Horizons Treatment Centre been arranged and confirmed?	☐ Yes ☐ No
Has transportation back home **from** Native Horizons Treatment Centre been arranged and confirmed?	☐ Yes ☐ No
Client has been notified and understands of the Non-Insured Health Benefits (NIHB) policy change, that whereby medical transportation benefits have been provided and the client self-terminates or Native Horizons Treatment Centre terminates the client anytime during the treatment process, the client will have to assume the costs of the next trip to access medically required health services and provide a confirmation of attendance to either the Health Centre Transportation Coordinator or Health Canada.	☐ Yes ☐ No

Client Authorization	
I authorize the documentation of my information for this application process. I understand and agree to accept the treatment program as described by Native Horizons Treatment Centre.	
Client Signature	**Date**
Referral Signature	**Date**

G. Referral Information

First Name:	Surname:
Agency:	Title/Position:
Agency Address:	Telephone Number:
Fax Number:	E-mail Address:

Has the client completed four pre-treatment appointments? (Not including filling out the application)	☐ Yes ☐ No

Please provide appointment dates: (DD/MM/YYYY)	Date 1:	Date 2:	Date 3:	Date 4:
Please provide session topics for each date:				

Will you continue to see the client once he/she has completed treatment? If not, why?	☐ Yes ☐ No

What other supports are available to the client in their community upon return from Native Horizons?

Name/Resource	**Description of Support**

Native Horizons Treatment Centre
130 New Credit Road
Hagersville, ON
N0A-1H0
T: 905-768-5144
Toll Free: 1-877-330-8467
F: 905-768-5564
E-mail: office@nhtc.ca

MEDICAL AUTHORIZATION

I hereby give authorization to the Physician signed below, for the release of all pertinent medical information related to my present medical condition, to Native Horizons Treatment Centre. I understand that by signing this form, Native Horizons Treatment Centre has the right to contact the Physician, if the need to consult arises. I also acknowledge that this is not an insured service and any cost incurred for the completion of this form is my sole responsibility. **Please note: A qualified medical practitioner is required to complete all areas of this form.**

Client Name:	Client D.O.B:
Health Card No:	Status (10 digit) or Social Insurance No:

Please indicate where the client has experienced any recent (within the past six (6) months) history of the following:

Medical Condition		**Describe**
Head/Body Lice	☐ Yes ☐ No ☐ Unknown	
Scabies	☐ Yes ☐ No ☐ Unknown	
Impetigo	☐ Yes ☐ No ☐ Unknown	
Rheumatic Fever	☐ Yes ☐ No ☐ Unknown	
Communicable Diseases	☐ Yes ☐ No ☐ Unknown	
Asthma	☐ Yes ☐ No ☐ Unknown	
Sexually Transmitted Diseases	☐ Yes ☐ No	

	☐ Unknown	
HIV/AIDS	☐ Yes ☐ No ☐ Unknown	
Hepatitis A/B/C	☐ Yes ☐ No ☐ Unknown	
Injectable Drug Use	☐ Yes ☐ No ☐ Unknown	
Cancer	☐ Yes ☐ No ☐ Unknown	
Pregnancy	☐ Yes ☐ No ☐ Unknown	
Diabetes	☐ Yes ☐ No ☐ Unknown	
Food/Other Allergy	☐ Yes ☐ No ☐ Unknown	
Psychiatric and/or Mental Health Involvement	☐ Yes ☐ No ☐ Unknown	
Withdrawal Symptoms (Please provide details of substance use)	☐ None ☐ Moderate ☐ Severe	
COVID:	☐ Yes ☐ No ☐ Unknown	
Other:	☐ Yes ☐ No ☐ Unknown	
Note: **A T.B. Test is required by all clients to attend Native Horizons Treatment Centre**. If a Mantoux test results in a positive, a chest x-ray is mandatory. Please send to Native Horizons Treatment Centre when results are completed.		

Test Type:	Date:	Results:
T.B. Test		
Chest X-Ray		

Please provide details of all current medication(s) prescribed to the client. If more space is needed, please attach a separate sheet of paper to this form.

Medication Name:	**Dosage:**	**Used For Treatment Of:**	**Initial Date Prescribed:**	**Prescribed By:**

Note: Please refrain from discontinuing medications prior to treatment admission date. Ensure that the client has been stabilized on the correct dose before attending treatment. Also, please ensure the client brings enough prescribed medications **(blister packaged)** to last for six (6) weeks of Native Horizons program.

Medical Practitioner First Name:	**Last Name:**
Telephone Number:	**Full Mailing Address:**
Medical Practitioner Signature:	**Date:**
Client Signature:	**Date:**

Native Horizons Treatment Centre
130 New Credit Road
Hagersville, ON
N0A-1H0
T: 905-768-5144
Toll Free: 1-877-330-8467
F: 905-768-5564
E-mail: office@nhtc.ca

RELEASE OF INFORMATION

Release of Information			
Having read and understood this form, I hereby authorize Native Horizons Treatment Centre to Release/Request the following information To/From the Person/Agencies listed. In order for this release to be valid, one column must be **check marked and initialed by the client** for each of the following persons/agencies and area of disclosure:			
Persons/Agencies *Please specify persons name(s) below*	**Yes**	**No**	**Initials**
1.			
2.			
3.			
4.			
5.			
Area of Disclosure	**Yes**	**No**	**Initials**
1. Discharge Summary			
2. Continuing Care Plan			
3. Progress Reports			
4. Treatment Plan			
5. Other – Specify:			
I understand that any other information will not be released to any other person without my written consent unless they have a court order or are concerned with my medical treatment in an emergency. I also understand that I can withdraw my consent to the release/request of information at any time and that in any event this form will be void ninety (90) days from the date of my signature.			

Client Signature	**Date**
Referral Signature	**Date**

When, in the opinion of the healthcare provider, the physical and/or mental condition of a client prevents him/her from having the ability to understand the subject matter in respect of which consent is requested and from being able to appreciate the consequences of giving or withholding consent, authorization for disclosure of the information may be given by the client's next of kin.

Signature of authorized person to sign in lieu of client	**Print Name**
Relationship to client	**Date**

Native Horizons Treatment Centre
130 New Credit Road
Hagersville, ON
N0A-1H0
T: 905-768-5144
Toll Free: 1-877-330-8467
F: 905-768-5564
E-mail: office@nhtc.ca

PERSONAL ITEMS CHECKLIST

FOR CLIENT INFORMATION ONLY

All community members are expected to always wear appropriate clothing. **Appropriate attire does not include**:		
☐ Short shorts	☐ Torn jeans	☐ Low-cut shirts
☐ Muscle shirts	☐ Halter tops	☐ Tube tops
☐ Clothing stamped with alcohol and/or drug symbols	☐ Clothing with violence or weapons	☐ Clothing with vulgar language
☐ Bikinis	☐ See-through clothing	
The first three (3) weeks of treatment are for the community members to focus on their healing, without distractions. Therefore, if any of the following items are brought into treatment, they will be locked-up and <u>may be</u> given back during scheduled passes, if granted. All other items not appropriate will be given back at the end of the program.		
☐ Cell phones	☐ Junk food/Pop	☐ Journal books
☐ Computers	☐ IPod/IPad/Tablet/MP3	☐ CD's
☐ DVD's	☐ Radios	☐ Clocks
☐ Colouring books	☐ Novels/Books/Magazines	☐ School work
☐ Craft material	☐ Hair dye	☐ Knives/Weapons
☐ Pornographic material		
Appropriate Clothing Items (Seasonal):		
☐ Underwear	☐ Socks	☐ Shirts
☐ Blouses	☐ Jeans	☐ Sweatpants
☐ Sweaters	☐ Running shoes	☐ Boots
☐ Bathrobe	☐ Slippers	☐ Pajamas
☐ Coat/Jacket	☐ Gloves	☐ Hats/Toques
☐ Snow pants	☐ Wind pants	☐ Sandals
Toiletries (All items must be alcohol free and non-aerosol):		
☐ Toothpaste	☐ Shampoo and Conditioner	☐ Deodorant
☐ Razors	☐ Feminine products	☐ Shaving items
☐ Brush/Comb		
Sweat Attire:		
☐ Skirt/Cotton night gown	☐ Shorts	☐ Large towel
Other Appropriate Items:		
☐ Watch	☐ Limited amount of make-up	☐ Money
☐ Bank/Credit card	☐ Cultural items	☐ Limited musical instruments

DUSI-R™ Drug use Screening Inventory-Revised® Adult Past Year Time Frame

Name:______________________________

Ordinarily, how many times each month have you used each of the following drugs in the past year?

Alcohol

Item					
1. Beer, Wine, Liquor	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
2. Non-Potable Alcohol - Hairspray, Sanitizer, Mouthwash, Aftershave	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Stimulants

Item					
3. Cocaine, Uppers, Khat	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
4. Methamphetamine - Crystal Meth	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
5. Methamphetamine - Ice/Glass	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
6. Methamphetamine - Speed	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Caffeine

Item					
7. Coffee, Tea, Soda/Pop, Energy Drinks, Chocolate	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
8. Over the counter Cold Remedies	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
9. Over the counter Weight Loss Aids	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

Opioids

Item					
10. Prescription Suboxone	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
11. Prescription Methadone	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
12. Prescription Oxycontin, Oxycodone, Codeine, Morphine	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
13. Non-Prescription Oxycontin	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
14. Non-Prescription Oxycodone	0 times	1-2 times	3-9 times	10-20 times	more than 20 times
15. Non-Prescription Codeine	0 times	1-2 times	3-9 times	10-20 times	more than 20 times

DUSI-R™
Drug use Screening Inventory-Revised®

Adult Past Year Time Frame **Name:**______________________________

16. Non-Prescription Morphine	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
17. Non-Prescription Heroin	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
18. Diverted Methadone	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
19. Diverted Suboxone	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
20. Fentanyl	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times

Sedatives, hypnotics, or anxiolytics

21. Benzodiazepines	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
22. Barbiturates	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
23. Sleeping Medications	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
24. Antianxiety Medications	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
25. Prescribed Sleeping Medications	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
26. Prescribed Antianxiety Medications	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times

Hallucinogens (phencyclidine)

27. Phencyclidine - PCP, Angel Dust, Ketamine, Cyclohexamine, Disocilpine	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
28. Other - LSD, Mescaline, MDMA/Ecstacy, DOM/STP, DMT, Magic Mushrooms, Morning Glory Seeds, Jimson Weed, Salvia Divinorum	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times

Cannabis

29. Marijuana/Pot/Weed/Hash	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times
30. Shatter	◯ 0 times	◯ 1-2 times	◯ 3-9 times	◯ 10-20 times	◯ more than 20 times

DUSI-R™ Drug use Screening Inventory-Revised®

Adult Past Year Time Frame **Name:**________________________________

Item					
31. Prescribed Cannabis	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
32. Prescribed CBD	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
33. Synthetic Cannabis - K2, Spice and others	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
Inhalants					
34. Glue	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
35. Gas/Fuels, Butane Lighters	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
36. Paint, Paint Thinner, Lacquer	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
37. Propane	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
38. Aerosols	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
39. Other Volatile Compounds	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
Tobacco					
40. Smoking	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
41. Chewing	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
42. Smokeless Tobacco	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times
Other (or unknown)					
43. Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas	○ 0 times	○ 1-2 times	○ 3-9 times	○ 10-20 times	○ more than 20 times

44. Which drug caused you the most problems? (circle one)

None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/Aftershave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxzone, Fentanyl, Benzodiazephines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstacy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer,

	Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas
45. Which drug do you prefer the most? (circle one)	None, Beer/Wine/Liquor, Non-Potable Alcohol - Hairspray/Sanitizer/Mouthwash/Aftershave, Cocaine/Uppers/Khat, Methamphetamine - Crystal Meth, Methamphetamine - Ice/Glass, Methamphetamine - Speed, Coffee/Tea/Soda/Pop/Energy Drinks/Chocolate, Over the counter Cold Remedies, Over the counter Weight Loss Aids, Prescription Suboxone, Prescription Methadone, Prescription Oxycontin/Oxycodone/Codeine/Morphine, Non-Prescription Oxycontin, Non-Prescription Oxycodone, Non-Prescription Codeine, Non-Prescription Morphine, Non-Prescription Heroin, Diverted Methadone, Diverted Suboxzone, Fentanyl, Benzodiazephines, Barbiturates, Sleeping Medications, Antianxiety Medications, Prescribed Sleeping Medications, Prescribed Antianxiety Medications, Phencyclidine - PCP/Angel Dust/Ketamine/Cyclohexamine/Disocilpine, Other - LSD/Mescaline/MDMA/Ecstacy/DOM/STP/DMT/Magic Mushrooms/Morning Glory Seeds/Jimson Weed/Salvia Divinorum, Marijuana/Pot/Weed/Hash, Shatter, Prescribed Cannabis, Prescribed CBD, Synthetic Cannabis - K2/Spice/Others, Glue, Gas/Fuels/Butane Lighters, Paint/Paint Thinner/Lacquer, Propane, Aerosols, Other Volatile Compounds, Smoking, Chewing, Smokeless Tobacco, Anabolic Steroids, Anti-Inflammatory Drugs, Antihistamines, Nitrous Oxide/Laughing Gas

Answer ALL of the following questions. Even if a question does not apply exactly, answer according to whether it is MOSTLY YES (TRUE) or MOSTLY NO (FALSE). Answer the questions as they apply to you within the past year and leading up to the present time. If a question does not apply to you, answer NO.

46. *	Have you had a craving or very strong desire for alcohol or drugs?	Yes	No
47. *	Have you had to use more and more drugs or alcohol to get the effect you want?	Yes	No
48. *	Have you felt that you could not control your alcohol or drug use?	Yes	No
49. *	Have you felt that you were "hooked" on alcohol or drugs?	Yes	No
50. *	Have you missed out on activities because you spend too much money on drugs or alcohol?	Yes	No
51. *	Did you break rules, miss curfew, or break the law because you were high on alcohol or drugs?	Yes	No
52. *	Did you change rapidly from very happy to very sad or from very sad to very happy because of drugs?	Yes	No
53. *	Did you have a car accident after using alcohol or drugs?	Yes	No
54. *	Have you accidentally hurt yourself or someone else after using alcohol or drugs?	Yes	No
55. *	Have you had a serious argument or fight with a friend or a family member because of your drinking or drug use?	Yes	No
56. *	Have you had trouble getting along with any of your friends because of alcohol or drug use?	Yes	No
57. *	Have you experienced any withdrawal symptoms following use of alcohol or drugs (e.g., headaches, nausea, vomiting, shaking)?	Yes	No
58. *	Have you had a problem remembering what you had done while you were under the effects of drugs or alcohol?	Yes	No
59. *	Did you drink large quantities of alcohol when you went to parties?	Yes	No
60. *	Did you have trouble resisting using alcohol or drugs?	Yes	No
61. *	Have you ever told a lie in your lifetime?	Yes	No
62. *	Did you argue a lot?	Yes	No
63. *	Did you brag a lot?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised® **Adult Past Year Time Frame** **Name:________________________________**

64. *	Did you tease or do harmful things to animals?	Yes	No
65. *	Did you yell a lot?	Yes	No
66. *	Have you been stubborn?	Yes	No
67. *	Were you suspicious of other people?	Yes	No
68. *	Did you swear or use dirty language a lot?	Yes	No
69. *	Did you bully, be mean to others a lot?	Yes	No
70. *	Did you have a bad temper?	Yes	No
71. *	Have you been very shy?	Yes	No
72. *	Did you threaten to hurt people?	Yes	No
73. *	Did you talk louder than most other people?	Yes	No
74. *	Were you easily upset?	Yes	No
75. *	Did you do things a lot without first thinking about the consequences?	Yes	No
76. *	Did you do risky or dangerous things a lot?	Yes	No
77. *	Did you take advantage of people?	Yes	No
78. *	Did you generally feel angry?	Yes	No
79. *	Did you spend most of your free time by yourself?	Yes	No
80. *	Were you a loner?	Yes	No
81. *	Were you very sensitive to criticism?	Yes	No
82. *	In your lifetime, do you behave better when you are around people you don’t know?	Yes	No
83. *	Have you had a physical exam or been under a doctor's care?	Yes	No
84. *	Have you had any accidents or injuries that still bother you?	Yes	No
85. *	Did you either sleep too much or too little?	Yes	No
86. *	Have you either lost or gained more than 10 pounds?	Yes	No
87. *	Did you have less energy than you think you should have?	Yes	No
88. *	Did you have trouble with your breathing or with coughing?	Yes	No
89. *	Did you have any concerns about sex or trouble with your sex organs?	Yes	No
90. *	Have you had sex with someone who shot up drugs?	Yes	No
91. *	Have you had trouble with abdominal pain or nausea?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**________________________________

92. *	Have your eye whites ever turned yellow?	Yes No
93. *	In your lifetime, did you ever feel that you wanted to swear?	Yes No
94. *	Have you intentionally damaged someone else's property?	Yes No
95. *	Have you stolen things?	Yes No
96. *	Have you gotten into physical fights?	Yes No
97. *	Have you been a fidgety person?	Yes No
98. *	Have you been restless and unable to sit still?	Yes No
99. *	Did you get frustrated easily?	Yes No
100. *	Did you have trouble concentrating?	Yes No
101. *	Did you feel sad a lot?	Yes No
102.*	Did you bite your fingernails?	Yes No
103. *	Did you have trouble sleeping?	Yes No
104. *	Have you been nervous?	Yes No
105. *	Did you get easily frightened?	Yes No
106.*	Did you worry a lot?	Yes No
107. *	Did you have trouble getting your mind off things?	Yes No
108. *	Did people stare at you?	Yes No
109. *	Did you hear things that no one else around you heard (outside of cultural or ceremonial activities)?	Yes No
110. *	Did you have special powers nobody else has (outside of dreams, cultural, or ceremonial activities)?	Yes No
111. *	Were you afraid to be around people?	Yes No
112. *	Did you often feel like you wanted to cry?	Yes No
113. *	Did you have so much energy that you did not know what to do with yourself?	Yes No
114. *	Have you ever felt tempted to steal something in your lifetime?	Yes No
115. *	Were you disliked by others?	Yes No
116. *	Were you usually unhappy with how well you did in activities with your friends?	Yes No
117. *	Was it difficult to make friends in a new group?	Yes No
118. *	Did people take advantage of you?	Yes No

DUSI-R™ Drug use Screening Inventory-Revised

Adult Past Year Time Frame **Name:**_______________________________

119. *	Were you afraid to stand up for your rights?	Yes	No
120. *	Was it hard for you to ask for help from others?	Yes	No
121. *	Were you easily influenced by other people?	Yes	No
122. *	Did you prefer doing things with people much older or younger than you?	Yes	No
123. *	Did you worry about how your actions would affect others?	Yes	No
124. *	Did you have difficulty standing up for your opinions?	Yes	No
125. *	Did you have trouble saying "no" to people?	Yes	No
126. *	Did you feel uncomfortable if someone gave you a compliment?	Yes	No
127. *	Did people see you as being unfriendly?	Yes	No
128. *	Did you avoid eye contact when talking to friends and family?	Yes	No
129. *	Has your mood ever changed in your lifetime?	Yes	No
130. *	Has a member of your family (mother, father, brother, or sister) ever used drugs to get high like marijuana, cocaine, or heroin?	Yes	No
131. *	Has a member of your family used alcohol to the point of causing problems at home, work, or with friends?	Yes	No
132. *	Has a member of your family ever been arrested?	Yes	No
133. *	Did you have frequent arguments with your children, parents or spouse which involved yelling and screaming?	Yes	No
134. *	Did your family hardly do things together?	Yes	No
135. *	Were your parents or spouse unaware of your likes and dislikes?	Yes	No
136. *	Were there no clear rules about what you can and cannot do?	Yes	No
137. *	Were your parents or spouse unaware of what you really think or feel about things that are important to you?	Yes	No
138. *	Did you argue with your parents or your spouse or other family members a lot?	Yes	No
139. *	Were your parents or your spouse often unaware of where you were and what you were doing?	Yes	No
140. *	Were your parents or your spouse away from home most of the time?	Yes	No
141. *	Did you feel that either your parents or your spouse don't care about you?	Yes	No
142. *	Were you unhappy about your living arrangements?	Yes	No
143. *	Did you feel in danger at home?	Yes	No
144. *	In your lifetime, did you ever get angry?	Yes	No
145. *	Did you dislike school?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised® **Adult Past Year Time Frame** **Name:________________________________**

146. * Did you have trouble concentrating in school or when studying? ◯ Yes ◯ No
147. * Were your grades below average? ◯ Yes ◯ No
148. * Did you cut/skip school more than two days a month? ◯ Yes ◯ No
149. * Were you absent from school a lot? ◯ Yes ◯ No
150. * Have you thought seriously about quitting school? ◯ Yes ◯ No
151. * Did you often not do your school assignments? ◯ Yes ◯ No
152. * Did you often feel sleepy in class? ◯ Yes ◯ No
153. * Were you often late for class? ◯ Yes ◯ No
154. * Did you have different friends at school this year than you did last year? ◯ Yes ◯ No
155. * Did you feel irritable and upset when in school? ◯ Yes ◯ No
156. * Were you bored in school? ◯ Yes ◯ No
157. * Were your grades in school worse than they used to be? ◯ Yes ◯ No
158. * Did you feel in danger at school? ◯ Yes ◯ No
159. * Have you failed a grade in school? ◯ Yes ◯ No
160. * Did you feel unwelcome in school clubs or extracurricular activities? ◯ Yes ◯ No
161. * Have you missed or been late to school because of alcohol or drugs? ◯ Yes ◯ No
162. * Have you been in trouble at school because of alcohol or drugs? ◯ Yes ◯ No
163. * Has your use of alcohol or drugs interfered with your homework or school assignments? ◯ Yes ◯ No
164. * Have you been suspended? ◯ Yes ◯ No
165. * In your lifetime, did you ever put things off that you needed to do? ◯ Yes ◯ No
166. * Have you had a paying job that you were fired from? ◯ Yes ◯ No
167. * Have you stopped working at a job because you just didn't care? ◯ Yes ◯ No
168. * Did you need help from others to go about finding a job? ◯ Yes ◯ No
169. * Have you been frequently absent or late for work? ◯ Yes ◯ No
170. * Did you find it difficult to complete work tasks? ◯ Yes ◯ No
171. * Have you made money doing something that was against the law? ◯ Yes ◯ No
172. * Have you used alcohol or drugs while working on a job? ◯ Yes ◯ No
173. * Have you been fired from a job because of drugs? ◯ Yes ◯ No

DUSI-R™ Drug use Screening Inventory-Revised® **Adult Past Year Time Frame** **Name:**_______________________________

#	Question	Yes	No
174. *	Did you have trouble getting along with bosses?	Yes	No
175. *	Did you mostly work so that you can get money to buy drugs?	Yes	No
176. *	In your lifetime, are you more happy if you win than lose a game?	Yes	No
177. *	Did any of your friends regularly use alcohol or drugs?	Yes	No
178. *	Did any of your friends sell or give drugs away?	Yes	No
179. *	Did any of your friends lie a lot?	Yes	No
180. *	Did your parents or spouse dislike your friends?	Yes	No
181. *	Have any of your friends been in trouble with the law?	Yes	No
182. *	Were most of your friends older than you?	Yes	No
183. *	Did your friends cut school or work a lot?	Yes	No
184. *	Did your friends get bored at parties when there was no alcohol served?	Yes	No
185. *	Have your friends brought drugs to parties?	Yes	No
186. *	Have your friends stolen anything from a store or damaged property on purpose?	Yes	No
187. *	Did you belong to a gang?	Yes	No
188. *	Were you bothered by problems you were having with a friend?	Yes	No
189. *	Was there no friend to confide in?	Yes	No
190. *	Compared to most people, did you have few friends?	Yes	No
191. *	Have you ever in your lifetime been talked into doing something you didn't want to do?	Yes	No
192. *	Compared to most people, did you do less sports?	Yes	No
193. *	Did you usually stay out late on nights when you had to go to school or work the next morning?	Yes	No
194. *	On a typical day, do you watch more than two hours of TV?	Yes	No
195. *	Did you go to bars/bootleggers, house parties, or bush parties with your friends on a regular basis at least twice a week?	Yes	No
196. *	Did you exercise less than most people you know?	Yes	No
197. *	Was your free time spent just hanging out with friends?	Yes	No
198. *	Were you bored most of the time?	Yes	No
199. *	Did you do most of your recreation or leisure activities alone?	Yes	No
200. *	Did you use alcohol or drugs for recreational reasons?	Yes	No
201. *	Compared to most people, were you less involved in hobbies or outside interests?	Yes	No

DUSI-R™ Drug use Screening Inventory-Revised®

Adult Past Year Time Frame **Name:**______________________________

	Question	Yes	No
202. *	Were you dissatisfied with how you spend your free time?	◯ Yes	◯ No
203. *	Did you get tired very quickly when you exerted yourself?	◯ Yes	◯ No
204. *	Have you ever bought anything in your lifetime that you did not need?	◯ Yes	◯ No
205. *	Have you felt your cultural identity doesn't matter?	◯ Yes	◯ No
206. *	Have you had frequent nightmares?	◯ Yes	◯ No
207. *	Have you felt helpless to change your life?	◯ Yes	◯ No
208. *	Have you experienced frequent emotions like fear, anger, guilt, or shame?	◯ Yes	◯ No
209. *	Have you frequently thought about ending your life?	◯ Yes	◯ No
210. *	Have you felt alienated from family, friends, or community?	◯ Yes	◯ No
211. *	Have you harmed yourself (cutting, scratching, etc.)?	◯ Yes	◯ No
212. *	Have you felt guilty about experiencing pleasant emotions?	◯ Yes	◯ No
213. *	Have you felt overwhelmed by upsetting memories?	◯ Yes	◯ No
214. *	Have you felt betrayed by others?	◯ Yes	◯ No
215. *	Have you lacked motivation to care for your health (diabetes, heart, diet, exercise, hygiene)?	◯ Yes	◯ No

OFFICE USE ONLY

Date of Completion ______________________

NOTES:

NATIVE WELLNESS ASSESSMENT (NWA)™

SELF-REPORT FORM

First Edition March 31, 2015

Acknowledgements:

This work was supported by the Canadian Institutes of Health Research [funding reference number AHI – 120535]. Our work was inspired by the devotion of Elder Jim Dumont and our Treatment Centre project partners to walk with First Nations' people on the path to wellness guided by cultural interventions.

Native Wellness Assessment (NWA-S)
(Self-Report Form)

Please complete this survey designed to assess your **Native wellness**. Once you have filled out the background section used for research, please complete the three sections concerning a rating of statements and cultural interventions/activities. You may provide any additional comments at the end of the survey if you like.

The survey answers must be entered on the web at the following address ***www.thunderbirdpf.org*** in order to receive the client report which provides the analysis and interpretation of results.

To be completed by Substance Use/Mental Health Service Staff prior to the client completing the survey:

Client ID: ____________________ *(number as used in Substance Use/Mental Health Service)*

Date of Assessment: ______________________________ *(dd/mm/yyyy)*

Completion: ○ 1st time completed ○ 2nd time completed ○ 3rd time completed by client

Point in time:
○ Entry to program (administered within 7 days of intake)
○ In-Progress (administered halfway through program)
○ Exit from program (administered within the last 7 days of the program)

Substance Use/Mental Health Service : ____
Length of Program: ______________________ weeks

Background:

Your responses in this section will be grouped with that of others to make sure the survey is statistically valid. The information you provide here will not be used to identify you specifically under any circumstances.

Gender: ○ Female ○ Male ○ Other(Ie: Two-Spirited/LGBTQ/Gender fluid) ____________

Age: _____________ years

Ethnicity:
○ **First Nations**
If Yes, which Nation ________________________________ **OR** ○ Don't Know

○ **Métis**
If Yes, which First Nation connection ___________________ **OR** ○ Don't Know

○ **Inuit**

○ **Other** ____

What is your FIRST Language? ______________________

If applicable, what is your SECOND Language? ______________________

If applicable, what is your THIRD Language? ______________________

How many times have you sought help for issues related to substance use/mental health prior to the service you are at now?

__________ time(s)

Please provide the name(s) of the prior Substance Use/Mental Health Service (s):

1. Program Name: ______________ Number of times: ________
2. Program Name: ______________ Number of times: ________
3. Program Name: ______________ Number of times: ________
4. Program Name: ______________ Number of times: ________
5. Program Name: ______________ Number of times: ________
6. Program Name: ______________ Number of times: ________

Instructions:

Please rate the following statements based on your own feelings and thinking. As this survey is not a test that you can pass or fail, there is no right or wrong way to answer any of the statements. Your first thought or impression is usually the best.

The following example will explain how to proceed. Please read the example statement. If you *mostly agree* with the example statement, draw a circle around the number 3 that corresponds with this.

Please use a dark black pen to complete the form. Please use the 'Don't Know' (DK) option sparingly and **ONLY** if you feel you are not able to respond to the statement within a range of 'Disagree' to 'Strongly Agree'.

	DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
The eagle is an important symbol in our culture.	DK	0	1	2	(3)	4

How to change an answer:

If you do need to change your answer, please draw an 'X' through your original circle and then draw another circle over the new number you have selected as follows:

	DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
The eagle is an important symbol in our culture.	DK	0	1	2	~~(3)~~	(4)

Statements: Section 1

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
1	I can see my loved ones who have gone on, or ancestors, in dreams or ceremony.	DK	0	1	2	3	4
2	My Native culture fuels my desire to live a good life.	DK	0	1	2	3	4
3	I believe that the Creator is the source of all life.	DK	0	1	2	3	4
4	My relationship to the land I come from is important.	DK	0	1	2	3	4
5	I feel comforted when I participate in cultural activities and ceremonies.	DK	0	1	2	3	4
6	I feel a need to connect with my spirit.	DK	0	1	2	3	4
7	My Native language is a sacred language.	DK	0	1	2	3	4
8	Knowing the names in the generations of my family is important for my identity.	DK	0	1	2	3	4
9	All living things have a spirit.	DK	0	1	2	3	4
10	Ceremonies and cultural activities open me up to share my thoughts and feelings with others.	DK	0	1	2	3	4
11	I learn about the Creator’s teaching to live a good life.	DK	0	1	2	3	4
12	I am known in Creation through my traditional name or clan family.	DK	0	1	2	3	4
13	The Creator made a way for me to live a good life.	DK	0	1	2	3	4
14	The more I learn about my culture, the more confident I feel about my life.	DK	0	1	2	3	4
15	The more I learn about the importance of my spirit the more I want a good life.	DK	0	1	2	3	4

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
16	I see my role in caring for water and fire as important for a balanced life.	DK	0	1	2	3	4
17	I believe there is a reason the Creator gave me life.	DK	0	1	2	3	4
18	The Creator gives me my Native identity.	DK	0	1	2	3	4
19	I connect to life by being on the land and learning the names and stories of plants and animals.	DK	0	1	2	3	4
20	I want to be like my ancestors who worked to have a good life.	DK	0	1	2	3	4
21	I need to pay attention to my spirit because it is important to my physical well-being.	DK	0	1	2	3	4
22	My connection to Mother Earth makes the land I come from my home.	DK	0	1	2	3	4

Interventions 1: How would you describe your connection during each of the following interventions lately?

		DP Did Not Practice	1 Weak	2 Moderate	3 Strong
1	Smudging	DP	0	1	2
2	Prayer	DP	0	1	2
3	Sweat lodge ceremony	DP	0	1	2
4	Talking / sharing circle	DP	0	1	2
5	Nature walks	DP	0	1	2
6	Meaning of prayer	DP	0	1	2
7	Use of drum / pipe / shaker	DP	0	1	2
8	Sacred medicines	DP	0	1	2
9	Use of natural foods	DP	0	1	2
10	Ceremony preparation	DP	0	1	2
11	Cultural songs	DP	0	1	2

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
23	I seek understanding of my purpose in life through cultural knowledge.	DK	0	1	2	3	4
24	I give thanks for what I receive from Creation.	DK	0	1	2	3	4
25	My language and a connection to the land help me to know who I am.	DK	0	1	2	3	4
26	The respect I feel for my relatives in Creation, makes me want to give something back.	DK	0	1	2	3	4
27	The Creation story is important to me because it helps me to feel my life is meaningful.	DK	0	1	2	3	4
28	My dreams help guide and direct me through my life.	DK	0	1	2	3	4
29	The Creation story that I believe in is Native in origin.	DK	0	1	2	3	4
30	I make offerings such as food and other gifts to my ancestors because they help me.	DK	0	1	2	3	4
31	I listen to traditional teachings to learn how my ancestors understood and lived life.	DK	0	1	2	3	4
32	Laughter heals me.	DK	0	1	2	3	4
33	I need to learn more about my Native identity.	DK	0	1	2	3	4
34	I respect sacred bundle items.	DK	0	1	2	3	4
35	I understand how the Creator helps me.	DK	0	1	2	3	4
36	I treat my body as sacred.	DK	0	1	2	3	4
37	My identity as a Native person helps me to know who I am and what to do in life.	DK	0	1	2	3	4
38	I know who my extended or adopted family is.	DK	0	1	2	3	4

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
39	It is important to me that I learn, speak and understand my Native language.	DK	0	1	2	3	4
40	The Creator gives me choices in how to live my life.	DK	0	1	2	3	4
41	My Native language comes from the Creator.	DK	0	1	2	3	4
42	I have a necessary role in my family.	DK	0	1	2	3	4
43	Understanding my spirit connection to all life helps me to be well.	DK	0	1	2	3	4
44	I gather traditional foods because they are important for my health.	DK	0	1	2	3	4

Interventions 2: How would you describe your connection during each of the following interventions lately?

		DP Did Not Practice	1 Weak	2 Moderate	3 Strong
12	Fishing / Hunting	DP	0	1	2
13	Spiritual teachings	DP	0	1	2
14	Water as healing	DP	0	1	2
15	Use of sacred medicines	DP	0	1	2
16	Community cultural activities	DP	0	1	2
17	Fire as healing	DP	0	1	2
18	Storytelling	DP	0	1	2
19	Culture-based art	DP	0	1	2
20	Pipe ceremony	DP	0	1	2
21	Sacred places	DP	0	1	2
22	Use of native language	DP	0	1	2
23	Creation story	DP	0	1	2
24	Cultural dances / pow wow	DP	0	1	2
25	Receiving help from traditional Healer / Elder	DP	0	1	2
26	Gardening, harvesting	DP	0	1	2
27	Giveaway ceremony	DP	0	1	2

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
45	I strengthen my connection by talking to the Creator.	DK	0	1	2	3	4
46	My family gives me strong identity.	DK	0	1	2	3	4
47	I know all of Creation has spirit caring for me.	DK	0	1	2	3	4
48	I take initiative to be physically active through land based activities.	DK	0	1	2	3	4
49	I need to have a connection with my ancestors.	DK	0	1	2	3	4
50	I feel all of Creation is my family.	DK	0	1	2	3	4
51	I feel the spirit is with me when I am on the land, in ceremony, or through my dreams.	DK	0	1	2	3	4
52	I use cultural ways such as ceremonies, food and medicine for cleansing and healing.	DK	0	1	2	3	4
53	How I dress shows pride in my culture.	DK	0	1	2	3	4
54	I feel a connection between my community history and my own story.	DK	0	1	2	3	4
55	I think my spirit lives forever.	DK	0	1	2	3	4
56	I show who I am as a Native person through the things I wear.	DK	0	1	2	3	4
57	The Creator gave me a good mind.	DK	0	1	2	3	4
58	I see the strengths Native people have as a community.	DK	0	1	2	3	4
59	I think about the whole of Creation - the universe, all nature, plants, animals, and all people - as my family.	DK	0	1	2	3	4
60	I go to Elders to learn about our Native ways.	DK	0	1	2	3	4

		DK Don't Know	0 Do Not Agree	1 Agree a LIttle	2 Kind of Agree	3 Mostly Agree	4 Strongly Agree
61	I recognize that I can contribute to my community.	DK	0	1	2	3	4
62	I understand my inner knowing is my spirit guiding me through life.	DK	0	1	2	3	4
63	I give back to Creation as a way of showing my thankfulness.	DK	0	1	2	3	4
64	I feel confident getting support from my community.	DK	0	1	2	3	4
65	It is up to me to ensure balance in every part of my life.	DK	0	1	2	3	4
66	I participate in traditional ways of sharing.	DK	0	1	2	3	4

Interventions 3: How would you describe your connection during each of the following interventions lately?

		DP Did Not Practice	1 Weak	2 Moderate	3 Strong
28	Shaker / hand drum making	DP	0	1	2
29	Naming ceremony	DP	0	1	2
30	Water bath	DP	0	1	2
31	Blanketing / welcoming ceremony	DP	0	1	2
32	Cultural events / marches	DP	0	1	2
33	Dream interpretation	DP	0	1	2
34	Land-based / cultural camp	DP	0	1	2
35	Ghost / memorial feast	DP	0	1	2
36	Hide making / tanning	DP	0	1	2
37	Fasting	DP	0	1	2
38	Horse program	DP	0	1	2
39	Other taught / participated in / experienced	DP	0	1	2
	Other (name):				

67	Do you have any other comments you would like to share in relation to the above?

Thank you for your participation!

About the Native Wellness Assessment™:

The Native Wellness Assessment™(NWA™) was launched on June 25, 2015 and is the first of its kind in the world. Statistically and psychometrically, the NWA™ content and structure performed well, demonstrating that culture is an effective and fair intervention for Indigenous Peoples with addictions. The NWA™ can inform Indigenous health and community-based programs and policy. The NWA™ is a product of the Honouring Our Strengths: Indigenous Culture as Intervention in Addictions Treatment (CasI) research project whose team included Indigenous and non-Indigenous researchers from across Canada, Elders, Indigenous knowledge keepers, cultural practitioners, service providers, and decision makers. To learn more about the validation of the NWA™ visit: http://nnapf.com/nnapf-document-library/

Acknowledgements:

Members of the Honouring Our Strengths: Indigenous Culture-as-Intervention Research team include:
nominated principal investigator, Colleen Dell (University of Saskatchewan); co-PI: Peter Menzies (Independent, formerly Centre for Addiction and Mental Health), Carol Hopkins (National Native Addictions Partnership Foundation), Jennifer Robinson (Assembly of First Nations; former designate, Jonathan Thompson); co-applicants: Sharon Acoose (First Nations University of Canada), Peter Butt (University of Saskatchewan), Elder Jim Dumont (Nimkee NupiGawagan Healing Centre), Marwa Farag (University of Saskatchewan), Joseph P. Gone (University of Michigan at Ann Arbor), Christopher Mushquash (Lakehead University), Rod McCormick (Thompson Rivers University, formerly University of British Columbia), David Mykota (University of Saskatchewan), Nancy Poole (BC Centre of Excellence for Women's Health), Bev Shea (University of Ottawa), Virgil Tobias (Nimkee NupiGawagan Healing Centre); knowledge users: Kasi McMicking (Health Canada), Mike Martin (National Native Addictions Partnership Foundation), Mary Deleary (Independent, formerly Nimkee NupiGawagan Healing Centre), Brian Rush (Centre for Addiction and Mental Health), Renee Linklater (Centre for Addiction and Mental Health), Sarah Steves (Health Canada; former designate, Darcy Stoneadge); collaborators (treatment centers): Willie Alphonse (Nengayni Wellness Centre), Ed Azure (Nelson House Medicine Lodge), Christina Brazzoni (Carrier Sekani Family Services), Virgil Tobias (Nimkee NupiGawagan Healing Centre; former designate, Mary Deleary), Patrick Dumont (Wanaki Centre), Cindy Ginnish (Rising Sun), Hilary Harper (Ekweskeet Healing Lodge; Acting Director, Yvonne Howse), Yvonne Rigsby-Jones (Tsow-Tun Le Lum), Ernest Sauve (White Buffalo Youth Inhalant Treatment Centre), Zelda Quewezance (Saulteaux Healing and Wellness Centre), Iris Allen (Charles J. Andrew Youth Treatment Centre), Rolanda Manitowabi (Ngwaagan Gamig Recovery Centre Inc./Rainbow Lodge); collaborators (leadership): Chief Austin Bear (National Native Addictions Partnership Foundation), Debra Dell (Youth Solvent Addiction Committee), Val Desjarlais (National Native Addictions Partnership Foundation; former designate, Janice Nicotine), Rob Eves (Canadian Centre on Substance Abuse; former designate, Rita Notarandrea), Elder Campbell Papequash (Saskatchewan Team for Research and Evaluation of Addictions Treatment and Mental Health Services Advisor); contractors (methodology): Elder Jim Dumont (Nimkee NupiGawagan Healing Centre), Randy Duncan (University of Saskatchewan), Carina Fiedeldey-Van Dijk (ePsy Consultancy), Laura Hall (University of Saskatchewan), Margo Rowan (University of Saskatchewan); management: Barbara Fornssler (University of Saskatchewan; former designate, Michelle Kushniruk); article editing: Marcia Darling (Toronto). This work was inspired by the devotion of Elder Jim Dumont and the treatment center project partners to walk with First Nations' people on the path to wellness guided by culture-as-intervention. With respect to this article, the authors most appreciatively thank Mike Martin for his assistance in facilitating the pilot testing process; Randy Duncan for his measurement expertise and work with the IKG in helping to revise early drafts of the instrument; and Roisin Unsworth (University of Saskatchewan) for her work in compiling information from the literature involving the application and validation of instruments to assess wellness.

Native Wellness Assessment™ – Copyright©2015, National Native Addictions Partnership Foundation Inc. All rights reserved.
22361 Austin Line, Bothwell, ON, N0P 1C0