

ONEN'TO:KON TREATMENT SERVICES

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Referral/Application Kit For Residential Services



REFERRAL INFORMATION

This section of the referral kit provides a brief description of our treatment program, includes an outline of our eligibility criteria, and gives detailed information to referral workers concerning our admission procedures. Referral workers are invited to keep this part of the referral kit for information.

1.0 ONEN'TO:KON TREATMENT PROGRAM

Onen'to:kon Treatment Services (OTS) is a 16-bed residential treatment program facility, located in the Mohawk community of Kanehsatake. "*Under the Pines*" is situated near Oka and Montreal, overlooking the lake of two mountains.

The program lasts six (6) weeks, follows the AA 12 steps approach, and includes traditional practices of healing. Our program rests on the belief that self-help comes from helping others. The program includes individual counselling, group therapy, lectures, and films; it also includes participation in Alcoholics/Narcotics Anonymous meetings and in cultural activities. The program also involves relaxation, occupational, social and recreational therapy.

The Cultural Component of our program is a set of traditional activities that seek to integrate traditional native practices and the twelve-step model of the AA program of recovery, which includes: Traditional ceremonies, Native languages, Bead/craft work, Traditional foods, Drumming and Traditional music.

1.1 PLEASE INFORM YOUR CLIENT, THAT WE DO RANDOM SEARCHES & DRUG TESTING.

2.0 ELIGIBILITY CRITERIA

Eligibility to our residential program extends to male or female adults (18 years of age or more), and our facility is accessible to physically disabled/ challenged persons. More specifically:

- 2.1** Applicant must be of aboriginal status, as reflected by a Band, Treaty or Benefit number, or otherwise recognized of aboriginal status by their community. Priority will be given to applicants from Kahnawake, Kanehsatake, Ahkwesasne, other Mohawk nations and the greater Montreal area.
- 2.2** Applicant must recognize that the use of alcohol and/or other drugs is a problem in his/her life.
- 2.3** Applicant must express a strong indication to change his/her current lifestyle.
- 2.4** Applicant **must be free from outside interference** for the entire duration of the residential program.
Outside interference includes court dates or Parole Board hearings; visits to or from any representative of the legal or penal systems; child care or other family obligations; financial obligations; and appointments related to physical or mental health issues. This does not include medical or social emergencies, and these are dealt with as they arise during treatment.

3.0 ADMISSION PROCEDURES

The following admission procedures are designed to help your client develop a more convincing awareness: (a) of the problems associated with his/her use of alcohol and/or other drugs, and (b) of his/her need for residential treatment.

3.1 Admission into residential treatment is based on an application, which includes the following documents:

- Application for Admission
- Medical Examination
- Informed Consent and Participation Agreement
- Pre-Treatment Check List
- Authorization for Release of Personal Information
- Transportation Information Sheet

3.2 Applications coming from the legal or penal system, require additional information, as follows:

3.2.1 Official confirmation of legal status of applicant (such as Court Orders or Parole Board Decisions or Certificates);

3.2.2 Confirmation that the applicant will be free to attend meetings held outside the Center, go on supervised outings, and benefit from unsupervised weekend passes near the end of the program; and

3.2.3 Available psycho-social information, including family and social background, past convictions, current behaviour, etc (such as in case summaries, psycho-social Assessments, etc.)

3.3 Referral Workers fill out the **Application for Admission into Residential Treatment. It is important to have the applicant fill out all of pages 13, 14, 15, 19, 20 & 21 so that we can evaluate literacy.** The Referral worker sends this completed Application for Admission, with the other admission documents to our In-take Worker.

3.4 Medical Examination

The Referral Worker sends the **completed** Medical Examination sheet with the other admission documents to our In-take Worker.

3.5 Transportation Information Sheet

This form is to be filled in by responsible parties for the purpose of medical transportation due to early termination of treatment by the individual or staff. Once completed, the Referral Worker sends this with the other admission documents, to our In-take Worker.

3.6 Applicants must read and sign the **Informed Consent and Participation Agreement**. The purpose of this form is to record, clearly, the applicant's commitment to participate in the program. (**House Requirements** are also enclosed in this kit on Page 25. The Referral Worker sends this completed Informed Consent and Participation Agreement with the other admission documents to the In-take Worker.

3.7 **In order to help their clients adapt to our Alcohol & Drug free environment, Referral Workers should hand out to applicants the "Items to bring and Not to Bring lists on Pages 23 & 24.**

- 3.8** The Referral Worker should send a completed Pre-Treatment Check List on page 20, with the other admission documents to the In-take Worker.
- 3.9** The **Deadline** for sending complete applications is two (2) weeks before the Intake Day, itself, on a Monday.

It is advisable to send completed pages 5 to 22 of this application to the In-take Worker as soon as they become ready, in order to get a file opened immediately.

PLEASE SEND ONLY THE REQUIRED PAGES REGARDING THIS APPLICATION, DO NOT SEND US BACK THE WHOLE APPLICATION.

- 3.10** **Intake Decisions** are reached on **completed files only**.
- 3.11** The In-take Worker confirms, in writing, the reception of the application as well as the acceptance or refusal of admittance into the Residential Treatment Program.
- 3.12** After confirmation of acceptance has been sent by the In-take Worker, **the Referral Worker confirms, in writing, the applicant's attendance to the program.**
- 3.13** On in-take Monday, new residents are asked to arrive by 2:00 p.m. or according to their transportation schedules.
- 3.14** On arrival, the individual will be searched and a bag check will be done.
- 3.15** An Orientation session follows on the morning after intake.
- 3.16** Outside communications: Clients are allowed phone privileges upon arrival into the program. On the third (3rd) Sunday after intake, clients may receive visitors.
- 3.17** Graduation of the program takes place on Thursday, at 11:00 a.m. of the 6th week of treatment. We encourage Referral Workers to attend graduation along with family members of their client.

Counsellors will communicate with Referral Workers for the development of After-Care plans.

We trust this Referral Information will prove useful to Referral Workers.

We welcome any comment(s) Referral Workers or others may wish to submit regarding this application kit.

Niá:wen Nakurmíik Meegkwetch Tsheneshkumeten Thank You

**APPLICATION FOR ADMISSION
INTO RESIDENTIAL TREATMENT**

PLEASE FILL OUT COMPLETELY

IDENTIFICATION OF APPLICANT:

Name: _____ Sex: Male Female
(Family/Maiden Name) (Given Name)

Home Address: _____ **Tel.:** (____) _____ - _____
_____ **Postal Code:** _____

Date of Birth: _____ **Age:** _____ **Nation:** _____
(day/month/year)

Band Name: _____ **Band Number:** _____
(or Village of Origin) (or Treaty/Beneficiary No.)

MEDICARE NUMBER: _____ **Prov:** _____ **Exp. Date:** _____
(month/year)

IDENTIFICATION OF REFERRAL WORKER:

Name: _____ **Tel.:** (____) _____ - _____

Title: _____ **Fax:** (____) _____ - _____

Mailing Address: _____
_____ **Postal Code:** _____



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TRANSPORTATION INFORMATION SHEET

REQUIRED CONTACT INFORMATION FOR THIS CLIENT

CLIENT'S NAME: _____

DATE: _____

TRANSPORTATION TO AND FROM ONEN'TÓ:KON TREATMENT CENTER

NAME: _____

PHONE NUMBER: (_____) _____ - _____

AUTHORIZED SIGNATURE: _____

MEDICAL TRANSPORTATION

NAME: _____

PHONE NUMBER: (_____) _____ - _____

AUTHORIZED SIGNATURE: _____

WHO WILL TRANSPORT THE CLIENT IF HE/SHE LEAVES PROGRAM OR IS RELEASED AFTER OFFICE HOURS OR ON WEEKENDS?

NAME: _____

PHONE NUMBER: (_____) _____ - _____

AUTHORIZED SIGNATURE: _____

I AM AWARE THAT I NEED TO HAVE \$200.00 TO BE HANDED TO STAFF ON INTAKE DAY, WHICH I WILL USE FOR TAXI FARE SHOULD I LEAVE THE PROGRAM BEFORE COMPLETION.

CLIENT SIGNATURE

Current Situation of Applicant

Languages Spoken

Languages Written

Level of Education

Can you Read and Write in the English language? Yes No

Current Employment Status:

Usual Occupation: _____

Unemployed How long? _____ Permanent

Self-employed Retired

Homemaker Student

Job Training Temporary

Seasonal Part-time

Is your attendance in treatment required by your employer or your school? Yes No

If so, please indicate name, address and telephone number of appropriate representative and ***sign an Authorization for the Release of Personal Information form:***

Source of Income: Employment U.I.C. Social Assistance

Pension Other: _____

Marital Status: Single Married Separated

Widowed Common-law Divorced

Is your attendance in residential treatment required by your spouse or partner? Yes No

Spouse's Name (if applicable): _____

Housing: With spouse & children With Friends Alone

With spouse/partner With child(ren) Other: _____

Family: Number of children: _____ Ages of Children: _____

During treatment, who will take care of your children (please give name & telephone number):

Are any of your children under Youth Protection or other childcare services? Yes No

Under Voluntary Measures: Since: _____ Until: _____

By court decision: Since: _____ Until: _____

If the above is applicable, please fill out the following:

Name of Social Worker: _____

Address: _____


Phone No.: (_____) - _____

Is there a signed Release of Authorization for Release of Personal Information form? Yes No

Is your attendance in Residential Treatment required by Youth Protection or other Childcare Services? Yes No

Describe, in client's words, what led to Youth Protection Services becoming involved:

USE OF ALCOHOL AND/OR OTHER DRUGS

Please fill in as many rows as relevant, and circle  favourite substance:

Substance Used	Used Now	Amount Taken Now	History
<u>ALCOHOL</u> (beer, hard liquor, wine) Used in combination with:	Age first used:	How much do you drink? _____ _____	Length of use: _____ (Months, Years)
	Frequency of use:		
	Date last used:		
<u>CANNABIS</u> (marijuana, hash, hash oil) Used in combination with:	Age first used:	How do you use? _____ (oral, snort, IV, smoke) How much do you use?	Length of use: _____ (Months, Years)
	Frequency of use:		
	Date last used:		
<u>COCAINE</u> (including crack) Used in combination with:	Age first used:	How do you use? _____ (oral, snort, IV, smoke) How much do you use?	Length of use: _____ (Months, Years)
	Frequency of use:		
	Date last used:		
<u>PRESCRIBED MEDICATION</u> Specify: Used in combination with:	Age first used:	How do you use? _____ (oral, snort, IV, smoke) How much do you use?	Length of use: _____ (Months, Years)
	Frequency of use:		
	Date last used:		
<u>OTHER</u> (acid, PCP, heroin, solvents, etc.) Specify: Used in combination with:	Age first used:	How do you use? _____ (oral, snort, IV, smoke) How much do you use?	Length of use: _____ (Months, Years)
	Frequency of use:		
	Date last used:		

ALCOHOL & DRUG HISTORY

Check substances that you have used:

- Alcohol
- Marijuana
- Hashish
- LSD
- Cocaine
- Crack
- Mescaline
- Peyote
- Heroin
- Hash Oil
- Methadone
- Morphine
- Sniff glue (solvents)
- Tranquillizers
- Opiates-Oxycoton
- Prescription Medication (*prescription pain killers, Ritalin, Ativan, etc.*)
- Over the counter medication (*cold medication, Tylenol*)

Have you ever experienced any of the following?

- Alcohol Seizure
- Delirium Tremors (D.T.'s)
- Visual Hallucinations
- Audio Hallucinations

Age when you accepted drugs or alcohol as a problem: _____

The **Referral Worker** may comment here on the use of substance(s) reported by the client:

TO BE COMPLETED BY THE APPLICANT

Describe in your own words, the difficulties alcohol or drug abuse has caused you in the following areas?

1. Mental Health: _____

2. Physical Health: _____

3. Spiritual Health: _____

4. Emotional Health: _____

5. Spouse Relationship: _____

6. Children Relationship: _____

7. Parents Relationship: _____

8. Extended Family Relationship: _____

9. Community Relationship: _____

10. Legal Issues: _____

11. Employment Issues: _____

12. Financial Issues: _____

13. Education Issues: _____

14. Living Arrangements: _____

Additional Comments: _____

If you continue to drink alcohol or use drugs, describe how the above problems could/will get worse:

ATTEMPTED SOLUTIONS

Have you tried to stop drinking by yourself before? Yes No

Please Specify: _____

Have you received help from others, for trying to solve your alcohol and/or drug related problems?

<u>PROGRAM TYPE</u>	<u>APPROXIMATE DATES</u>	<u>LOCATION</u>	<u>LENGTH</u>	<u>COMMENTS</u>
<u>Supervised Detoxification</u>				
<u>Self Help Groups</u>				
<u>Healing Circles</u>				
<u>Health Professionals</u>				
<u>Outpatient Treatment Services</u>				
<u>Residential Treatment Services</u>				
<u>Other</u>				

Have there been times when you were successful in staying sober? Yes No

For how long? _____

What (or who) did you find helpful? _____

What (or who) did you **not** find helpful? _____

If you have already been to a previous treatment, **please write a separate letter** stating **how** you think another residential treatment can be **more** useful to you **this time** and what has changed?

What actions have you been taking, recently, to help you stop drinking alcohol and/or using drugs:

- How many counselling session have you attended in the last three (3) months? _____
- How many AA/NA/CA meetings have you attended in the past three (3) months? _____
- Have you been using other support groups (Healing, Talking, Men's or Women's Circles, etc.)?

If a previous treatment was **not completed**, please identify and give reason:

DOCTOR or RN MEDICAL EXAMINATION

PLEASE FILL OUT COMPLETELY IN CLEAR PRINT

Full Name of Patient: _____ Date of Birth: ____/____/____
mm dd yyyy

- Onen'tó:kon Treatment Services will only allow the prescribed medication listed on this medical, to be dispensed. We need to know if the client was diagnosed with mental health issues such as Bi-polar or Depression, etc., while actively using drugs and alcohol. We recommend that clients see their physicians to get reassessed to see if they can be weaned off drugs with psycho-active effects in order to deal with their chemical addiction in our treatment program.
- **Clients must be fit to undertake treatment, and not be a risk for themselves or others.**

1. Is the patient experiencing current health problems?

2. Past and Current History:

Medical Problems: Diabetes Epilepsy Asthma Others(specify)

Surgeries: _____ Gyn-Obstetrical: _____

Traumas/Disabilities: _____ Allergies: _____

Uses an Epipen: Yes No

(NEWLY ADDED SECTION) Degree of Allergy: Severe Mild

3. **Infectious Diseases:** Please pay special attention to infectious diseases, particularly to tuberculosis, scabies and lice.

HIV AIDS Hepatitis_____ STD:_____

Scabies Lice Tuberculosis Other:_____

Please report results of PPD Test (_____ mm) AND

Date of PPD Test: _____

THE PPD TEST MUST BE A RECENT ONE, WITHIN THE YEAR. If the PPD reading is high we require a recent chest x-ray taken with results, along with any other tests you deem necessary to carry out:

4. **Psychiatric history and treatment:** In the case of past history: the year of hospitalizations, diagnoses, treatments and their results. More details will be useful for recent mental difficulties, including suicidal ideas or attempts (eg: dates & methods); please note where we can get a more detailed report.

4.a) If the person has a psychiatrist who is presently involved in working with them, we require their name and phone number.

Name () -
Phone Number

5. Is there any current medical follow up required for any of the above (1,2,3 & 4)?

6. Current Medication: Identify all medication prescribed by yourself or others. **(if not listed, will not be dispensed)**

Medication & Dosage	Corresponding Diagnosis	Prescribing Doctor	Permanent (P) or date of ending	Psycho-active effect (Yes / No)	Compliant (Yes / No)

7. Withdrawal difficulties (detoxification requiring medical supervision in a hospital or a Detox Centre prior to admission into residential treatment). Are withdrawal symptoms apparent or to be expected for this patient? Is so, please specify:

9. Please note anything special that should be taken into account in the treatment of this patient:

Name: _____ Signature: _____

TITLE/FUNCTION: _____ Date: _____

I, the undersigned, authorize the health professional identified above to submit the results of this medical examination to Onen'tó:kon Treatment Services, for the purposes of my application for residential treatment.

Signature of Client

Date

CONSENT FOR RELEASE OF INFORMATION
(PLEASE PRINT CLEARLY)

Referral to Release to Onen'tó:kon Treatment Services

I, _____ hereby consent voluntarily for the following:
(Client's Name)
_____ to release information regarding all aspects of my
(Referring agency(ies) and/or person)
clinical record regarding addictions, legal matters, medical _____
(Other information)
to Onen'tó:kon Treatment Services.

Onen'tó:kon Treatment Services to Release

Furthermore, I _____ hereby consent to Onen'tó:kon
(Client's Name)
Treatment Services to release information to: _____
(Agency/Persons)

Regarding:

- | | | |
|---|---|--|
| <input type="checkbox"/> Progress Report ** | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Notification of early departure |
| <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Treatment Issues | <input type="checkbox"/> Reason for departure |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Completion Statement | <input type="checkbox"/> Other (specify) |
- _____

Name of Client: _____

Date of Birth: _____

	Signature	Print
Client:	_____	_____
Witness :	_____	_____
Date :	_____	

*I understand that:

- The information being released between the referring agency(ies) and/or person(s) is to assist me in my treatment.
- Any other information will not be released to any other persons without my consent unless it is information that the Onen'tó:kon Treatment team is obligated by law to release.
- This consent lasts for a period of **60 days**.

**** Progress Report is an overall report of how the person is doing in treatment.**

INFORMED CONSENT
AND PARTICIPATION AGREEMENT

I, the undersigned, know that the residential program involves:

- learning the 12 Step AA model and traditional Native practices of healing;
- sharing personal matters in individual counselling and in Talking and Healing Circles;
- reading and written assignments; attend meetings, lectures and films;
- active involvement in household and maintenance chores;
- participating in social and recreational activities;
- participating in the Cultural Component of our program, which is a set of traditional activities that seek to integrate traditional native practices and the twelve step model of the AA program of recovery. The Cultural program includes: Traditional Ceremonies, which follows the cycle of ceremonies of the Haudenosaunee, Native Languages, Bead/Craft work, Traditional Foods, Drumming and Traditional Music;
- participating in spiritual activities in accordance with my spiritual beliefs;
- developing an Aftercare Plan;
- therefore, I shall at all times indemnify and hold harmless Onen'tó:kon Treatment Services, its Board of Directors, Executive Director, Clinical Staff, Support Staff and Administration from and against all claims, actions, suits, losses, costs, or damages that could be made or brought by myself or a third party, as a result of an act or omission on my part or others, during my stay at Onen'tó:kon Treatment Center and thereafter all in accordance with Article 5.15 of the Onen'tó:kon Treatment Services Guidelines.

House Requirements are set up to promote safe and harmonious relationships, and to help me develop self-discipline, respect, and my sense of responsibility. I commit myself to follow this participation agreement. ***I am aware that failure to adhere to this agreement will result in consequences or dismissal from the program.***

I am coming to treatment of my own free will, and my consent is voluntary.

Applicant's Signature

Date

Referral Worker's Signature

PRE-TREATMENT CHECKLIST FOR APPLICANT

(PLEASE PLACE A CHECK MARK ON ALL COMPLETED ITEMS ON THIS PAGE.)

- 1. I have a status Card, Benefit Card that certifies my nationality. **A photocopy of the card is enclosed.**
- 2. I have a valid Medicare Card (or official confirmation of my number). **A photocopy of the card is enclosed.**
- 3. **I have at least three days (72 hours) of sobriety from alcohol and/or one week (7 days) of sobriety from other drugs, including psycho tropic prescription drugs.**
- 4. I have taken care of general health concerns, including medical appointments and prescription refills. **If it is necessary to seek medical help while I am in treatment, I will make the appointment and arrange my own transportation, except when I need an ambulance.**
- 5. I have informed my Referral Worker and the doctor or nurse filling out the Medical Examination of all prescribed and over-the-counter medication I am taking.
- 6. I have taken care of eye doctor appointments, prescription glasses and broken glasses. **If it is necessary to see an eye doctor while in treatment, I am responsible for making an appointment, arranging necessary funding and my own transportation.**
- 7. I have taken care of dental problems (fillings, toothaches, infections, dentures, etc.) **If I have dental needs while in treatment, I am responsible for making an appointment, arranging necessary funding and my own transportation.**
- 8. I am free of legal commitments, including Court dates, Parole Board Hearings and other appointments (such as with lawyers, probations or parole officers, Youth Protection representatives, etc.)
- 9. I have made arrangements for my financial affairs to be taken care of at home while I am away in treatment, and **for personal expenses (concerning personal hygiene, cigarettes, weekend passes, etc.)**
- 10. I understand and agree that I am responsible for transportation to get myself to the Treatment Center by 2:00 p.m. or according to transportation schedules on Intake day (Mondays).
- 11. I understand and agree that I am responsible for transportation to leave the premises and territory immediately if I do not complete the program.
- 12. I understand and agree that I am responsible for transportation to leave the premises at 1:00 p.m. on Graduation Day.
- 13. I have read and signed the Informed Consent and Participation Agreement.
- 14. I have read the House Requirements and I commit myself to follow these rules.
- 15. I understand the list of Items to Bring and Items **NOT** to bring and I will adhere to it.
- 16. **I have been informed that during my time in the residential treatment program, there could be random drug testing as well as random searches (building, room, personal belongings, etc.) carried out during my stay.**
- 17. I have made an appointment with my Referral Worker, so that I may meet with him/her after I leave treatment.

This appointment is scheduled for: _____

Applicant's Signature

Date

Referral Worker's Signature

CLIENT FILLS OUT THIS SECTION

PLEASE ENSURE THAT THE APPLICANT FILLS OUT THE FOLLOWING SECTION BY HIM/HERSELF.

YOUR EXPECTATIONS

What is your reason for wanting residential treatment now? _____

From what you know about our treatment program, what do you think will be difficult?

What do you hope to gain from our treatment program?

When you leave treatment, who will be available (family, friends) to help you stay clean and sober?

When you leave treatment, who will be your After Care Worker?

Name: _____ Tel.: (_____) _____ - _____

Mailing address: _____ Fax: (_____) _____ - _____

_____ Postal Code: _____

Applicant's Signature: _____ **Date:** _____

≈ Please Give to Client ≈

PERSONAL ITEMS TO BRING

- ❑ **Personal Identification**
- ❑ **Medicare Card**
- ❑ **Status Card**
- ❑ Bank/ATM/Credit Cards
- ❑ Return Travel Tickets
- ❑ Parole/Probation Papers
- ❑ Calling Cards (for the pay phones)
- ❑ **Money for personal use:** Plan enough money for personal expenses, including day and weekend passes.
- ❑ **Smokers should bring enough cigarettes to last them until their first day pass.**
- ❑ A Canteen is available on Thursdays for the purchase of chips, chocolates, toiletries, gum, etc.

CLOTHING

- ❑ Please bring clothes appropriate to the season (such as snow boots, jackets, hats and gloves for winter, lighter clothing for summer, including planning for rain)
- ❑ At least four (4) separate changes of clothing (pants, shirts, sweaters, dresses, etc.)
- ❑ Gym clothes, including sweat suits and white soled or non-scuff running shoes.
- ❑ Underwear, pyjamas, nightgowns, socks, stockings, slippers and/or moccasins.
- ❑ Graduation Clothing

TOILETRIES (Personal Hygiene)

- ❑ Face soap and soap dish
- ❑ Toothbrush and Toothpaste
- ❑ Deodorant
- ❑ Shaving Supplies
- ❑ Shampoo and Conditioner
- ❑ Hairdryer
- ❑ Hairspray/Mousse/Gel
- ❑ Curling and/or Straightening Iron
- ❑ Hairbrush/Comb
- ❑ Sanitary Napkins/Tampons

THE FOLLOWING ARE NOT ALLOWED

1. Mouthwash (with alcohol)
2. Very short cut shorts, skirts, low rise jeans, low cut shirts/blouses/t-shirts.
3. Personal garments that are sexually explicit and/or promote the use of alcohol and/or drugs. For example: T-shirts, jackets, caps, posters, cards, etc.
4. Portable televisions, clock radios, and videotapes and/or DVD's.
5. Tylenol, Aspirin, or medicated nasal sprays (unless prescribed).
6. Glue, nail polish and remover, etc.
7. Clients are not permitted to leave their vehicle at the Treatment Center during treatment.
8. Chewing tobacco, cigars or snuff.
9. Do not bring linens. (Blankets, bed sheets, pillows or pillow cases, towels and face cloths; as these are already provided for).
10. **Should you bring the items listed below, you will only be allowed to use them when you go on pass(es). These items will be kept in safekeeping.**

Cell phone, laptop computer, I-Pod, I-Phone, MP3 players and any other audio/visual/electronic devices.

On In-take and when returning from weekend pass, residents undergo mandatory personal, room and baggage checks. Random checks can also be done when returning from a supervised outing and departure from the Center. Staff wear latex gloves when carrying out these duties.

MEDICATION:

1. Only prescribed medication listed on your medical report will be dispensed.
2. All medication brought to the Center is to be handed in and will be monitored by staff.
3. Some medication, such as ointments, asthma medication, etc., will be handed back to the resident.

It is the responsibility of the resident to: (a) take his/her medication only as prescribed, and (b) ask a staff member for his/her medication.

HOUSE REQUIREMENTS

House requirements seek two (2) purposes: (a) set boundaries that will promote safe and harmonious group life for everyone, and (b) encourage residents to develop self-discipline, a sense of responsibility and respect of oneself and of others. Respect of and meeting House Requirements also reflects resident's motivation and willingness to "**work the program.**"

A. BEHAVIOURS THAT RESULT IN INSTANT DISMISSAL

Behaviours that result in **instant dismissal** are as follows:

1. using alcohol and/or other drugs (including having some in one's possession), offering or soliciting drugs to anyone ***and any paraphernalia such as pipes or empty baggies, etc.***
2. withdrawing oneself from the program in a major and significant way (such as leaving the premises, missing any scheduled AA, NA, or CA meeting, etc.); or
3. if a client returns from a Pass without a signed Attendance Slip from the AA, NA or CA meeting. If the client returns from his/her medical appointment without a signed doctor's medical note. (The note must include the client's time of arrival and departure and have the doctor or clinic's name clearly printed on it); or
4. criminal offences (such as theft, threats or physical violence); or
5. any sexually explicit activity or sexual harassment; between residents, between residents and staff or with visitors.

The dismissal that results from the above-mentioned behaviour is "instant." Neither prior "warnings", nor resident's progress in the program have any influence on the decision of instant dismissal.

ALL STAFF MEMBERS HAVE THE AUTHORITY TO REACH A DECISION ON INSTANT DISMISSAL AND SUCH A DECISION CAN BE TAKEN ANY TIME DURING THE PROGRAM.

B. OTHER HOUSE REQUIREMENTS

Concerning Program or Scheduled Activities

1. **PUNCTUALITY:** Residents attend program or scheduled activities, on time.
2. **ASSIGNMENTS & JOURNAL:** Each client is personally responsible to complete and hand in their assignments to their counsellors, when due. It is also the responsibility of the client to write in their Journal.
3. Twenty (20) minutes of **Chores** is carried out three (3) times a day, according to the schedule. **Residents are to keep themselves busy and useful for the full twenty (20) minutes**, including helping someone else if they complete their chores early.

Concerning Responsibility and Respectful Manners

1. At all times, residents who use dishes (such as cups, glasses, etc.) must rinse & brush their dishes in the sink and put them in the tray on the counter before bedtime.
2. Residents need to show respect to other residents and staff. Disrespectful behaviour, (such as name calling, put downs, swearing, roughhousing, etc.) is **NOT** accepted.
3. Laying on the floor or on the grass is not accepted. Nor is laying or putting feet up on the furniture (indoors or outdoors.)
4. Defacing, graffiti or vandalizing any of Onen'tó:kon's property (furniture, books, etc.) is not acceptable behaviour.
5. Residents are not allowed in each other's bedrooms.
6. Bedroom doors remain open, unless a situation calls for privacy, such as when sleeping, changing or showering.

Concerning Health and Safety

1. Smoking is authorized on personal time only and restricted to the AA Entrance or on the back porch. **No cigars or chewing tobacco are permitted.**
2. Residents do not answer the doors except if it is a co-resident or a recognized staff personnel.

Several other House Requirements are outlined in documents already handed out or to be handed out to you or posted in various locations or as directed by Staff.

C. CONSEQUENCES OF NOT RESPECTING HOUSE REQUIREMENTS

Meeting House Requirements is an important part of the treatment program and residents face consequences for actions that go against House Requirements. Counsellors meet with residents and address the issues involved.

Consequences for repeated or serious breaking of House Requirements include:

- Carrying out special assignments
- Losing telephone or other privileges
- Warnings

“Warnings” are more important ways of advising a resident that the behaviour must change. A first warning asks the resident to revise their behaviour. The second warning reminds them that disrespect of House Requirements must stop immediately; otherwise, dismissal from the program may be the next step. The resident will meet the Clinical Staff on the second warning. There is also a Contingency Contract, which can come into place with or without warnings having been previously given. This is letting the resident know that they need to change several things. The resident and Counsellor sign it. Should it be broken, then the resident would be asked to leave.

PEOPLE DO NOT GET “KICKED OUT”, THEIR BEHAVIOUR SHOWS US THAT THEY ARE NOT READY & DO NOT WISH TO BE HERE.

OUTSIDE COMMUNICATIONS

1. **Telephones and Mail**

Outgoing calls are made with the public telephone in the hall near the elevator and main entrance, during “Break time”, unless a scheduled activity is going on.

Residents who wish to make telephone calls, must sign up near the public telephones. Consideration for other persons who wish to use the phone is expected.

Residents are not allowed to receive incoming calls. Staff takes incoming calls: urgent messages are passed on immediately to residents.

Resident’s incoming personal mail is to be opened in the presence of a Staff member.

Cell/Speaker/Pager Phones:

- These phones need to be off in the building & must be handed in to Staff members for safekeeping for the duration of their stay.

2. **Visitors**

Visiting is allowed as of the 3rd Sunday after intake, from 1:00 p.m. to 3:45 p.m.

ONEN'TO:KON TREATMENT SERVICES

2012 IN-TAKE SCHEDULE

1	2	3	4
<u>RECEIPT OF APPLICATIONS</u>	<u>IN-TAKE DECISIONS</u>	<u>IN-TAKE DAY</u>	<u>GRADUATION</u>
December 12, 2011	December 14, 2011	January 9, 2012	February 16, 2012
February 6, 2012	February 8, 2012	February 20, 2012	March 29, 2012
<i>April 2-6, 2012</i>	<i>ADMINISTRATION & PROGRAM REVIEW</i>		
March 26, 2012	March 28, 2012	April 9, 2012	May 17, 2012
May 7, 2012	May 9, 2012	May 21, 2012	June 28, 2012
<i>July 2-13, 2012</i>	<i>ADMINISTRATION & STAFF TRAINING</i>		
July 2, 2012	July 4, 2012	July 16, 2012	August 23, 2012
August 13, 2012	August 15, 2012	August 27, 2012	October 4, 2012
<i>October 8-12, 2012</i>	<i>ADMINISTRATION & PROGRAM REVIEW</i>		
October 1, 2012	October 3, 2012	October 15, 2012	November 22, 2012
October 22, 2012	October 24, 2012	November 5, 2012	December 13 2012

(Schedule subject to change)

- 1. Complete application forms must be received by the Monday two weeks before a new intake. See column 1.**
- 2. Intake decisions are taken on the Wednesday two weeks before a new intake. See column 2.**
- 3. New residents are expected to arrive at 2:00 pm or earlier on intake day. See column 3.**

The duration of the treatment program is six weeks. Referral workers who wish to participate in the development of the aftercare plan are invited to communicate with residential counsellors. They may also attend graduation.

This schedule has been up-dated on January 18, 2012