

KTUNAXA/KINBASKET HEALTH & WELLNESS SOCIETY



3246 Riverview Rd • Creston, BC V0B 1G2



Telephone: 250.428.5516 Facsimile: 250.428.5235
Electronic mail: kkwc@shawcable.com
Web Site: www.healingisajourney.com

GENERAL INFORMATION

The primary "Mission" of the KTUNAXA/KINBASKET WELLNESS CENTRE Treatment Program is *to promote and strengthen First Nations people and other Aboriginals to live Holistic lives.*

The KTUNAXA/KINBASKET WELLNESS CENTRE Philosophy and Treatment approach is based on Personal Development programs dealing with the Disease Concept of Alcoholism and Drug addiction, and the Personal History that contributes to the Abuse of Alcohol and other Drugs. This Philosophy is maintained through Holistic and Cultural concepts.

The KTUNAXA/KINBASKET WELLNESS CENTRE is a 14-bed Non-Medical Residential Treatment facility for both Male and Female clientele ranging from the ages of 19 years and over who are currently experiencing Substance Abuse Problems. The program is designed to assist these individuals in freeing themselves from their Chemical dependency and discover/re-discover healthy, responsible living.

The KTUNAXA/KINBASKET WELLNESS CENTRE offers Six-Week In-Patient Treatment Programs which are followed by an Individualized Aftercare Program appropriate to the individual, to provide further assistance in re-establishing stability in their own Community.

THE PROGRAM OFFERS:

- *1x1 Counselling*
- *Group Counselling*
- *Men/Women Groups*
- *Alcohol/Drug Education*
- *Recreational Activities*
- *Physical Fitness*
- *Traditional/Cultural Activities*
- *Personal Development*
- *Psychological Services*

QUALIFICATIONS:

- *Ages 19 and over*
- *Committed to the full length of Program*
- *Have a need or desire to improve life style*
- *Participate in all aspects of the Program*
- *"Focus" on Self (Self-Awareness)*
- *Complete Referral Application*
- *Complete Medical Examination*
- *Complete T.B. Test (negative results)*

The KTUNAXA/KINBASKET WELLNESS CENTRE is located in the beautiful Creston Valley, three (3) miles south of the town of Creston and three (3) miles north of the Idaho Border on Highway 21. The location has easy accessibility to Hospitals, Churches, Shopping facilities, Restaurants, and various Recreational facilities.

For your information, we have enclosed an "Admission Criteria", "Referral Assessment", and "Referral Application Package" for your department and prospective Clients. Please make copies of this Package for your Clients as needed. If you require further information, please feel free to give us a call or write the KTUNAXA/KINBASKET WELLNESS CENTRE at the above address. Or E-mail us at: kkwc@shawbiz.ca or visit our website at: www.healingisajourney.com.

Thanking you in advance for your interest in our Program. We look forward to working with you in our combined efforts to promote a Healing Journey within our Aboriginal Communities.

IMPORTANT

To: ALL REFERRAL WORKERS & APPLICANTS
From: KKWC Director
RE: Mandatory T.B. Testing

The Ktunaxa/Kinbasket Wellness Centre would like to take this opportunity to inform all possible applicants that **Tuberculosis Tests are now required by Law in British Columbia** with your application to any B.C. Treatment Centre.

Please send your T.B. Test Results with your Application for Treatment or you **will not** be considered for admission to our facility.

Please note that if you have received a negative T.B. Test **within the past 12 months**, we will accept a copy of those results with your Application.

Thanking you in advance for your attention to this matter. If you have any further questions, please feel free to contact us at:

Ktunaxa/Kinbasket Wellness Centre Society
3246 Riverview Rd - Creston, BC V0B 1G2
PH: (250) 428-5516 or FAX: (250) 428-5235

or you may choose to E-mail us at: **kkwc@shawbiz.ca**

or visit our Website at: **www.healingisajourney.com**

KKWC ADMISSION CRITERIA - Please read carefully!

1. Client recognizes that Alcohol/Drug abuse is a problem in his/her life.
2. Client recognizes that life conflicts (e.g. impaired driving, child apprehension, etc.) are caused as a result of alcohol/drug abuse.
3. Client expresses a need and desire to change his/her present life-style.
4. It is determined that Client has not been abusing residential services such as ours.
5. Client must have a **minimum of two-weeks detoxification from Alcohol/drugs** prior to admission.
6. Client has **no outside interference during the six week treatment program** (e.g. court appearances, child care, doctor, physiotherapist, dentist, etc.).
7. **Per-diem payment is arranged prior to client entry to treatment.**
8. **ALL travel arrangements, comfort allowance and any additional expenses are pre-arranged with the Referral Worker and/or Social Worker prior to the client's entry to treatment.** (Note: Clients who will receive a comfort allowance while attending KKWC should have the cheque **made payable to the Client**, not the KKWC, as we will not to process cheques for clients.

NOTE: We require proof that social assistance, comfort allowance, and travel arrangements have been arranged prior to acceptance to the Program. We also require proof from the Referral Worker/Social Worker that the Clients rent, utilities, or other necessary payments are looked after prior to attending treatment.

- Clients are here to focus on themselves and will not be allowed to deal with this while attending Treatment.
9. Client is able to pay for their return travel if they leave or are discharged early.
 10. The application for treatment is complete. (We may transfer over any incomplete applications received for a program to the Waitlist for the next available Intake date available to allow for a complete package. After one transfer to another Waitlist, all incomplete packages will be filed away and your Client will not be placed on the next Waitlist.
 11. Client is physically able to participate in an *intense* counseling experience.
 12. Client is over 19 years of age.
 13. If client does have a history as a Sex offender (known or charged as such), he/she will let it be known to the Ktunaxa/Kinbasket Wellness Centre.
 14. Client does not have any legal issues and/or court cases during treatment.
 15. Client may only be allowed maximum two-days grace for arrival, **in emergency situations ONLY.**

ADDITIONAL MEDICAL CRITERIA

1. Client does not require hospital acute care or detox facilities.
2. If the client has a dual diagnosis, the referral worker is required to obtain and submit all documentation including those from a doctor, that the client is stable and capable to enter our treatment. The Referral Worker shall provide the Doctor(s) with Ktunaxa/Kinbasket Wellness Centre information to ensure they are knowledgeable about our program *prior* to presenting their recommendation. **NOTE: THIS INFORMATION IS MANDATORY BY THE PROVINCIAL A&D SERVICES.**
3. Client not on any psycho-active drugs or mood altering medications (e.g. anti-depressants, tranquilizers, Tylenol 3, morphine, codeine, Methadone, etc.)

RECOMMENDATIONS: IF CLIENT DOES NOT MEET THE ADMISSION CRITERIA

1. Encourage client to become involved in sober social and recreational activities.
2. Link client with a sober social network in the community.
3. Refer client to A.A., N.A., or other Support Group.
4. Engage client in regular individual and/or family counseling sessions.
5. Monitor and keep track of client, so when the opportunity presents itself, you will be available to begin preparation for Treatment.
6. Conduct a re-assessment of client's readiness for treatment again in three to six months.
7. Refer Client to Detoxification Unit within a Medical facility.

KTUNAXA/KINBASKET WELLNESS CENTRE

*3246 Riverview Rd
CRESTON, BC CANADA V0B 1G2
PH#: (250) 428-5516 FAX: (250) 428-5235
E-mail: kkwc@shawbiz.ca
Website: www.healingisajourney.com*

REFERRAL SOURCE:

(Name of Organization Referral)

ADDRESS:

PHONE: _____ FAX: _____

ORGANIZATION E-MAIL:

REFERRAL WORKER: _____ TITLE: _____

(Name of Counselor Filling-out this Form for Client)

- *We need a 24 hour contact number in case of emergency for arranging transportation as well as informing of evacuation or other crisis.*

NAME _____ PHONE: _____

Please ensure **ALL** Legal, Financial, Travel, and Family matters are in order **prior** to attending Treatment. **While the client is in treatment, there is NO Contact with anyone other than the Referral Worker for the purpose of focusing on the Self & Program.**

PACKAGE CHECKLIST

REFERRAL PACKAGE T.B. TEST MEDICAL EXAM CONSENT SIGNED
TRAVEL ARRANGEMENTS
(DATE/TIME/MEANS): _____

A/D Referral Package

KTUNAXA/KINBASKET WELLNESS CENTRE
REFERRAL ASSESSMENT

**** Please circle Yes/No Answers ****

STRENGTHS:

1. Does the client express a desire or willingness for change? **YES NO**

2. Describe what action the client has taken in preparation for the Ktunaxa/Kinbasket Wellness Centre treatment program:
 - a) Attended AA, NA, or other Support Groups *at least six times within the last six months*? **YES NO**
 - b) If the client has not attended AA, NA, other Support Groups, or six Counseling sessions what type of additional Support is client seeking?

3. Has the client attended *at least six* Counseling sessions with the Referral Worker prior to Treatment? **YES NO**

4. Has the client recently attended a Detoxification Unit? **YES NO**
 - a) If yes, When? _____
 - b) How long in Detox? _____
 - c) Has client maintained Sobriety since Completion of Detox? **YES NO**

5. Has your client been clean and sober from Alcohol & Drugs for a minimum of 14 days? **YES NO**
Date of last use of Alcohol and/or Drugs: _____

6. Is the client willing to participate in *intensive* counseling activities? **YES NO**

7. Is the client willing to participate in daily Smudge & Cultural activities? **YES NO**

NEEDS:

8. a) Does the client express a need to change his/her life situation? **YES NO**
b) Does the client have specific needs to be addressed in treatment? **YES NO**
(Physical, Mental, Emotional, Spiritual)

ABILITIES:

9. Is the client Physically and Mentally able to do daily living chores, treatment, and recreational activities? **YES NO**

10. Is the client **free of all personal factors** (family situations, job/school responsibilities, medical and legal problems, etc.) that would interfere with the Ktunaxa/Kinbasket Wellness Centre Treatment Program? **YES NO**

11. Is the client able to pay the return travel costs if their treatment is incomplete? **YES NO**

NOTE: *If the client has answered NO to any of the questions one (1) through ten (10) – with the exception of Question four (4), the client may NOT be ready for intense treatment. Please DO NOT proceed with the Ktunaxa/Kinbasket Wellness Centre Treatment Application. (Please refer to “Recommendations: If Client Does Not Meet Admission Criteria” (Pg. 3)*

<i>Please check off all applicable:</i>	Problem Area:	Details/Brief Explanation:
	Adult Trauma	
	Anger Management Issues	
	Anxiety/Panic	
	Attention-Deficit/ Inattentive Disorder	
	Borderline Personality Traits	
	Childhood Trauma	
	Chronic Physical Pain	
	Cognitive Deficits	
	Dependency	
	Depression	
	Dissociation	
	Eating Disorder	
	FAS/FASD	
	Financial Stress	
	Grief/Loss – Unresolved	
	Impulse Control Disorder/Impulsivity	
	Intimate Relationship/ Family Conflict	
	Living Environment Deficiency	
	Low Self Esteem	
	Mania or Hypomania	
	Medical Issues	
	Narcissism	
	Obsessive-compulsive issues	
	Paranoid Ideation	
	Parenting	
	Peer Group Negativity	
	Phase of Life Problems	
	Phobias	
	Post Traumatic Stress Disorder	
	Psychosis	
	Residential School Issues	
	Sexual Dysfunction	
	Sexual Identity Confusion	
	Sleep Disturbance	
	Sociopathy	
	Social Discomfort	
	Somatization	
	Spiritual Confusion	
	Suicidal Ideation	
	Vocational Stress	
	Other	
	Other	
	Other	

Note: Please attach another sheet if you need to provide more detail to us.

KKWC REFERRAL PACKAGE

APPLICATION FOR TREATMENT

SURNAME (legal): _____ GIVEN NAME(s): _____

Known as (if different from above): _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

PHONE: _____ E-MAIL: _____

BIRTH DATE: YR: ____ MO: ____ DY: ____ GENDER: Male Female

MARITAL STATUS:

Married Divorced Separated Single Widowed Common Law

ANCESTRY/NATION: _____

BAND NAME: _____ STATUS #: _____
(All ten digits)

SIN: _____ MEDICAL NUMBER: _____

HOW ARE MEDICAL INSURANCE PREMIUMS PAID? DIA Social Services Self

FAMILY PHYSICIAN: _____ PHONE: _____

PHYSICIAN ADDRESS:

SOCIAL WORKER AND/OR SOCIAL DEVELOPMENT WORKER:

ADDRESS: _____ PHONE: _____

NEXT OF KIN: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

KKWC REFERRAL PACKAGE

I. PERSONAL IDENTIFICATION INFORMATION

FAMILY TYPE: Couple Spouse & Children Single Parent Living Alone Living w/Parents
Living w/Extended Family Living w/Friends

OF CHILDREN: _____ At home In-care Apprehended: _____

Do you have secure child care for the six-week treatment program? YES NO

Have you been raised by your natural parents? YES NO

Have you been in foster care? YES NO
When? _____ How long? _____

Do you speak your traditional language in your home? YES NO

Primary Language spoken: _____

Native culture and spirituality practiced? YES NO

Are you Allergic to any Medication? YES NO
If so, What? _____

Are You Allergic to any Foods? YES NO
If so, What? _____

Are you a diabetic? YES NO
If so, explain your special diet: _____

Any eating disorders (e.g. anorexia, bulimia, overeating, etc.)? YES NO
If yes, please identify: _____

Has your Alcohol and/or Drug Abuse affected your sleeping habits? YES NO
If yes, what are your sleeping habits? _____

Have you Attempted, Thought About, or had feelings about suicide? YES NO

Recent suicide attempts? YES NO
If yes, when? _____

Is your medical doctor fully aware of your medical problems? YES NO
If yes, is this included in the pre-admission medical report? YES NO

EDUCATION: Public school Residential School: How long? _____

Last Grade Completed: _____ A.B.E. Trade School College University

What is your comprehension of: (e.g. Poor, Fair, Good, and Excellent?)
Reading: _____ Writing: _____

Special Training Certificates/Diplomas/Degrees: _____

KKWC REFERRAL PACKAGE

II. CLIENT ADDICTION HISTORY

What is your Motivation for coming into Treatment? _____

Date of last Alcohol and/or Drug use: _____
 (Minimum of 2 weeks prior to Treatment)

CHEMICAL USE HISTORY:

1. History of Substance Use (including current use):

SUBSTANCE	TYPE	TIMES PER DAY/WK	AMOUNT	AGE STARTED USE	DATE OF LAST USE
ALCOHOL: (Beer, Wine, Whiskey, Vodka, Coolers, Lysol, etc.)					
HALLUCINOGENS: (Marijuana, Mushrooms, Hash, etc.)					
NARCOTICS: (Cocaine, Codeine, Opium, Meth., Heroine, Crack, Speed, etc.)					
PRESCRIBED: (Tylenol-3, Anti-Depressants, Valium, Morphine, Seconal, etc.)					
INHALANTS: (Gas, Glue, Aerosols, Spray Paint, White-out, etc.)					
TOBACCO: (Cigarettes, Cigars, Pipe, Chewing Tobacco, etc.)					
OTHER: (Coffee, Pop, Gambling, Shopping, Sex, etc.)					

KKWC REFERRAL PACKAGE

II. CLIENT ADDICTION HISTORY

(Continued)

- | | | |
|--|-----|-------|
| 3. Have you ever Injected Drugs? | YES | NO |
| 1) If so, Date of First Injection use: _____ | | |
| 2) If so, Date of Last Injection use: _____ | | |
| 4. Have you shared needles from other Intro-venous Drug users? | YES | NO |
| 5. Do you have Process Addictions (e.g. Gambling, Shopping, etc.)?
If yes, please identify: _____ | YES | NO |
| 6. Are you currently on any Medications? | YES | NO |
| 1) For what Purpose: _____ | | |
| 2) Name of Medication: _____ | | |
| 3) Amount Prescribed: _____ | | |
| 7. Any Alcohol and/or Drug problems in your Family of Origin? | YES | NO |
| 8. Has there been a Death in the Family due to Alcohol and/or Drugs? | YES | NO |
| 9. Have you suffered any of the following Abuses? | | |
| 1) Physical Abuse | YES | or NO |
| 2) Emotional Abuse | YES | or NO |
| 3) Sexual Abuse | YES | or NO |
| 4) Mental Abuse | YES | or NO |

What was your Reaction to the Abuse? _____

TREATMENT HISTORY:

1. Prior Treatment:

PRESENTING PROBLEM	NAME & ADDRESS OF TREATMENT FACILITY	DATES OF ATTENDANCE	COMPLETED?
ALCOHOL/DRUG: (Treatment, Detox, etc.)			YES NO
EMOTIONAL PROBLEMS: (Anger, Depression, etc.)			YES NO
FAMILY PROBLEMS: (Family Counseling, etc.)			YES NO
PROCESS ADDICTIONS: (Gambling, Shopping, etc.)			YES NO
SUICIDE: Please submit relevant Reports			YES NO

KKWC REFERRAL PACKAGE

II. CLIENT ADDICTION HISTORY

(Continued)

2. Have you had previous contact with this Referring Agency? YES NO
 If yes, how often? YES NO
 Just once weekly bi-weekly monthly Total Times Visited: _____
3. Have you had previous Psychiatric Care? YES NO
 If yes:
 1) Purpose: _____
 2) When: _____
 3) Where: _____
 4) Results: _____
4. What are the Factors that resulted in client seeking help at this Centre?

III. CLIENT ISSUES

REASONS FOR REFERRAL TO RESIDENTIAL TREATMENT:

IDENTIFIED ISSUES	GOALS (to Address Issues)

REFERRAL WORKER/COUNSELLORS ASSESSMENT:

1. Is the client receiving counseling from you? YES NO
 If yes:
 1) How many sessions in the last six months? _____
 2) How many sessions in the last two months? _____
 If no:
 1) How was the client referred to you? _____

KKWC REFERRAL PACKAGE

III. CLIENT ISSUES

(Continued)

2. What issues has the client addressed prior to attending this treatment program?

3. What is the client's presenting problem(s)? _____

And what is his/her insight of the problem(s)? _____

4. What do you believe is the Ktunaxa/Kinbasket Wellness Centre's role in the Client's recovery?

5. What is your perception of the client's readiness for treatment? _____

6. Will you continue to see the client once he/she has completed treatment? YES NO

If no, what steps have been taken to ensure that the client is following his/her Aftercare Plan? _____

KKWC REFERRAL PACKAGE

IV. CONSENT FOR TREATMENT

I, _____, agree to enter the Ktunaxa/Kinbasket Wellness Centre for the purpose of treatment and healing myself.

I understand that if I need medical attention, I will be attended to by the proper personnel and/or transferred to an appropriate facility.

I also agree to be involved in my Aftercare Plan and Outpatient Counseling after attending the Ktunaxa/Kinbasket Wellness Centre.

I fully understand the above points and the Ktunaxa/Kinbasket Wellness Centre Guidelines; therefore I consent to undergo Alcohol & Drug Treatment at the Ktunaxa/Kinbasket Wellness Centre.

I fully understand that any false information given may be cause for dismissal from the program.

Date: _____ **Signature:** _____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I hereby give my consent for staff personnel of the Ktunaxa/Kinbasket Wellness Centre to use my client file for the purpose of data collection for the outcome study and program development.

I hereby give my permission for staff personnel of the Ktunaxa/Kinbasket Wellness Centre to contact:

Name: _____ Title: _____
(Example: referral worker, probation officer, parole officer, psychologist, etc.)

Address: _____ Phone: _____
(Of Contact person named above)

for information to be released which shall be limited to

(Example: progress during treatment, discharge summary, etc.)

Date: _____ **Signature:** _____

Witness Signature: _____
Name (print please): _____
Location: _____

(Note: This form is applicable for one year after signed and dated)

KKWC REFERRAL PACKAGE

V. PRE-ADMISSION MEDICAL EVALUATION

CLIENT NAME: _____ D.O.B.: _____

B.C. MEDICAL #: _____ STATUS #: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

CLIENT RELEASE

I, _____ hereby request and permit Dr. _____

my physician, to release medical information about me to:

Ktunaxa/Kinbasket Wellness Centre
3246 Riverview Rd - Creston, BC V0B 1G2
PH: (250) 428-5516 - FAX: (250) 428-5235

and my Referral agency:

AGENCY NAME: _____
CONTACT NAME: _____
ADDRESS: _____
PHONE: _____ FAX: _____

Client Signature: _____ Date: _____

TO THE PHYSICIAN:

Your patient is being considered for admission to the Ktunaxa/Kinbasket Wellness Centre, an in-patient Alcohol & Drug Treatment Facility. Please Indicate whether or not this patient suffers from Psychological Disorders of any kind...and if you would recommend Treatment for this client.

For patients who suffer from chemical dependency, treatment is usually the beginning of a life long process of recovery and not an end unto itself. It is essential that an aftercare plan be in place upon return to their communities for there to be much hope of keeping the disease in remission. Family physicians are in a unique position to help co-ordinate such plans with various other resources in our communities, such as chemical dependency counselors, and other recovery resources, e.g. AA and NA groups.

Also, please NOTE: The applicant is responsible for any fees incurred by filing this Medical Examination information for Treatment.

KKWC REFERRAL PACKAGE

V. PRE-ADMISSION MEDICAL EVALUATION (CONTINUED)

MEDICAL EXAMINATION

Would you like to receive a Discharge Summary on your patient? YES NO

Would you Recommend in-patient Alcohol & Drug Treatment? YES NO

FUNCTIONAL INQUIRY AND PHYSICAL EXAM:

Diabetes: YES NO Allergies: _____

EENT: Hearing Loss YES NO Impaired Vision YES NO

RESP: Asthma YES NO S.O.B. YES NO Chronic Cough YES NO

CVS: CHF YES NO Angina YES NO Prev. Endocarditis YES NO

GI: Ulcers YES NO Reflux YES NO Dyspepsia YES NO IBD YES NO

GU: Frequent UTI YES NO Prostatism YES NO

Menstrual: LMP: _____ Pregnant? YES NO EDC: _____

PHYSICAL EXAMINATION:

BP: _____ / _____

EENT: NEG POS _____

CHEST: NEG POS _____

HEART: NEG POS _____ Murmurs _____

ABDM: NEG POS HEP: _____ Type: _____ Liver _____ Scars _____

GU: NEG POS _____ Last Pap _____

NEURO: NEG POS _____

LOCOM: NEG POS _____

SKIN: NEG POS _____ Infestations _____ Infections _____

HIV/AIDS: Testing YES NO Results: _____

KKWC REFERRAL PACKAGE

V. PRE-ADMISSION MEDICAL EVALUATION (CONTINUED)

Is this patient on any prescribed medication? YES NO

2) For what purpose: _____

3) Name of Medication: _____

4) Amount prescribed: _____

Any current or recent medical problems which may or may not require follow-up while in treatment? YES NO

If so, please explain: _____

Is this patient able to participate in scheduled Recreational activities (e.g. Aerobics, Bowling, etc.)? YES NO

If not, please explain: _____

AS A PRE-REQUISITE TO TREATMENT YOUR PATIENT MUST:

7. Is your patient free from all communicable diseases (i.e. STD, Scabies, Lice, etc.) YES NO

8. **Have a negative T.B. Test in the last 12 months.* POS NEG

Date: _____ (Please attach documentation/results)

9. Be clean and sober from Alcohol & all Psychoactive Medications/Drugs (all mood or mind altering substances) for a minimum of 14 days. YES NO

Date of last use of Alcohol and/or Drugs: _____

A copy of recent lab work, if available, would be appreciated (e.g. CBC, liver, FBS, etc.).

ADDITIONAL COMMENTS:

I have examined this client and find him/her to be fit to attend Alcohol & Drug Treatment.

PHYSICIAN'S SIGNATURE DATE

NAME OF DOCTOR:

ADDRESS:

PHONE #: _____ FAX #: _____

Ktunaxa/Kinbasket Wellness Centre Referral Assessment

GUIDELINES

(Please review with your Client as Clients are monitored by these Guidelines)

1. ALCOHOL & DRUGS

- a) Possession or use of alcohol and/or drugs by clients while in treatment is not acceptable.
- b) A personal baggage check is conducted upon entry and any items containing alcohol or inhalants will be kept in "Safekeeping".
- c) "Safekeeping" will include some of the following:
 - Prescribed medications, nail polish remover, shavers, inappropriate reading material, personal entertainment items - Walkmans, CD players, MP3 players, cellphones, TVs, stereos - and personal vehicle keys, etc.)

2. HEALTH & SAFETY

- a) Smoking is allowed only in the designated outside smoking area. Smoking in the buildings is a fire hazard and is not allowed and will result in a discharge from the Centre.
- b) The bedroom doors are to be left unlocked all the time (FIRE MARSHALL'S ORDERS).
- c) Inform the staff person if you want to smudge your sleeping area.
- d) Upon entering treatment, all medication (including vitamins, herbal supplements and/or protein drinks) will be turned in to the staff on duty.
- e) A high standard of personal hygiene is required which includes daily shower/bath and brushing teeth.
- f) Shorts, skirts and dresses are to be at a respectful and modest length, muscle shirts worn **ONLY** at specified times, no cropped or tube tops, no revealing low cut or see through clothing nor inappropriate slogans/pictures/messages on clothing. (E.g. Alcohol, Drugs, Sexually explicit material, etc.)
- g) Use only the bed and bedroom assigned to you. This is a safety precaution.
- h) All clients are expected to keep their room clean and tidy at all times.
- i) Clients are assigned regular daily chores.
- j) Refrain from profanity (one exception of intensive healing work).
- k) Violence (physical or verbal) and/or willful destruction or damage of KKWC property will result in dismissal.
- l) Withdrawal from the Program requires prompt exit from the premises.
- m) No Smudging in the rooms as risk of fire.
- n) Medication is given out **ONLY** at the following times: 8am-9am, 12pm-1:30pm, 4pm-5:30pm, and 9pm-10pm. (Unless written directions from a doctor stating otherwise.)

3. TELEPHONE CALLS

- a) Telephone calls are for **EMERGENCY USE ONLY! NO EXCEPTIONS**
- b) All incoming calls or messages including emergencies will be given to Counselor and then relayed to client if appropriate.
- c) Office Telephones and Fax and Computers are for Staff business **ONLY**.
- d) There are absolutely no telephone calls for the first 3 weeks of Treatment. (Special exceptions are to be determined by the Counselor i.e. Human Resources, Parole and UI)
- e) If caught using the phone clients will get a warning which may lead to dismissal.

4. VISITORS

- a) During the first twenty-one days (21) of treatment, no visits are allowed.
- b) Visits are limited to Sundays between Noon and 4:00 pm.
- c) Visitors will refrain from entering the sleeping quarters.
- d) Visitors under the influence of alcohol or drugs are prohibited from the Centre.
- e) Visitor/Clients are requested to refrain from intimate behaviors during visitations.
- f) Visitors will give a minimum of **48 hours** advance notice before visiting. (Via telephone - during office hours 9: am - 5: pm)
- g) Visits are to be supportive and beneficial to the client. Visits can be denied if it is felt that it is not in the best interest of the client.
- h) Clients who leave or are discharged from treatment will refrain from contacting the remaining clients as a "Visitor".

5. WEEKDAY SCHEDULE (Monday - Friday)

- a) Wake-up call is at 7:00 am from Monday to Friday.
- b) Breakfast is at 8:00 am from Monday to Friday.
- c) Clients are in their room by 10:30 pm and lights out by 11:00 pm from Sunday to Thursday.
- d) Clients are expected to attend all sessions on time, including A.A. meetings.
- e) The T.V. and Music *may* be turned on from 5:00 pm to 9:00 pm Monday - Thursday at a reasonable volume.

6. WEEKEND SCHEDULE (Friday Night - Sunday)

- a) Clients are to be up by 9:00 am on Saturdays and 10:00 am on Sundays.
- b) Clients not on overnight passes must be in the building by 10:00 pm on Saturdays and 9:00 pm on Sundays.
(*The 4th Weekend ONLY*)
- c) The T.V. & Music *may* be turned on from noon to 12:30 am on Saturdays and from noon until 9:00 pm on Sundays.
- d) Brunch is scheduled for 10:00 am on Saturdays and 11:00 am on Sundays.
- e) Supper is at 4:30 pm on Saturdays and Sundays.
- f) Clients are in their room by 12:30 am and lights out at 1:00 am on Fridays and Saturdays.

7. PASSES (Scheduled for the 4th Weekend ONLY)

- a) Passes are a **PRIVILEGE** and will only be issued to clients who attend all sessions, complete chores on a timely basis and demonstrate progress in their treatment. Passes are **EARNED** and are **NOT** an automatic **RIGHT**.
- b) All clients are required to remain on the grounds for four weeks after admission. This does not include scheduled Program activities or client Walks.
- c) Only the Director and the assigned Counselor may approve a pass.
- d) After four weeks of treatment, a client **MAY** receive a pass.
- e) Clients on a *Weekend Pass* shall return by Sunday at 9:00 pm. *Saturday Day Passes* are scheduled from noon to 10:00 pm and *Sunday Day Passes* from Noon to 9:00 pm. **NO EXCEPTIONS!** (Subject to Completion of General Clean-up duties)
- f) Clients who fail to return by the designated time (without a valid reason) will be dismissed from Treatment.
- g) Clients may return to the Ktunaxa/Kinbasket Wellness Centre **before** the designated time on their day/weekend pass.
- h) Clients on day/weekend passes are still in treatment and must act accordingly - **ALL** drinking establishments or places where Alcohol is being served (including Casinos) are **strictly prohibited**.

8. OTHER

- a) Money (up to \$100) and other valuables may be checked in with the Counselor on duty for safekeeping.
- b) The Ktunaxa/Kinbasket Wellness Centre is not responsible for lost or stolen personal belongings that are not in Safekeeping.
- c) Sexual relationships between clients and staff are strictly prohibited.
- d) The forming of relationships of a romantic or sexual nature between clients is destructive to both individuals and not acceptable at the Ktunaxa/Kinbasket Wellness Centre.
- e) Clients are to remain within the boundaries of the Ktunaxa/Kinbasket Wellness Centre at all times except when accompanied by Staff, or using the "buddy system" when going for walks. (The "Buddy System" is defined as 3 clients)
- f) Only those clients who are assigned to each bedroom are allowed in them.
- g) No unsupervised group/circle work at any time. No "counseling" of other clients.
- h) Clients admitted to the Ktunaxa/Kinbasket Wellness Centre will sign a Contract to accept and follow the Centre's "House Rules".
- i) Clients who bring their own vehicles will turn their keys over to the Counselor on duty upon arrival for Safekeeping until the end of their Treatment.
- j) Clients will attend A.A. meetings in the Centre and in the surrounding community.
- k) Clients belongings left in the Centre after a client has been discharged will be disposed of after seven (7) days - if they are not claimed via a phone call. These items will be forwarded to the client via mail.
- l) Clients are not allowed to bring radios, walkmans, Discmans, TV's, Cell phones or recorders. (If these items are brought, they will be put under lock & key until Graduation or Discharge - whichever comes first)

ITEMS TO BRING

CLOTHING:

- Pants/Jeans
- Shirts/Blouses
- Sweatshirts/Sweaters
- Socks & Underwear
- Bathing Suit
- Shoes and Runners
- Slippers/Moccasins
- Pajamas & Housecoat
- Gym Clothes (Shorts, T-Shirts, Track Pants)
- Jacket

~ WASHERS & DRYERS ARE AVAILABLE FOR USE ~

SEASONAL:

- Winter Coat or Rain Coat
- Mittens/Gloves
- Winter Boots
- Scarf
- Hat (toque)
- Rubber Boots

TOILETRIES & PERSONAL ITEMS:

- Toothbrush & Toothpaste
- Deodorant
- Bath Soap
- Female Personal Hygiene Items
- Hairbrush/Comb
- Shampoo & Conditioner
- Lotion

YOU MAY WISH TO BRING:

- A favorite Stuffed Animal
- A cuddly blanket
- Your favorite pillow
- Pictures from home (no glass frames)
- Books/Magazines (appropriate)
- Cultural items

DO NOT BRING ANY OF THE FOLLOWING RESTRICTED ITEMS:

- Aerosols (of any kind)
- Hair Spray
- Perfumes/Colognes
- CD's, Tapes, Stereos
- Meal replacements
- Mouthwash
- Razor Blades
- Knives (any Sharps)
- Discmans/Walkmans
- Nail Polish
- Polish Remover
- Anything containing Alcohol
- Cell phones

*~ **LUGGAGE IS SEARCHED UPON INTAKE AND DISCHARGE** ~*

If restricted items are found or turned in at Intake, the items will be put under lock & key or disposed of

CARE PACKAGES THAT ARE RECEIVED DURING TREATMENT **WILL BE SEARCHED** AND **ANY RESTRICTED ITEMS WILL BE DISPOSED OF OR SENT HOME**

TOBACCO PRODUCTS ARE NOT PROVIDED

Clients should bring:

- Personal Toiletries (e.g. Shampoo/conditioner, shavers, soap, toothbrush, etc.)
- adequate clothing (pertaining to the weather)
- swim wear (for group trip to Ainsworth Hot Springs - last weekend of Treatment)
- slippers (to wear in the house at all times)
- white running shoes (for aerobics and other Gym activities)
- small amount of money for personal needs (if desired)
- their own over-the-counter medications (e.g. Tylenol, vitamins, Tums, Cough drops, etc.)

There are laundry facilities at the Ktunaxa/Kinbasket Wellness Centre. Clients are required to do their own laundry.



KTUNAXA/KINBASKET HEALTH & WELLNESS SOCIETY

3246 Riverview Rd • Creston, BC V0B 1G2



Telephone: 250.428.5516 Facsimile: 250.428.5235

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2007 TREATMENT PROGRAM SCHEDULE

DURATION	PROGRAM	INTAKE	GRAD
1 WEEK	Staff Development	JAN. 01	JAN. 05
9 WEEKS	CO-ED ALCOHOL AND DRUG TREATMENT	JAN. 07	MARCH 8
1 WEEK	STAFF DEVELOPMENT	MARCH 12	MARCH 16
6 WEEKS	CO-ED ALCOHOL AND DRUG TREATMENT	MARCH 18	APRIL 26
1 WEEK	STAFF DEVELOPMENT	APRIL 30	MAY 4
6 WEEKS	CO-ED ALCOHOL AND DRUG TREATMENT	MAY 6	June 14
1 WEEK	Staff Development	JUNE 17	JUNE 23
6 WEEKS	CO-ED ALCOHOL AND DRUG TREATMENT	JUNE 24	AUG 2
1 WEEK	STAFF DEVELOPMENT	AUG 5	AUG 18
6 WEEKS	CO-ED ALCOHOL AND DRUG TREATMENT	AUG 19	SEPT 27
3 WEEKS	STAFF DEVELOPMENT	SEPT 30	OCT 6
6 WEEKS	CO-ED ALCOHOL AND DRUG TREATMENT	OCT 7	NOV 15
1 WEEK	STAFF DEVELOPMENT	NOV 18	NOV 24
3 WEEK	REFRESHER/RESIDENTIAL SCHOOL TRAUMA TREATMENT	NOV 25	DEC 13
1 WEEK	STAFF DEVELOPMENT & CHRISTMAS HOLIDAYS	DEC 16	JAN. 01/08

Please "book" your client at least **3 Weeks** prior to the Intake Date. Your client will require an updated **KKWC Referral Application** with a **Medical Examination** (expires after 6 mos.) and **Negative T.B.** Test results (expires after 1 yr.) to be considered for Admission.

It is the responsibility of the Referral worker to ensure client Travel "To" and "From" Creston. KKWC Staff will transport clients to and from the Greyhound bus depot if you have pre-arranged so with the KKWC.

You can download our Referral Pkgs from our website: www.healingisajourney.com

If you have any questions please call us at (250)428-5516. We look forward to working with you in the journey towards Healing.