Ngwaagan Gamig Recovery Centre Inc.
(Rainbow Lodge), Wikwemikong, Ontario

2025 TREATMENT REFERRAL PACKAGE

- Program Information
- 2025 Treatment Cycle Dates
- Adult Intake Application
- Consent to Release Information
- Pre Admission Medical Form
- Drug Use Screening Inventory
- Native Wellness Assessment

ATTENTION: REFERRAL AGENCY /APPLICANT

The treatment program utilizes a culturally-based, cognitive-behavioural approach for addictions treatment. Addictions treatment may also include community based counselling, programs and services offered at Ngwaagan Gamig Recovery Centre Inc.

Please find attached, the 2025 client referral package for community based services and for the four-week Addictions Treatment Program at Ngwaagan Gamig Recovery Centre Inc. (Rainbow Lodge). Please begin utilizing this package for referrals. Your cooperation is appreciated.

This package contains information on the referral process, program information, application form, pre-admission medical Form, assessments, admittance procedures, and upcoming cycle dates. Please make copies of this Treatment Referral Package for future use. You may fax the completed Treatment Referral Forms to (705) 859-2325, email intakeworker@ngwaagangamig.ca or mail it to us.

Please ensure all areas of the referral forms are completed in full. We require

1. the Adult Intake/Referral Application
2. the Standardized Medical Assessment, and
3. the DUSI-R (Drug use Screening Inventory-Revised) Assessment, and the
4. The Native Wellness Assessment (NWA)

All information is to be submitted before the application is reviewed by Management for suitability for our services and the treatment programs. Other information may also be requested. Missing information will delay the process.

Clients are required to provide one (1) piece of picture identification before proceeding to Ngwaagan Gamig Recovery Centre Inc; this identification will be requested by the drivers at the pick- up location prearranged or by staff upon arrival at the centre.

Thank you for considering Ngwaagan Gamig. If you have further inquiries regarding our intake procedure, please do not hesitate to call.

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P.O Box 81
56 Pitawanakwat Street
Wikwemikong, Ontario P0P 2J0

Telephone: 1.705.859.2324
Toll free: 1.877.649.2242
Toll free: 1.877.Ngwaagan

PROGRAM INFORMATION

REFERRAL PROCESS FOR TREATMENT

Referrals will be accepted from the following sources:

- Self-referrals
- Community-based counsellors, CHR's, NNADAP
- Social service workers
- Health-related agencies

The residential treatment program is intended for First Nations males and females, 18 years of age and older, determined to address the impact of substance misuse/abuse challenges. Community based services and programs are for community residents only.

INTAKE PROCEDURES FOR RESIDENTIAL TREATMENT

1. Completion of the Adult Intake/Referral Form
2. Send in the Standardized Medical Assessment signed by a Physician or Nurse Practitioner
3. Submit the DUSI-R (Drug Use Screening Inventory-Revised) and the NWA (Native Wellness Assessment)
4. Please also submit a copy of any legal conditions order ie. probation, bail orders.
5. Screening of applications will be completed prior to management review for consideration into the program. Incomplete applications will delay the process of screening.
6. When a bed becomes available, a final telephone interview with the client will be scheduled to complete the application process, and additional information may be requested.
7. Failure to contact us for the final telephone interview or to reschedule the final telephone interview will result in withdrawal of the application.
8. **Clients approved for our program will receive an admission letter** with the date expected for arrival at our centre. The client is expected to continue preparing for treatment by engaging in pre-treatment services.
9. If any concerns/issues are disclosed, there may be a delay in admission.
10. Travel arrangements to and from the centre are the responsibility of the referral worker or client and are confirmed with our Intake office. Lack of confirmation of travel arrangements may be considered cancellation of the admission.
11. If there are no shows on the Admission Date, the intake will be considered cancelled on that day, and beds will be filled with another person the next day.
12. Please note that applications closed can be reactivated at any time although updated information may be requested.

PRE-TREATMENT CRITERIA

The referring agency representative is expected to prepare clients for treatment by making the client aware of the following:

- To review the treatment process with the client, to familiarize the client with addictions treatment programs, review house policies, resident's rights/responsibilities, and client expectations.
- Encourage clients to attend any pre-treatment activities and/or refer to an addictions agency.
- A pretreatment checklist is attached and serves as a guide in preparing for the treatment program.
- It is preferable to have clients detoxified from all substances not prescribed and free with withdrawal symptoms for at least one month
- The Clients must demonstrate willingness and be able to participate in the treatment program.

- All clients must be willing to abide by Ngwaagan Gamig Recovery Centre Inc.'s policies and procedures.
- Personal/Business matters which include finances, medical appointments, childcare, family, personal relationships and legal issues must be taken care of prior to admission so as not to interfere with the treatment program.
- It is recommended that couples not be referred to the same four-week program.
- If a client is on methadone or suboxone treatment, they must agree to attend the local pharmacy daily, **No carries** are permitted on the premises at any time.

ADMISSION PROCEDURES FOR TREATMENT RESIDENTIAL

- Monday is the usual travel day for admission day into the four-week treatment program and may change at the discretion of the treatment centre.
- Time of arrival must be forwarded to intake office prior to admission. Any delays/cancellations must be reported as soon as possible by the worker or client. If we do not receive information of delays, this may result in cancellation.
- If a client changes their mind regarding admission, please telephone us as soon as possible to allow others the earliest possible notice for bed availability.
- If a client appears on admission day **without having received the Admission letter,** this client **will not** be admitted into the treatment program nor the facility. The client will be requested to return home to contact their referral source.
- If a client cancels their admission, their application will not be kept active, they will need to reapply.

WAIT GROUP

- Once the beds have been filled, all other applicants (wait group) are waiting for a bed to be available. As cancellations occur, we will fill the bed spaces with applicants who are treatment ready and available to attend on short notice.
- The referral agency will be contacted if a bed becomes available to determine if the client is ready for treatment and able to attend. The client will need to arrive at our facility as soon as possible. We will not wait for call backs on an available bed. It is filled with the first person contacted by us who notifies that they ready to attend.
- While waiting for the next available bed, clients are expected to continue pretreatment services.

NO SHOW

- On the next day following the day of admission, we will telephone and advise the referral source if their client did not arrive for admission.
- If a client calls to cancel, we will ask client to contact their referral source to advise of same.

RE-ADMISSION

- Requests for re-admission into our treatment program will be dealt with on an individual basis.
- Any referring agency requesting re-admission of a former client must be able to provide reasons why re-admission is likely to be helpful.

NGWAAGAN GAMIG RECOVERY CENTRE INC.

CYCLE DATES – TREATMENT PROGRAM

2025

Cycle number	Admission Day	End Date	Duration
Cycle 8	January 6, 2025	January 31, 2025	4 week program
Cycle 9	February 10, 2025	March 7, 2025	4 week program
Cycle 9b	March 24, 2025 Healing program to address grief	March 28, 2025	1 week program
Cycle 1	April 7, 2025	May 2, 2025	4 week program
Cycle 2	May 12, 2025	June 6, 2025	4 week program
Cycle 3	June 16, 2025	July 11, 2025	4 week program
Cycle 3b	July 14, 2025 Healing program on forgiveness	July 18, 2025	1 week program
Cycle 4	August 5, 2025 tuesday	August 29, 2025	4 week program
Cycle 5	September 8, 2025	October 3, 2025	4 week program
Cycle 6	October 14, 2025 tuesday	November 7, 2025	4 week program
Cycle 7	November 17, 2025	December 12, 2025	4 week program

Approved: Executive Director **Revised November 22, 2024**

Subject to change

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAYBE RETURNED, DELAYING THE PROCESS.
Form to be completed by referring agent. Attach a separate sheet of paper if more room is needed.
If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA.

ADULT INTAKE/REFERRAL APPLICATION

A. General Information

Date Application Received by Community Worker		Date Application Received by Treatment Centre	
Last Name:	First Name:	Nickname or other name known by:	
Date of Birth:	Age:	Gender:	Provincial Heath Card Number:
Address:			Telephone:
Language Spoken:	Language Preferred:	Email address:	
Emergency Contact Name: 1) 2)		Telephone: 1) 2)	Relationship: 1) 2)
Status Indian:	Status Number: (10-digit status number)	Band Name:	
Non-Status/Metis/Inuit			
Literacy: ☐ Yes ☐ No ☐ Needs assistance	Highest Education (completed):	Employment Status:	
	High School Grad		
	Post Secondary Grad		

B. Family/Relationships

Marital Status:

Does Client have dependent children?	☐Yes ☐No	
If yes, do they have access to adequate childcare while in treatment?	☐Yes ☐No ☐N/A	
Are the children in care?	☐Yes ☐No ☐N/A	
Does the client have other dependents?	☐Yes ☐No	

Provide information on client's children or other dependents:

Name	Status Number	Age	Relationship

Family Supports:

Family Strengths:

C. Legal Status

Has client been court ordered to attend treatment?	☐Yes ☐No
If yes, provide details (include details/copy of Probation Order if applicable and/or available):	
Is the client under any of the following legal conditions?	☐Bail ☐Parole ☐Temporary Absence Order ☐Probation Order
Other (provide details, dates, etc.):	

D. Treatment History

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

Year	Treatment Centre	Type of Addiction	Completed	Comments
			☐Yes ☐No	
			☐Yes ☐No	
			☐Yes ☐No	

Reason(s) for currently requesting treatment:

E. Withdrawal Symptoms

Has client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

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 ☐Unknown	
Ever experienced DTs?	☐Yes ☐No	

F. Process/Behavioural Addictions

Has client experienced problems with any of the following?

Process/Behavioural Addiction		Describe
Gambling (slots, cards, Keno, bingo, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Eating (obesity, anorexia, bulimia, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Sex (promiscuity, etc.)	☐Yes ☐No ☐Not Applicable ☐Unknown	
Internet/texting	☐Yes ☐No ☐Not Applicable ☐Unknown	
Gaming/video games	☐Yes ☐No ☐Not Applicable ☐Unknown	
Other	☐Yes ☐No ☐Not Applicable ☐Unknown	
Other	☐Yes ☐No ☐Not Applicable ☐Unknown	

G. Mental Health Issues

Provide the following information about the client's health status:

Mental Illness		Describe
Been diagnosed with a mental illness	☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently being treated	☐Yes ☐No ☐Not Applicable ☐Unknown	
Currently on psychiatric medication	☐Yes ☐No ☐Not Applicable ☐Unknown	

Taking medication consistently	☐Yes ☐No ☐Not Applicable ☐Unknown	
Taking Traditional Medicine If yes, identify	☐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	
Engaging in self injury	☐Yes ☐No ☐Not Applicable ☐Unknown	
Name of psychiatrist/psychologist (if applicable):		

H. Other Issues/Needs

Does client have cultural and/or spiritual beliefs and practices we need to be aware of? If yes, please describe:	☐Yes ☐No
Does client have any literacy, reading, writing, or learning needs or issues we need to be aware of? If yes, please describe:	☐Yes ☐No
Are there any other significant issues we need to be aware of? If yes, please describe:	☐Yes ☐No
Does client understand there is an expectation of completion of a minimum of four (4) 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 7 days prior to admission to residential treatment (or 14 days if withdrawing from benzodiazepines). (Client with less than the required days must notify the treatment centre prior to admission).	☐Yes ☐No
Personal Strengths:	

I. Application Checklist	
Confirmation of transportation to Treatment Centre through referral	☐Yes ☐No
Confirmation of transportation back home	☐Yes ☐No
Client has been notified and understands the Non-Insured Health Benefits policy change whereby anytime during treatment and the client self-terminates, or the Treatment Centre terminates the client, and medical transportation benefits have been provided, 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 the Treatment Centre.

Client Signature	**Date**

Consent to release information related to discharge or completion from the program:

Upon leaving the program, for any reason including completion of the program, please identify who we ought to contact to advise of your departure date (can be emergency contact, family, referral source, or other person).

Name:

Contact information:

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

COUNSELLOR OR OTHER REFERRAL INFORMATION

Has the client completed four pre-treatment appointments?				☐Yes ☐No
Please provide appointment dates:	Date 1:	Date 2:	Date 3:	Date 4:
Will you continue to see the client once he/she has completed treatment?				☐Yes ☐No

What other supports would be available to your client in their community upon completion of treatment?

Name/Resource	Description of Support

Please provide/attach a brief assessment summary, (Assessment Summaries completed within 6 weeks of this application may be substituted and attached) including summarization of any assessment processes completed with the client (e.g. SASSI, MAST, DAST, etc.) which support the application to treatment, and evaluate how addictions have affected your client in all domains (e.g. domestic, medical, school, psychological, spiritual, emotional).

Client's Stage of Readiness:

☐Pre-contemplation - Not considering change; resistant to change
☐Contemplation - Unsure of whether or not to change; chronic indecision
☐Determination - Preparation; committed to changing behaviour within one month
☐Action - Begin changing behavior
☐Maintenance - Behaviour change has persisted for 6 months or more

Please list any questions or concerns the client has indicated during the intake process:

What other areas might need to be addressed in treatment? (e.g. abandonment, residential schools, anger, grief, loss, parenting skills, sexual abuse, rejection, financial, spirituality, suicide, mental health, gambling and other addictions, etc.):

Referral Agent assessment of client's strengths and potential challenges for completing treatment:

Referral Checklist Please initial each item that has been completed:

Check off any items attached to this application:

Item	Attached	Initials
Psychiatric evaluations	☐Yes ☐No	
Probation order/Court Order	☐Yes ☐No	

Pending Court Dates	Date: _____	
Current Medical Assessment Form	☐Yes ☐No	
Assessment Summary	☐Yes ☐No	
Substance Abuse Profile/Assessment (DUSI)	☐Yes ☐No	

Please initial each item that has been completed:	**Initials**
Confirmation of transportation to the treatment centre	
Confirmation of transportation back home after completion of treatment	
All medical, dental and optical appointments have been dealt with prior to treatment	
All financial matters have been dealt with prior to treatment	
All legal matters have been dealt with prior to treatment	

Referral Signature	Date (D/M/Y)
Name:	
Contact Information:	

NGWAAGAN GAMIG RECOVERY CENTRE INC. (RAINBOW LODGE)

CONSENT FOR RELEASE OF INFORMATION

I_____ hereby authorize and consent for the release of
(Name of client)

the following information or documentation pertaining to the records or any portion thereof, as

compiled by _____regarding _____
(Name of organization with the information) *(Myself or name of child in guardianship)*

to be released to Ngwaagan Gamig Recovery Centre Inc. for purposes regarding continuation

_____

I also authorize and consent for the release of the following information or documentation pertaining to the records or any portion thereof, **as compiled by Ngwaagan Gamig Recovery Centre Inc. to be released to** _____
(Name of organization to release to)

Specify the information authorized to be released –

_____
_____
_____
_____

The entirety of this consent form was reviewed with the client.

Date: _____ Signature: _____

Witness: _____

This consent for release of information may be withdrawn at any time with Written Request by the client and/or will expire on _____.

Ngwaagan Gamig Recovery Centre Inc.

PRE-ADMISSION MEDICAL FORM

(To be completed by Physician or Nurse Practitioner)

CLIENT'S SURNAME: _____ FIRST NAME: _____

Sex: ☐ M ☐ F ☐ Other D.O.B.(mm/dd/yr): _____ HEALTH CARE #: _____

Address: _____ City: _____ Postal Code: _____

Telephone: _____

I, _____ hereby request and consent for my physician to release medical facts and assessments about me to Ngwaagan Gamig Recovery Centre Inc. (Rainbow Lodge) and my referring agency for the purposes of addictions treatment. The photocopy of my signature on this form is as valid as the original.

CLIENT'S SIGNATURE: _____ DATED: _____

PRESENT HEALTH CONDITIONS

Heart Disease ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Epilepsy ☐ Yes ☐ No

Pediculosis ☐ Yes ☐ No Communicable Disease ☐ Yes ☐ No

Other Medical Conditions: If Yes, List: _____

Allergies ☐ Yes ☐ No
If yes, please list: _____

_____

TB Symptom Screening is now mandatory to be completed prior to entering the treatment program at Ngwaagan Gamig Recovery Centre Inc. The Page 3 **screening form** is now a mandatory part of the Pre-Admission Medical Form.

continued →

Psychological/Psychiatric Conditions ☐ Yes ☐ No Specify _____

Suicide Ideations: ☐ Yes ☐ No

Suicide Attempts: ☐ Yes ☐ No Other: _____

If yes to any health condition, please elaborate on progress to include dates of diagnosis, nature, outcome:

_____

_____

_____

MEDICATION

List Current Medications	Purpose Medical Condition	Date First Prescribed

Is the client currently participating in a Methadone/Suboxone Maintenance Treatment Program? ☐ Yes ☐ No

If yes, please provide details_____

and note that additional criteria and arrangements will be necessary.

Is special diet indicated? ☐ Yes ☐ No

Is the client able to participate in a Sweat Lodge ceremony? ☐ Yes ☐ No

continued →

Symptom Screening for Tuberculosis (TB)

1. Have you ever had TB disease? ☐ NO ☐ YES

2. Have you ever had a TB skin test? ☐ NO ☐ YES (If yes, date:_____ and result:_____)

3. Do you have any of the following symptoms?

New or worsening cough? ☐ NO ☐ YES How long? _____

Productive cough? ☐ NO ☐ YES Colour? _____

Fever? ☐ NO ☐ YES How long? _____

Chills? ☐ NO ☐ YES How long? _____

Fatigue? ☐ NO ☐ YES How long? _____

Night sweats? ☐ NO ☐ YES How long? _____

Weight loss? ☐ NO ☐ YES How long? _____

Loss of appetite? ☐ NO ☐ YES How long? _____

4. Are you taking any antibiotics now? ☐ NO ☐ YES

Name:_____

5. Do you have any other illnesses?

_____

I hereby certify, that I have examined the above named individual as required, stating this person is free from communicable disease, stabilized, and that this person is physically, mentally, and emotionally able to undertake the program at Ngwaagan Gamig (Rainbow Lodge) Recovery Centre Inc.

Print Name of Physician/Nurse Practitioner: _____

Signature of Physician/Nurse Practitioner _____

Telephone:

Date: _____ _____

Ngwaagan Gamig Recovery Centre Inc. is not responsible for any fees associated with completion of this form.

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					
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					
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					
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					
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:_____

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,

DUSI-R
Drug use Screening Inventory-Revised

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

	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 <u>past year</u> 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

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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

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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

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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

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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

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

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

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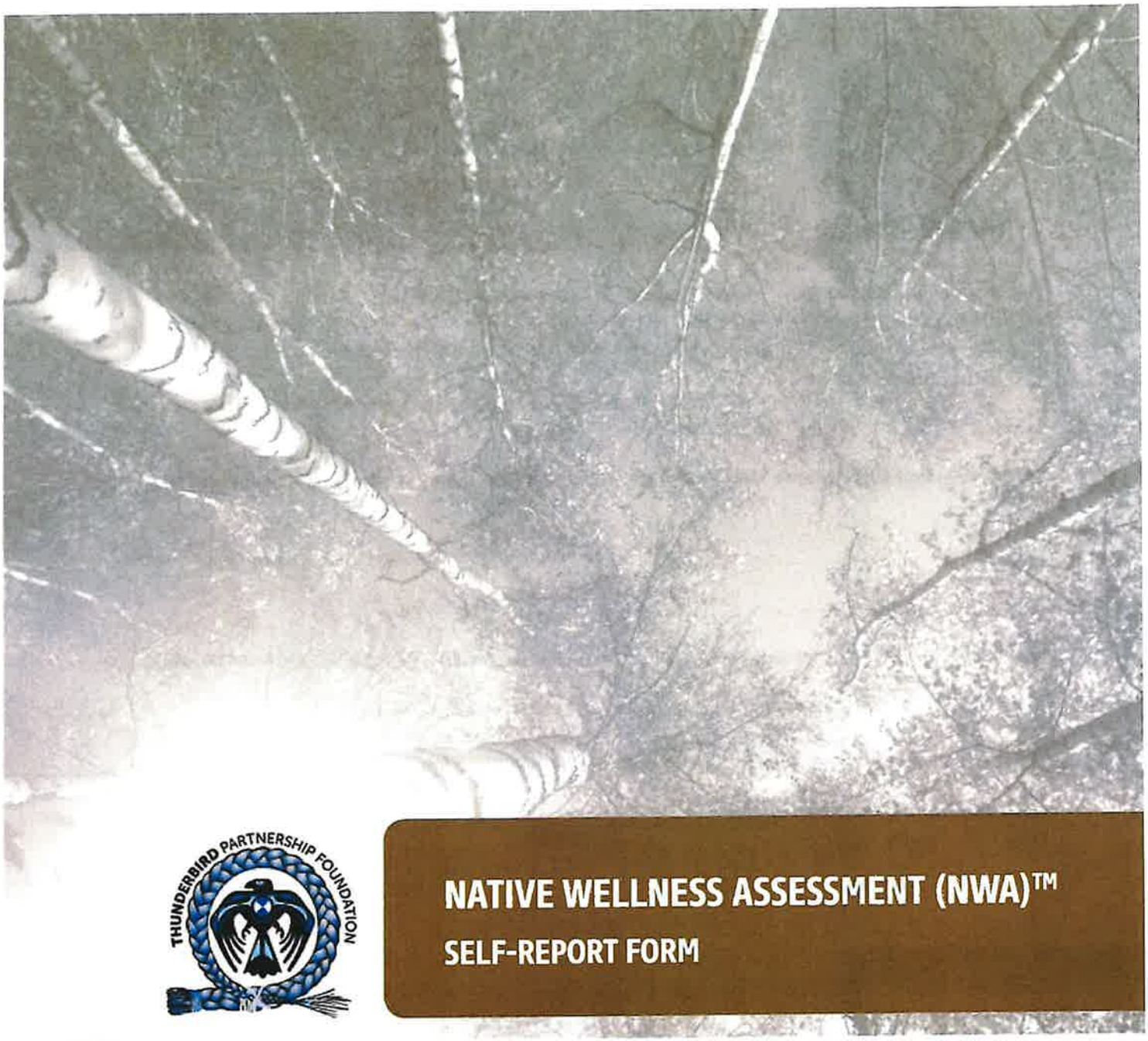
Adult Past Year Time Frame **Name:**_____

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:

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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

Statements: Section 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

Statements: Section 3

		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/

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