Referral Package

Night Wind Treatment Centres
26130 Twp. Rd. 572
Sturgeon County, Alberta

Email: info@Night Wind.ca
Telephone: 780-983-1874
Fax: 780-961-3420

Night Wind Treatment Centre
26130 Township Road 572,
Sturgeon County, T0G 1L1

Email: info@Night Wind.ca
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Introduction

The Night Wind Treatment Centres (NWTC) are unique healing facilities designed to meet the needs of referral agents, youth, their families, and communities. NWTC provides clear, congruent, and in-depth treatment created for youth and their families. The vision is to have culture and spirituality as the core essence of all programming within the centres, and to combine with best practices in the treatment and healing of trauma.

Over the last ten years, we have continued to enhance to services we to meet the needs of youth, families, case workers and the communities we serve. From humble beginnings as a small group care facility NWTC has grown to include two separate healing centres, a transition to independent living home **Grandmother Turtle House** for clients graduating the treatment program, and a mentor program **KIHEW House** for youth who are too young for independent living. Although NWTC has always provided support to families of youth in our care, we are now in the process of further expanding a family program.

As we continue to grow and learn we are continuously grateful for the guidance we have received spiritually, and remain open to the needs of our youth and all those involved in their care. After all, youth started as our priority ten years ago and youth remain the centre of all that we do.

Guiding Principles of NWTC

NWTC is guided by principles of holistic treatment. The principles we use respect both cultural and evidence-based practices that integrate the mental, physical, emotional, and spiritual aspects of the whole self. NWTC guiding principles are:

- Emphasize the distinction of Indigenous beliefs and traditions;
- Integrate evidence-based practices aligned with trauma-informed care;
- Recognize Aboriginal healing practices and culture as important to developing self-identity and give clients the opportunity to be exposed to culture and traditional methods of treatment;
- Effective treatment requires us to infuse cultural practices, treatment and trauma-informed care into everything we do;
- Respect the individual healing preferences of all clients;
- A systems approach to treatment is carried out with the understanding that a client's support network is essential to meaningful and lasting change;

- Teaching and modelling healthy coping strategies and building resiliency to support clients with significant issues including addiction-oriented attitudes and behaviors, and
- The client will graduate from treatment possessing self-determinism, attitudes and skills that can be generalized to their home and community following treatment.

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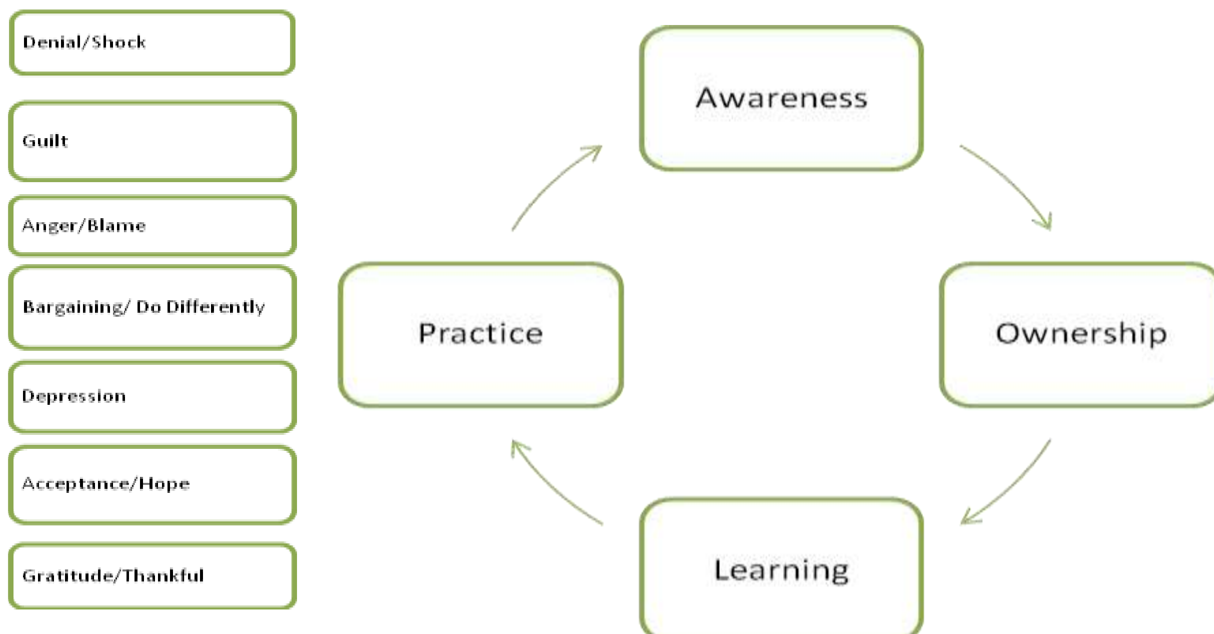
Stages of Treatment

Based on therapeutic research for residential care, Aboriginal Healing Foundation found clients in treatment responded well to a healing model combining both cultural and clinical services for Aboriginal people. NWTC's healing model focuses on four phases known as **STAGES** (**S**piritual **T**ransformation towards an **A**wareness and **G**uidance of **E**motional **S**elf) that integrates the 7 Traditional Values (Humility, Honesty, Kindness, Caring, Respect, Sharing and Courage), and the twelve steps of Alcohols Anonymous to enhance our healing framework.

These four stages are useful in learning about oneself, others and clients environment. The **STAGES** of treatment can be done four to six months if clients are receptive, motivated and open to change. These **STAGES** are interchangeable and can allow for the client to continue to use and apply to all areas of their life after treatment and are continuous. For example, learning new things once they have mastered a concept. Clients are able to reflect on their own progress or treatment duration when using these **STAGES**.

Clients continue to go through these **STAGES** each time they learn new things about themselves. This model continues to increase self-awareness that is life-long. In treatment, once a client enters these **STAGES**, the process becomes easier and quicker. Stages of Grief and Loss are intertwined with the **STAGES** of Treatment because it allows the client to learn how to grieve/heal from any type of loss and work towards having hope. Loss can include breakdown in family, sexual abuse, death etc.



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In addition to traditional indigenous healing and treatment approaches, Night Wind Treatment Centre integrates other evidence-based approaches through a focus on trauma-informed care.

Night Wind Treatment Centre - Fee's for Service

The per diem rate for the treatment beds at the Night Wind Treatment Centre is three hundred seventy nine dollars and eighty eight cents per day ($379.88) for the duration of the clients stay.

Per Diem Breakdown:

1. Staff	Cultural Coordinator and cultural resource people Clinical team (Psychologist, Clinical Coordinator) Program Coordinator Child and youth care Program Attendants Treatment Program staff	$223.01
2. Client Costs	Food Client travel Cultural Program Material Recreation Personal Needs	$99.87
3. Facility	Utilities Physical space Maintenance and Repairs Fuel and Insurance	$45.00
4. Administration	Human resources, Finance and Clerical support	$12.00

Per Diem Summary:

1. Staff	$ 223.01
2. Client Costs	$ 99.87
3. Facility	$ 45.00
4. Administration	$ 12.00
	$379.88

Night Wind Treatment Centres will be responsible for the following:

1. Providing clothing incidentals such as underwear and socks, as well as personal hygiene items. The client's clothing needs must be to standard when they enter the NWTC program or a plan from the case worker to bring it to standard. Any additional clothing that a client requires over and above incidentals is the responsibility of the referring agency. This includes funding for clothing should a client require additional clothing due to growth, or for seasonal changes. Also, our program is based on a minimum estimate of 4 month placement and up to 1 year. However, clothing needs will be reviewed every 4 months should the client remain in the program for an extended period of time.

2. Transport clients to medical/dental/optical services
3. Therapeutic/counseling services
4. Cultural services
5. Program recreation (funding for recreation beyond that which is provided in the standard Night Wind Treatment Centres programming is the responsibility of the referring agency. i.e. – skiing, personal recreational equipment, etc.).

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Client Referral Form

Referral Agent Name:	Position:	
Organization:		
P.O. Box/Address:	Town/City:	
Province:	Postal:	Email:
Telephone:	Fax:	Cell phone (optional):
How long have you worked with the youth?		
Identify the circumstances that lead to the referral, including any critical incidents:		
Client Information:		
Surname:	First Name:	Middle Name:
Date of Birth(mm/dd/yy):	Current Age:	Gender:
Health Care No. (6 digit):	Band No. (Treaty):	
Mother's Name:	Father's Name:	
Home Address:	Community:	
Province:	Postal:	
Telephone (home):	Cell:	
Legal Guardian Information:		
Legal Guardian(s):		
Relationship to client:	(Bio/adoptive parent/child welfare authority)	
Length and time as Guardian:		
Address:	Ph# (home):	
City/Town:	Cell #:	
Postal Code:		
Child and Family Services Involvement:		
Has the client ever been involved with a Child & Family Services Agency: Yes or No		
Is the client currently in care: Yes or No	Indicate expiry date on any court orders:	
If yes, indicate: ___ Permanent ward ___ Voluntary placement Agreement ___ Family Services		

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Temporary Ward	Under apprehension	Other:

Date of Referral:______________
Date of Referral:______________

History of Placements: ***Please include all Client Placement History.**			
Name of Agency Guardian	Dates	Length	Details of Placement breakdown

*** Please provide all documentation/information of client's History of Placements, including assessments if available.**		
Inter-department, Inter-agency Involvement:		
Has the youth been involved with the criminal justice system? ___ Yes___ No Provide details:		
Is the youth currently on parole? ___Yes___ No Provide details:		
Is the youth currently under a court order? ___ Yes___ No Provide details:		
Has the client been involved with any of the following professionals:		
Social Services, Court Worker, Mental Health Worker, Therapist (psychologist, psychiatrist, social worker) or RCMP? ___ Yes___ No Provide details:		
Community Resources Available to Client & Family:		
Name:		Title:
Phone:	Fax:	Email:
Name:		Title:
Phone:	Fax:	Email:
Name:		Title:
Phone:	Fax:	Email:

Name:	Title:	
Phone:	Fax:	Email:

Medical History:

Has the youth been diagnosed with FASD, FAE or ADHD? Yes or No	
If yes, what medications are prescribed?	
Date of last visit to Dentist:	
Date of last visit to Optometrist:	
Date of last Medical visit:	
Current Medical Doctor telephone #:	Fax #:
Allergies:	History of Serious Illness:
History of physical trauma (i.e. surgery, burns):	
History of physical Impairments (i.e. deafness, walking, vision, fainting):	
Alcohol /Drug use by Mother during Pregnancy: ___Yes ___No ___Suspected ___Unknown	
Does the youth have a history of suicide attempts? ___ Yes ___ No	
If yes, when was the last attempt?:	Methods used?

Client Social /Behaviour History:
A) Client has a history of:

	Yes	**No**	**Suspected**	**Provide Details:**
Fire setting				
Cruelty to animals				
Destruction of Property				
Physical Aggression				
Sexual Aggression				
Verbal Aggression				
Truancy-skipping school				
AWOL				
Sleeping disturbance				
Eating disorders				
Bed wetting				
Self-destructive behaviours				
Abuse towards others				
Depression/Suicide ideation				

Other behaviours (abandonment, hearing voices, psychosis)				

B) Substance Abuse Experience:
Has the youth tried any of the following:

	Yes	No	How often	Age of first use	Last Date used
Gasoline					
Glue/Lacquer					
Propane					
Nail Polish/Remover					
Paint/Air Freshener					
Contact Cement/Hairspray					
Marijuana					
Hash					
Alcohol					
Pills (Prescribed/un-prescribed)					
Cocaine					
Crack					
Ecstasy					
Crystal Meth					
Other: Specify					

C) Traits and Views:

	Yes	No	Provide Details:
Unhealthy & destructive Behaviours			
Disrespects the law			
Withdrawn			
Depressed			
Happy			
Emotionally Expressive			
Spirituality			
Age Appropriate Communication Skills			

D) Concerns:

	Yes	No	Provide Details:
Eating Disorders			
Anti-Social			
Self-Harm			
Neglect/Abandonment			
Grief			

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Anger/Rage			
Shame			
Anxiety			
Depression			
Psychosis			
Sleeping difficulties			
Impulsive Behaviours			
Learning Difficulties			
Head Injury			
Developmental Delay			
FASD (suspected)			
FASD (diagnosed)			

***Please provide any assessments you may have for your client.**

Clients Interests:

	Yes	No	Provide Details:
Aboriginal traditional Practices			
Church Groups			
Sports/Physical Activity			
Arts & Crafts			
Music			

What are the youths observed/current positive coping mechanism:

1.	
2.	
3.	
4.	

Medical/Physical/Psychological History:

	Yes	No	Provide Details:
Health problem/Disability			
Seizures			
Hepatitis			
Diabetes			
Respiratory Conditions (i.e. asthma)			
Heart Conditions			
TB			
Physical Disability			
Psychological Disorders			

Hyperactivity / A.D.H.D			
Self-harm			

Prescription Medication:

Name of Medication	**Medication dosage**	**How long**	**Reason for Medication:**

Academic Information:

Is the youth in school (please circle one)	Yes or No	**Last attended regularly**:	
Name of School:		**Address:**	
Last grade completed:		**Functional Grade Level at Present:**	
Has your client been through an IQ psychological assessment (please circle one):			Yes or No

If yes, please send a copy when returning the referral package.

Any additional Comments:	

Present/Past Experience of Abuse:

a. Has the client ever experienced any of the following?

	Yes	**No**	**Provide Details:**
Physical Abuse			
Emotional Abuse			
Sexual Abuse			
Spiritual Abuse			
Neglect/Abandonment			
Physical Abuse			

b. Relationships:

With whom does the youth have significant relationships?	1.	
	2.	
	3.	
	4.	

Does the youth have close friends (please circle one):	Yes or No
If yes, does the youth abuse substances with these friends (please circle one):	Yes or No
Who does your client feel closet to?	

Family History:

a. Immediate Family Information:

Name of Family Member	Age	Relationship to client

b. Family Characteristics and Presenting Issues:

Notable Strengths with Family	Yes	No	Provide Details
History of Residential School Involvement			
History of Substance Abuse: Mother			
History of Substance Abuse: Father			
History of Substance Abuse: Guardian			
History of Substance Abuse: Siblings			
Family Traumas (losses, accidents, fires, suicide)			
Maintain spiritual/traditional practices: Mother			
Maintain spiritual/traditional practices: Father			
Maintain spiritual/traditional practices: Guardian			
Involved with Legal system: Mother			
Involved with Legal system: Father			
Involved with Legal system: Guardian			

C. Family Strengths:

Does the family communication well together? (please circle one): Yes or No

Does the family/ foster/guardian participate in Traditional/Cultural Activities together? (please circle one): Yes or No

Has anyone in the family attended treatment before? (please circle one): Yes or No

Family History of Mental Illness:

Is there a history of mental illness in the family (depression, PTSD, Schizophrenia, OCD, Anxiety,

(please circle one): Yes or No | **If yes, please provide details:**

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Consent to Treatment:

I, ___________________________, do hereby consent admission to attend the treatment Program at Night Wind Treatment Centres.

I agree to cooperate with the following:

__________ Medical and Physical Examination
__________ Laboratory Testing
__________ Prescribed Medical Care
__________ Psychological and/or Psychiatric Testing
__________ Treatment / Treatment Plan
__________ Family Treatment
__________ After Care Plan

I agree and consent to being transported to the appropriate referral agency for specified treatment and testing as may be necessary.

Client Signature:	
Signature of Parent/Guardian:	
Signature of Referral Agent:	
Date of Signing:	

AUTHORIZATION FOR TELEPHONE CONTACT

Clients admitted into Night Wind Treatment Centres are encouraged to have contact with family members whom are involved in their life and play a healthy influence on them. It is up to the case worker to provide us at Night Wind Treatment Centres an approved contact list for their client.

Please provide us with a few contacts with whom you would like your client to have telephone contact with.

Please be advised that you can add or remove contacts throughout your client's stay at Night Wind Treatment Centres. Also note that if you wish for your client to have telephone contact with a parent and/or siblings to be on speaker phone for safety, please advise us and we will do so until trust can be gained.

Name:	**Relationship to Client**	**Phone #**

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, __________________________, Parent or Legal Guardian of the said Youth _________________________, does hereby give my permission to release the following information:

___ Birth Certificates ___ Medical Records
___ School Records ___ Other Records, as required for Treatment

In respect of: ____
(Name of client)

____
(Date of Birth)

____
(Band & Treaty #, if applicable)

Guardian:	**Date:**
Referral Worker:	**Date:**

AUTHORIZATION FOR NON-PRESCRIPTION DRUGS

The Child Care Facilities (other than Foster Homes) Licensing Regulation requires that all non-prescription drugs be authorized by a qualified physician, dispensing pharmacist, or registered nurse prior to their administration to individuals in residential care.

Approval may be in the form of a written standing order, by completion of this form, or through verbal consultation with the physician or pharmacist. Verbal authorizations must be documented and retained on the resident's file.

The following non-prescription drugs may be administered to ______________________on an "as required" basis. (Client's name)

	Yes	**No**		**Yes**	**No**
Cough Preparations			Common Cold Preparations		
Antihistamines			Analgesics/Painkillers (Aspirin/Ibuprofen/etc.)		
Laxatives			Vitamins		
Others			Common Cold Preparations		

Indicate any known allergies:____ This authorization will be periodically revised as required.

Referral Worker/Guardian:	**Date:**

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PARENTAL PARTICIPATION

Family participation in the Night Wind Centres Program is highly recommended and encouraged. I,________________________________and ___________________________agree to participate with my child(ren) during their program at the Night Wind Centres upon request.

Client Name: _________________________________ **Birth Date**:______________________

Guardian:	**Date:**
Witness:	**Date:**

Note: In the event that parental participation is not available, please indicate who else may be available or interested in participating in the family portion of the treatment program.

CONSENT TO CONDUCT ROOM SEARCHES

I do hereby consent and authorize the Night Wind Treatment Centre's Staff to search the room of my child, ____, for the purpose of safety, with or without their presence.

Guardian:	**Date:**
Referral Worker:	**Date:**

INFORMED CONSENT TO VIDEOTAPE

My signature below means that the following points have been explained to me, and I agree with them and give my permission to be videotaped:

- I don't have to be videotaped and my counselling won't be affected if I refuse.
- I can change my mind at any time during or after the session.
- I have the right to review this videotape with my counsellor.
- This tape may be viewed during counselling supervision groups at Night Wind Treatment Centres (NWTC) as a way to help train counsellors.
- The tape will stay confidential within the supervision group at NWTC and will not be shown to anyone else.
- The original copy of this consent form will be kept in my records at NWTC. or my guardian may contact the NWTC at any time with questions or concerns.

Client:	**Date:**
Guardian:	**Date:**
Referral Worker:	**Date:**

CONSENT TO PHOTOGRAPH

Sometimes NWTC takes photos of the clients at various activities, for inclusion in displays or Student projects. (Client's names will not be included). We also require a recent picture for our emergency binder and client file. These photos will remain with file or be destroyed upon the client leaving the program.

Client:	**Date:**
Guardian:	**Date:**
Referral Worker:	**Date:**

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WAIVER AND RELEASE FORM FOR EQUINE RELATED ACTIVITIES					
Client/Participant Name:			**Date of Birth:**		
Address:		**City/Province:**		**Postal Code:**	
Phone Number:		**Medical Condition:**			

I understand that to a client of Night Wind Treatment Centre participating in equine-related activities there are inherent risks and I have full knowledge of the nature and extent of these risks. I acknowledge that equine-related activities and/or programs include the potential for injury.

I consent to participation in all related events and hereby waive liability, from any injury or loss occasioned by client, without limitation. I hereby request that the participant named above assumes the unavoidable risks inherent in all horse-related activities.

I have read and understood this release.

Print Name of Client/Participant:		
Signature of Client/Participant:		**Date:**
Print Name of Parent/Guardian:		
Signature of Parent/Guardian:		**Date:**
Signature of NWTC Staff:		**Date:**

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DESCRIPTION OF THERAPEUTIC SERVICES

Clinical services are guided by a psychologically current and culturally relevant model that speaks to NWTCs client's issues and needs.

Therapeutic Goals:

- Addiction Awareness
- Social awareness-Relationship building strategies and Social skills
- Develop positive self-concept and an Healthy sense of self
- Health education and healthy choices
- Parental re-attachment
- Emotional expression
- Communication and Problem-Solving Strategies
- Building empathy
- Grief and Loss
- Healthy Relationships

Therapeutic Approach:

- Client-Centered
- Trauma-informed care
- Creative Art Expression
- Culturally Informed Therapeutic Techniques
- Experiential Techniques
- Recreational Activities

Individual therapy occurs a minimum of once per week, often more depending on the client's needs. Each client participates in Group therapy four days a week.

All clients have the right to confidentiality and privacy and the right to refuse therapy. Each client is provided with informed consent during their first counseling session which outlines the boundaries around confidentiality at NWTC. Each client's therapeutic treatment plan and progress are managed by the clinical team which includes the NWTC staff Psychologist, Clinical Coordinator, Cultural Coordinator and Program Coordinator/Supervisor.

Print Name of Client/Participant:		
Signature of Client/Participant:		**Date:**
Print Name of Parent/Guardian:		
Signature of Parent/Guardian:		**Date:**
Signature of NWTC Staff:		**Date:**