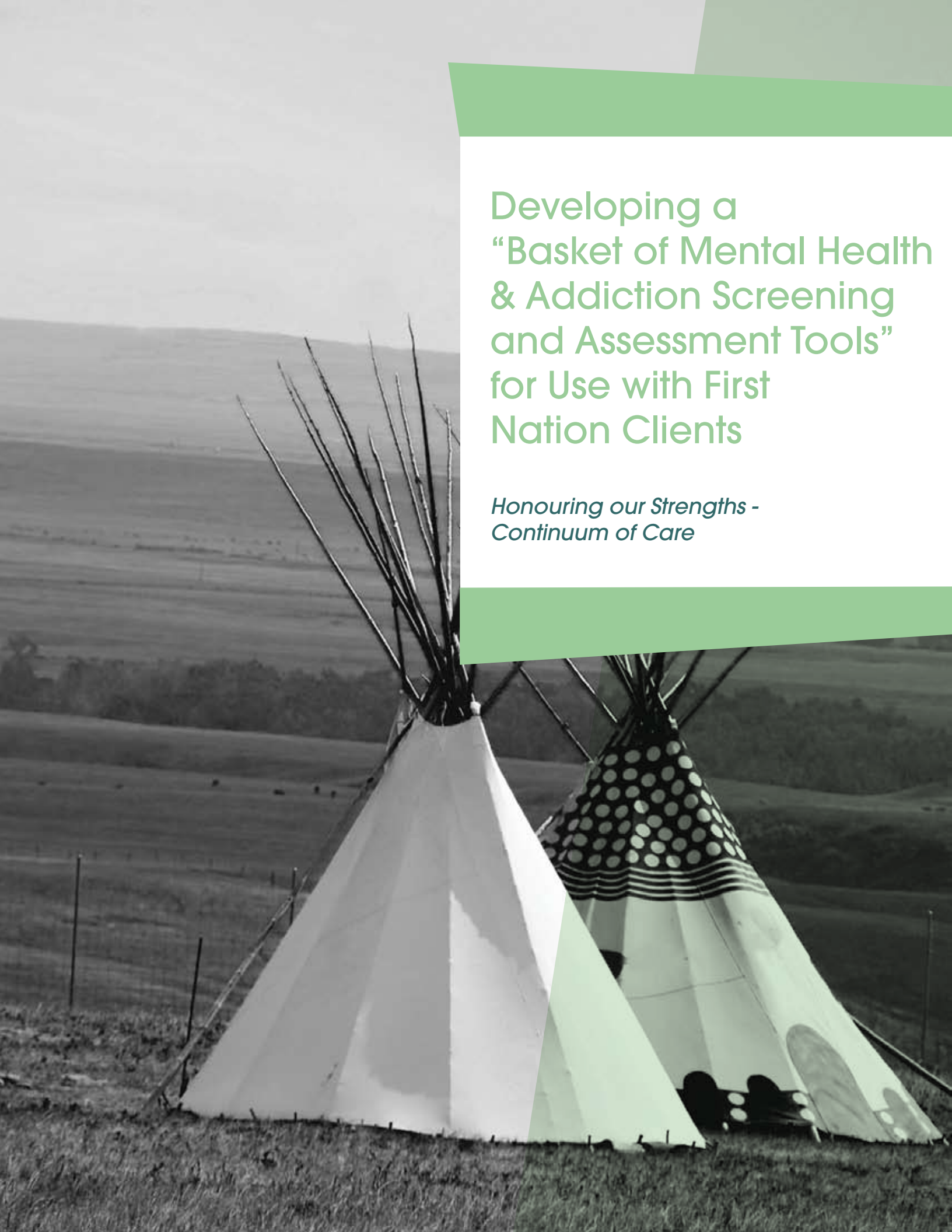

Developing a "Basket of Mental Health & Addiction Screening and Assessment Tools" for Use with First Nation Clients

Honouring our Strengths - Continuum of Care

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Objectives of the *'Basket of Tools'*

The goal of this project is to create a proposed standardized set of screening and assessment tools for NNADAP and NNYSAP workers that are (or could be adapted to be) culturally appropriate and diagnostically sound for use with First Nation clients. It is hoped that as the field reviews these proposed tools, workers across all levels of the care continuum will begin adopting them as core screening and assessment tools for use with their clients.

The over arching objectives for this project are:

• To provide a summary of a core set of screening and assessment tools to be utilized by NNADAP and NNYSAP practitioners; and,

• To promote standardized, clinical practices that will improve First Nations` substance abuse and mental health as outlined in *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada (2011).*

Target Population

The target client population for the 'basket of tools' are adult and youth1 First Nation and Inuit clients seeking and/or receiving services from community-based and treatment centre-level NNADAP/NNYSAP providers.

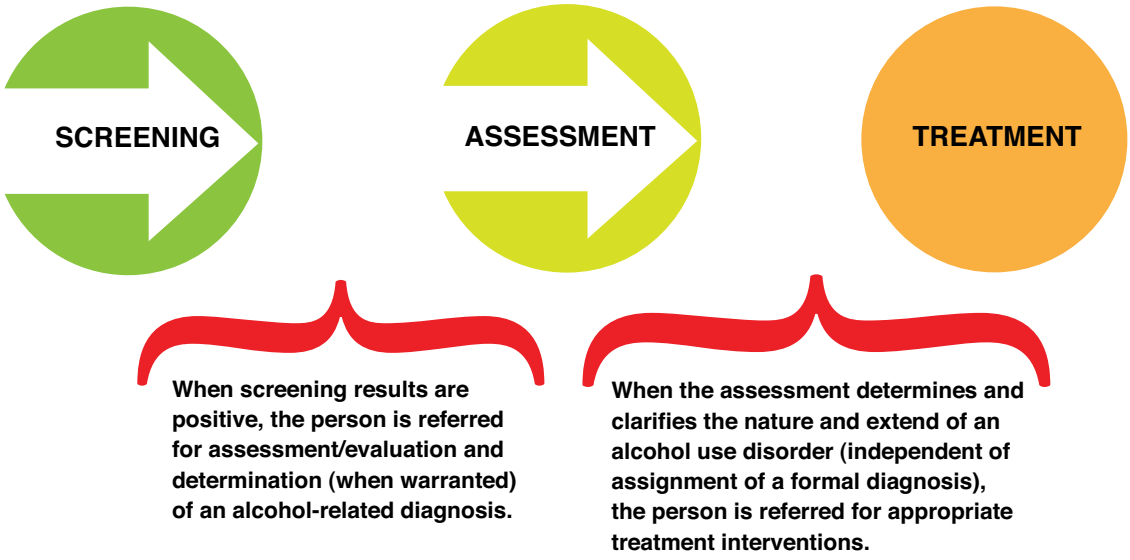
Screening

Screening is the first stage of intervention with individuals who are chemically dependent. Screening is a comprehensive appraisal of a person's alcohol or drug problem and how it affects their health and functioning. Screening is an essential service component for selecting treatment resources that best meet a client's needs and includes a determination of:

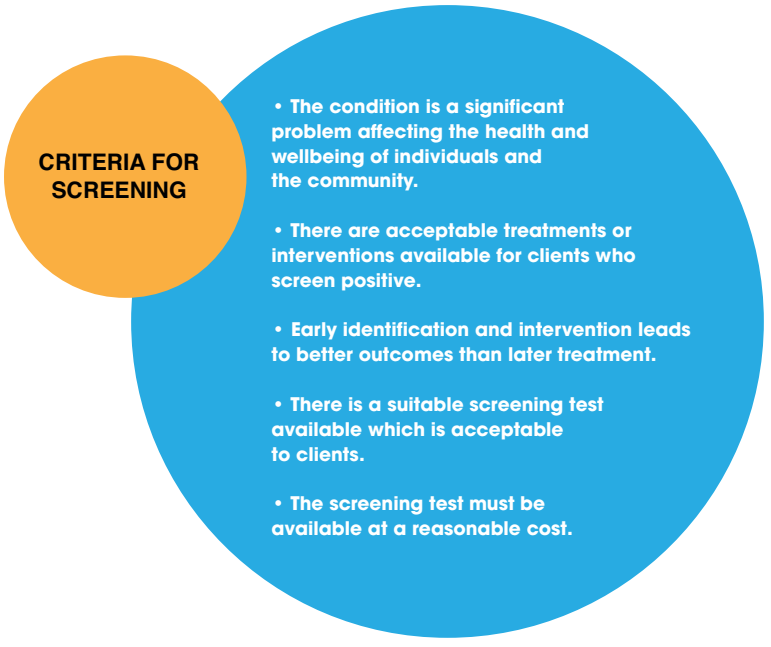
• Severity of the problem;
• Possible influences that have perpetuated chemical use, culminating in addiction;
• Related difficulties; and,
• An individual's perceptions of and attitude toward treatment.

Screening is key to effectively identifying an issue and ensuring that clients are matched with the most appropriate type and level of treatment.

The following process illustration (Allen et al, 2003); Connors and Volk (2004) demonstrates the inter-relatedness between screening, assessment, and treatment (alcohol-related) and how each informs the other:



The World Health Organization (WHO, 2010) states that "screening aims to detect health problems or risk factors at an early stage before they have caused serious disease or other problems, and is part of maintaining prevention practice activities in health care settings". The WHO has further identified a set of criteria for general practitioners (applicable to other care providers) for determining which conditions are suitable for screening:



[1] Tools highlighted for 'youth' are specifically targeting adolescents as they are the most vulnerable age group of those aged 18 or younger.
[2] From: http://www.kap.samhsa.gov/products/manuals/taps/11e.htm Treatment for Alcohol and Other Drug Abuse: *Opportunities for Coordination Technical Assistance Publication (TAP) Series 11*

From the literature, there are a wide range of process-based questions or processes that doctors and other health care providers are encouraged to follow during screening. For example, in *Screening and Brief Interventions (SBI) for Unhealthy Alcohol Use: A Step-by-Step Implementation Guide for Trauma Centers (2009)*, Higgins-Biddle et al. outline a progression of questions and observations the trauma (emergency department) physician should make when screening for an alcohol problem:

TO DELIVER AN APPROPRIATE INTERVENTION, WE NEED TO KNOW THREE THINGS ABOUT OUR PATIENTS.

1. Screen positive or negative
Does drinking create some risk for the patient or others should receive an intervention. Screening is an objective means to determine whether a patient requires such help; it is far more reliable than a staff judgement that a patient "looks like he drinks too much."

2. Problems
Can we connect a patient's drinking with something else considered a problem? The effectiveness of an intervention may be strengthened by connecting patients' drinking with something they recognize to be a problem, such as the injury or condition that lead to trauma admission or other problems they have reported themselves.

3. Likely Dependent
Is the patient likely alcohol-dependent? Knowing whether a patient is likely dependent on alcohol is important for guiding the patient in the right direction. For patients who are not likely dependent, a brief intervention will often be sufficient to help reduce drinking to safe levels. For example, for a patient who got drunk for the first time in two years, a referral to treatment is not advisable. For patients who are likely dependent, the goal of the brief intervention could assist them in finding and accepting more extensive help.

The Centre for Addiction and Mental Health defines screening as a process of testing to determine if a client requires further attention at the time of screening in regard to a particular substance abuse or mental health issue. As will be discussed later in the context of concurrent disorders, screening is also used to determine whether a client exhibits signs of a possible mental health or substance use problem that requires a more comprehensive assessment (Centre for Addiction and Mental Health, 2010).

Screening is not the same as assessment (CAMH, 2010). The key principle of screening is to identify the possibility of a substance abuse or mental health issue. Assessment gathers more detailed information on the nature, and extent of a problem as well as other information necessary to develop (with the client) an appropriate treatment plan.

As highlighted in many NNADAP renewal Regional Needs Assessment reports and of note here, screening (and assessment) tools and their use is primarily based on the western medical model: asking a battery of questions and making a diagnosis based on the client's responses. For First Nation and Inuit clients, because the initial meeting is engulfed in answering questions, i.e., completing the screening, they very often feel alienated as most screening tools neither address the emotional needs of the individuals nor attend to the clientís strengths or resiliency traits. Western-based screening tools and the "clinical" process employed by providers to complete them often leave First Nation and Inuit clients with a negative self-image.

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[3] It is not the number of questions or administration time that make one tool a screener and another an assessment instrument (CAMH, 2009). Some screening tools are more like that of comprehensive assessment tools due to their length and comprehensiveness in the coverage of disorders. Some assessment tools are briefer than some screening tools if they are focused on specific disorders, and the screening tool is multidimensional in its coverage. The authors further raise the importance of distinguishing between the screening or assessment tool and the screening or assessment process. "Calling something a "screening tool" does not make it one—it depends on how it has been developed, for what purpose, and how it is linked to further assessment processes that will confirm or disconfirm the screening results (CAMH, 2009)." In the context of the juvenile justice system, Grisso (2005) also states that some tools, whether they be screening or assessment, may work better for one process or the other. But the mere fact that a tool's author has labeled it a screening tool does not guarantee that it will serve all juvenile justice programs' needs for a screening process. "Screening and assessment provide the context within which we can decide what types of instruments can best accomplish the objectives of these two broad types of identification."

The Key Ingredients of a Screening Tool:

There are several considerations in selecting screening methods and instruments and conducting screening procedures. These should be deliberated carefully by those who will be endorsing or conducting screenings (McLellan & Dembo, 1992; Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination, *Technical Assistance Publication (TAP) Series 11*). Screening should also include an exploration of social determinants of abuse such as educational or job-related problems, relationship or family difficulties, past or current trauma experience, financial and legal issues, etc. If screening procedures indicate that substance abuse or dependency is probable, the individual should be referred for a more comprehensive assessment.

Key criteria for screening include:

• Screening should be conducted on persons recognized to be at risk, in a variety of settings, by a range of professionals;

•There should be collaboration among agencies and professionals on screening processes, techniques, and instruments;

• All instruments and processes should be sensitive to racial, cultural, socioeconomic and sex-related concerns;

• Initial screening procedures should be brief; and,

• Information should be gathered from various sources.

Stout and Jodoin (2006) succinctly describe the four "key ingredients" that mainstream research and clinicians deem essential for a valid and reliable screening and assessment tool. The strength of a tool is referred to as the psychometric properties". The psychometric properties of a screening and/or assessment is based on a statistical formula used to determine how a tool consistently measures what it says it will measure and the results are consistently accurate despite client differences. The *strength* of a screening tool is based on the following criteria:

1. Validity refers to how well a tool measures what it was designed to measure.

a. There are several measures of validity of which sensitivity and specificity are worth mentioning. Sensitivity, or "true positive rate," answers the question: How good is this test at picking up people who are truly at-risk? A screening tool with a sensitivity of 80% is picking of 80% of all people who are truly at risk and missing the other 20%. In a screening program, it is important to have the ability to identify as many individuals at-risk as possible; therefore the sensitivity of a tool is important.

b. Specificity, or "true negative rate," answers the question: How good is this test at correctly excluding people who are truly not at-risk? A screening tool with a specificity of 95% is correctly excluding 95% of all the people who are truly not at risk.

Stout and Jodoin note that screening tests are seldom 100% accurate, however, a screening tool is considered valid if it is proven to detect most people with the target disorder (high sensitivity) and exclude most people without the disorder (high specificity).

2. Reliability refers to how stable or dependable the results of a screening test are across administrations or respondents. There are various indicators of reliability of which test-retest reliability and internal consistency are worth mentioning.

a. Test-retest refers to the stability or consistency of results across different administrations at different points in time. It answers the question: Will the screening tool produce the same results if the same rater screens the same individual twice?

b. Internal consistency refers to the degree to which a tool's individual items contribute to measuring the same construct. It answers the question: Does a tool measure a specific content area? Internal consistency is often assessed by correlating performance on two halves of a test ("split-test").

The overall usefulness and accuracy of a screening tool is further narrowed to a discussion about screening vs. severity of dependence measures. As Dawe et al. (2002) note, there is a distinction between the usefulness of screening tools for the general population and those more suited for detecting issues of severity in people with an 'established dependence'. The authors describe their findings as follows:

1. Tools that screen for the presence of drug and alcohol abuse;
2. Tools that obtain a descriptive account of frequency and quantity of use;
3. Tools that assess the severity of dependence; and,
4. Biochemical measures.

Dawe et al. state that the decision regarding which type of tool to use depends on the assessment's purpose. Most screening tools are sensitive to low-level misuse of a substance, but are less sensitive to determining a range of use and dependence (i.e., they have a "ceiling effect"). Thus, screening instruments are most suitable for research in the general population and for detecting the presence of potential abuse and dependence. Conversely, measures of severity of dependence are often insensitive to low-level use and are more appropriately used with clients with established dependence and to monitor treatment outcomes. Frequency/ quantity measures are most useful clinically for diagnostic purposes and determining treatment goals.

As previously noted, there are a myriad of (mostly western-based) assessment instruments developed as tools for the assessment process. The essence of good assessment tools is that they measure what they say they measure and consistently provide the same results[4] (Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination, *Technical Assistance Publication (TAP) Series 11*). When assessment instruments are used, it is important to ascertain that research has been conducted to determine their validity and reliability on populations similar to those on whom the instrument will be used.

[4] http://goo.gl/W5pQ9

Assessment

The process of assessment can be referred to as "the glue that holds the treatment system together" (Author). An initial assessment identifies critical information that is used by the practitioner and client to make decisions about the next steps for treatment.

Assessments [6][7][8] are critical components of the care continuum and have the following characteristics:

• Providing information to clients about the link between their problems and substance use. The assessment process helps clients realize the role alcohol and other drugs play in their lives and examine the consequences of their use on important life areas;

• Providing motivational feedback to clients by providing a personalized individual profile of the assessment results. Individualized feedback presented in a motivational manner assists in engaging the client in treatment planning;

• Informing treatment planning, helping to match the appropriate level and intensity of treatment;

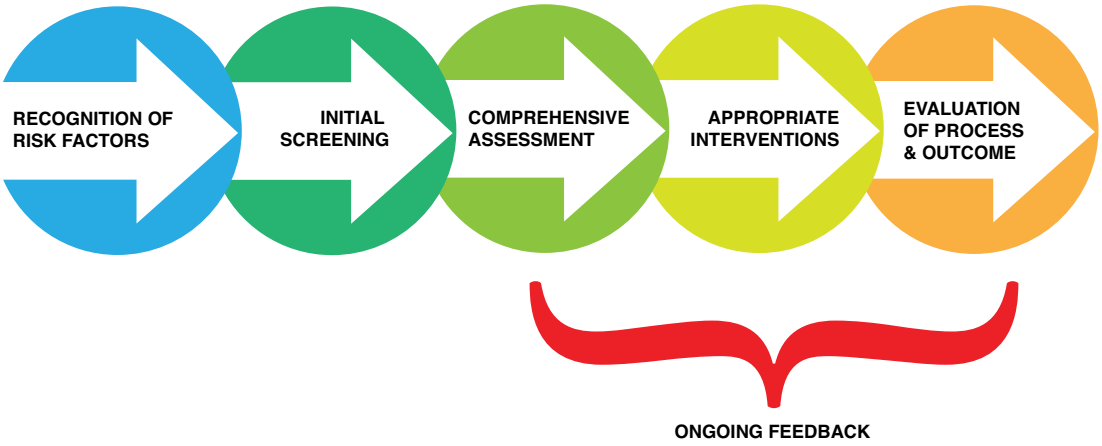
• Monitoring the treatment plan through ongoing assessment helps to determine whether clients should continue their current level of service or move to a different level; and,

• Gathering baseline levels of client functioning allows for comparison between the clients' levels of functioning at the onset of contact with the treatment system with their level of functioning at various points throughout their treatment and aftercare journey.

Key questions to ask when selecting an assessment tool are:

- What do you want to measure?
- What do you need to know about the client in order to develop an appropriate treatment plan?
- What are the key client characteristics (for example, culture, sex, age) you need to assess in order to determine next steps?
- What is the community/intergenerational context of substance use?
- Is the assessment tool trauma informed?

Assessments, unlike screening, are, or should be, ongoing actions throughout a client's treatment. As depicted below, a comprehensive assessment process consists of five consecutive stages:



Ongoing Feedback

The Schizophrenia Fellowship of NSW Inc.[9] (http://goo.gl/tWtOa) cautions that the implementation and use of screening and assessment tools are too often done so to the detriment of Aboriginal people. The Fellowship emphasizes that the key barrier in mental health assessment and service delivery is that practitioners fail to acknowledge Aboriginal worldview and the place of culture in the lives of Aboriginal people. The website author(s) state that services often fail from the outset because they do not acknowledge that indigenous people view mental health differently from the predominately white, mainstream European view. The western medical-model approach of diagnosing and treating a specific physical or mental problem of an individual is incongruent with needs of many indigenous people "who take a more holistic approach to mental health and social, emotional and spiritual well-being and who place a high emphasis on family and community input" (The Schizophrenia Fellowship of NSW Inc.).

The assessment process should also include the inclusion of information from a variety of sources - client, family member(s), notes and/or records from other service providers currently involved with the client, medical records, etc. When the information is collected, it is reviewed and evaluated by a trained professional. The information and the treatment professional's interpretation of it are then used to develop plans for treatment. Other people close to the client should

[5] For example, an instrument might be a valid and reliable assessment tool for white adult males, but it may not necessarily be useful for assessing adolescent females.
[6] Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. (SMA) 09-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration,2009.
[7] Youth Justice Board. Screening for Mental Disorder in the Youth Justice System Supporting Notes, 2003
[8] Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.
[9] New South Wales.
[10] From: http://www.kap.samhsa.gov/products/manuals/taps/11e.htm. Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination, Technical Assistance Publication (TAP) Series 11

also be interviewed in the assessment process - i.e., people who are, or have been, associated with the person being assessed. Sometimes referred to as "collateral sources,"[10] these individuals should be asked to provide descriptive information rather than to form judgments about the person. As with patient interviews, information received is not always accurate. Possible collateral sources include family members, peers, teachers, employers, and others who might have helpful information.

A key advantage of using standardized instruments is that information regarding their reliability and validity may be available. If an instrument has high validity, it will accurately measure what it intends to measure. An instrument that has high reliability will produce stable results; the test's outcome will not be significantly influenced by fluctuating or extraneous factors (such as a person's mood or the time of day). The instrument should be *normed*, or validated, with a population similar to those with whom it will be used.[12] However, even when the credibility of these tests has been proved, test outcomes may be affected by other factors, including:

- Attempts by individuals using them to "slant" the outcome by deliberately answering questions incorrectly;
- Ability of individuals to read and understand the test items;
- Motivation of persons to take the test seriously; and
- Cultural sensitivity of the test.

The assessment process is likely to be most helpful and informative when a variety of techniques are used. Testing instruments are a tool to guide decision-making efforts. As with all other techniques, the limitations of these tests must be realized. Staff members who are given the responsibility of administering and interpreting them should be fully trained.[13]

The continuum of screening-assessment-treatment is represented by a progressive set of issues and for each issue there are corresponding questions to be asked at each stage. It is important to also mention the context of the client/counsellor therapeutic relationship in the continuum. The client/counsellor relationship is the forum where screening and assessment generally occurs, and it is the place where individual and cultural biases and the domination of mainstream theories and practices exist. For First Nation and Inuit clients just entering substance abuse and/or mental health services, this can be the beginning of a series of misdiagnosis, racism and stigma. Such setbacks can be attributed to the lack of acknowledgement of culture, family/community issues and inter-generational trauma, and by service providers narrowly defining individual experience as separate and distinct from the social determinants of health. As such, the role of the counsellor becomes a significant issue in the screening and assessment process.

There are standardized testing instruments available to assess individuals in a variety of areas. When selecting these tools, consideration should first be given to the areas to be assessed and options should be limited to instruments designed to address those areas.

The following factors should be considered in reviewing the various assessment tools:

- Ease of use;
- Expertise and time required of staff to administer and score test;
- Training required to administer and score the instrument, and whether or not such training is available;
- Possibility of bias (cultural or in administration of the test);
- Validity (Have studies proved that it accurately measures what it was intended to measure?);
- Reliability (Have studies shown that if the test were repeated with the same person, the results would be the same?);
- Credibility of test among members of the judiciary and treatment professionals;
- Adaptation of test to management information system input and retrieval;
- Whether the test has been normed with a population similar to the client group;
- Availability of test in languages other than English;
- Motivation level, verbal and reading skills required of persons to be assessed;
- Propensity for test to be manipulated; and,
- Average cost per test.

The Need for Culturally Appropriate Tools

The foregoing discussion on screening and assessment is most relevant to how western science and western-based practitioners have defined the key ingredients of a "good screening or assessment tool". A crucial omission from this western bias is the overall lack of acknowledgement of the role of First Nations and Inuit culture.

The focus of the western biomedical model is the individual, whereas First Nations or Inuit people perceive health and wellness, including issues of substance abuse and mental health, as connected parts, part of larger holistic way of life where individuals are part of and affected by family, community, culture and the intimate and intricate connection to the land. If a First Nations or Inuk person is dealing with a substance abuse or mental health issue, it is indicative of an imbalance between the person's physical, mental, social or spiritual life which must also be considered within a First Nations or Inuit definition of the social determinants of health and the historical context of such. As affirmed in *Honouring Our Strengths* (2011), First Nations-specific social determinants of health – the revitalization of culture, language, family, community, connection to the land, etc., play an integral role in reducing the extent of substance use issues. The acknowledgement of the need for and use of culturally-specific and culturally appropriate screening and assessment tools for mental health and addiction issues, together with more services and service integration is necessary to meet the needs of clients and communities.

[10] From: http://www.kap.samhsa.gov/products/manuals/taps/11e.htm. Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination, Technical Assistance Publication (TAP) Series 11

[11] From: Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination, Technical Assistance Publication (TAP) Series 11.

[12] For example, an instrument used with adolescents should be normed on other adolescents. An instrument to be used with criminal offenders should have been normed on other offender populations.

[13] This underscores the necessity, especially in remote regions and the North, to have the requisite training resources available to NNADAP/YSAP and other substance abuse and mental health workers/practitioners.

Much of the Aboriginal-led research from Australia, New Zealand, and Canada stresses that screening and assessment tools developed from a western, biomedical model seldom acknowledge the cultural aspect of Aboriginal people. For example, many participants attending the Atlantic Chiefs *Health Priority Planning Session* (2011) stated that there is an urgent need for the development of a 'culturally safe tool/process to identify and screen individuals at risk'. One participant stated the need to (referring here to mental health):

> "Develop and use a culturally appropriate screening tool. Teach community workers and members to recognize mental health risks. Increase awareness of services: Mental health services community user's guide. Develop a tool or mechanism/process to identify and screen community members at risk that is culturally safe and appropriate."

Indigenous scholars and practitioners in the area of mental wellness in Australia and New Zealand have long emphasized that assessments, especially for mental health problems, are largely inappropriate for indigenous clients due to the following: (O'Shea 1996)

- Failure to recognise indigenous views of mental health;
- The use of non-indigenous cultural standards to evaluate the appropriateness of behaviour;
- The use of inappropriate tools and diagnostic criteria; and,
- Lack of understanding of language or specific language variations, including recognition of expressions, slang and colloquialisms.

Australia and New Zealand indigenous research further underscores that assessment and treatment services can be more effective and appropriate if they incorporate the following principles:

- Take into account the holistic view of mental health and social, emotional and spiritual well-being, including the importance of community well-being;

- When treating or supporting an indigenous person with a mental illness, the clinician should be prepared to acknowledge and address other issues that are important to and impact upon that person, such as trauma and loss The clinician should be aware of these issues, but ensure that the individual is determining what is important;

- Do not make generalisations and assumptions about Indigenous people, as there are many indigenous groups, with varying cultural issues;

- Be receptive to requests to incorporate traditional treatments into mental health services, especially when the community perceives the person's unusual behaviour (such as hallucinations) as a normal reaction to spiritual matters;

- Conduct assessment, diagnosis and treatment within the community as far as possible. Relationships and context are important to Indigenous people yet often assessment and treatment is conducted far from home and family; and,

- Support Indigenous peoples' right to self-determination in mental health care processes by:

- employing indigenous health workers to liaise between communities and mental health services (accessing indigenous expertise and knowledge)

- providing cultural awareness training for non-indigenous mental health workers

- educating and training indigenous health workers in mental health issues

- training indigenous workers to educate non-indigenous health workers

- including/involving indigenous people with schizophrenia, their families and carers, and other community members in training and education programs.

The centrality of culture and the need for culturally appropriate assessment tools came to the forefront in an evaluation of Ontario's Common Assessment of Need (OCAN)[14]. The OCAN is an assessment tool for gathering comprehensive and consistent individual client information from across Ontario's community mental health services system. Feedback on the effectiveness of the OCAN for some First Nation clients was gathered from staff from the James Bay Community Mental Health Program, N'Mninoeyaa Aboriginal Mental Health Services and Noojmowin Teg Health Access Centre. Sutherland and Maar (2010) state that regardless of cultural differences and mental health service models across the three participating First Nation agencies, participants identified several consistent issues related to the OCAN:

- While a common assessment tool was supported by providers, such a tool must be able to address trauma and abuse history and related need for services of Aboriginal clients;

- A common assessment tool must be culturally safe;

- In order to prepare mental health workers to complete an assessment tool with Aboriginal clients, there is a need for culturally specific, realistic case scenarios to be used during the worker training sessions;

[14] The OCAN is comprised of the Camberwell Assessment of Need (CAN-C) and additional data elements. The OCAN tool covers 24 domains or areas of a person's life (i.e., Accommodation, Self-care, Daytime Activities, etc.) that assess the client's current life situation. It also covers the level of informal (e.g. family and friend) and formal (e.g. service provider) support that clients currently receive and further need. This tool allows key information to be gathered quickly from both the client and clinician (service provider) while also ensuring consistent assessment practices are used across Ontario.

• Specific to OCAN, several questions include the terms and language that are not commonly used should be rephrased for Aboriginal clients;

• Several sections of the OCAN appear to be neither reliable or valid in Aboriginal populations, because of cultural, language and literacy differences, the questions are interpreted differently;

• Lack of integration of provincial and federal mental health services is a significant barrier to realize the potential benefits of a common assessment tool;

• Several domains were consistently described as problematic within Aboriginal communities; and,

• OCAN has not been validated in Aboriginal communities in Canada, nor any other Indigenous communities.

Almost all participants in the evaluation stressed the need for an Aboriginal-driven process to further develop an assessment tool that better reflects the Aboriginal populations for which it may be used, by incorporating the following aspects:

• A culturally safe assessment protocol that is designed in concert with the community being served, is more reflective of the Aboriginal patient journey which would assist in determining how, when and with whom the tool would be administered;

• Refinements to the tool's overall design to render it less of an intrusive, linear succession of questions to one more in keeping with a holistic medicine wheel approach;

• Reorientation from an 'assessment tool' focused on needs and unmet needs to a more strengths-based "personal wellness inventory"; and,

• Improvements in specific domains such as transportation, sexual expression, housing, money and access to a telephone to better reflect Aboriginal cultural, geographic and community realities.

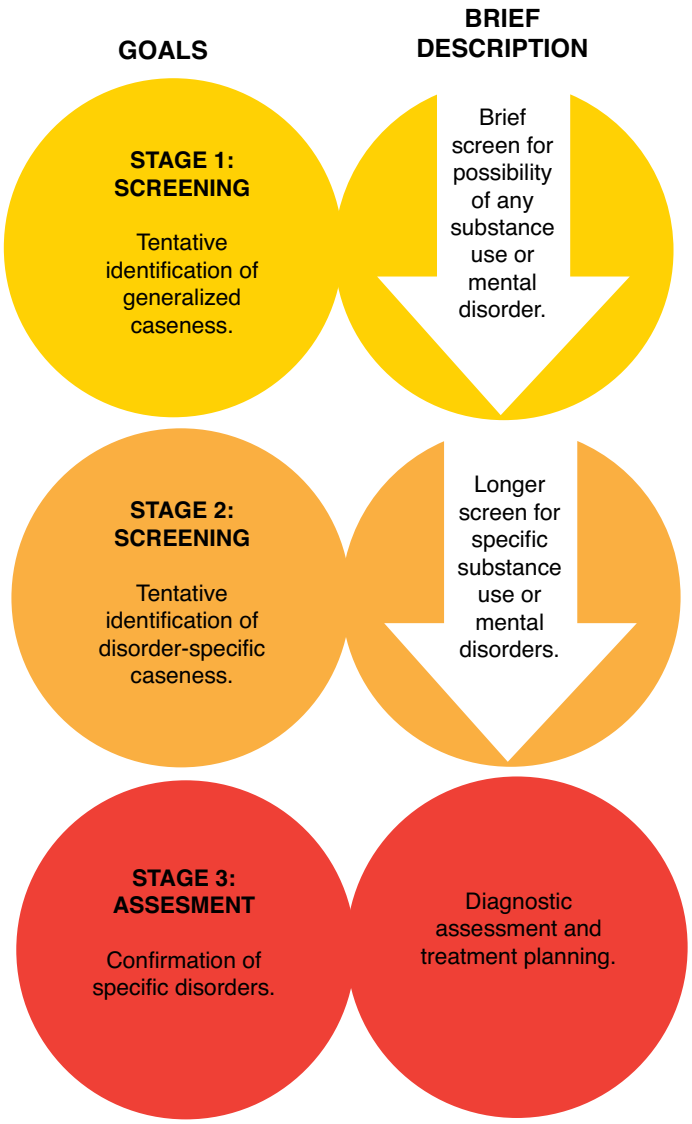
Screening & Assessment Tools for Concurrent Disorder Issues

Concurrent disorders or co-occurring issues is a condition wherein a person is experiencing an addiction and a mental health issue simultaneously. Dr. Brian Rush (2002) defines concurrent disorder as "the co-occurrence of at least one mental disorder and at least one abuse of, or dependence on, a substance as defined by the DSM-IV". For some people, the addiction may have been brought on by an underlying mental health problem, or, someone may be experiencing a mental health problem brought about by substance abuse. Research indicates that a significant proportion of clients entering the addiction, mental health, and other health care sectors across the country have a co-occurring or concurrent disorder.

Screening and assessing people with a concurrent disorder is often complex and the complexity is confounded by the fact that there exists no single screening tool for concurrent disorders that is appropriate for all substance use and mental health settings (CAMH, 2006). For many agencies and clinicians, this has meant adding new components to their current work. For agencies whose focus is substance abuse, this often requires adding a mental health screening process to the screening procedures already in place. Mental health service providers are now adding substance abuse screening to their existing screening procedures (CAMH, 2006).

Screening for Concurrent Substance Use and Mental Health Problems in Youth (CAMH, 2009) depicts the staged approach to screening and assessment as:

FIGURE 1: A STAGED APPROACH TO SCREENING AND ASSESSMENT.



CAMH (2006) proposed the use of screening and assessment "Roadmaps" when working with clients with potential concurrent disorder issues. Such tools at specific junctures in the screening and assessment process provide a common approach to screening. CAMH argues that agencies should screen for concurrent disorders because:

• They can best help clients when they have more complete information about their problems;

• The prevalence of concurrent disorders in mental health and substance use clients is very high;

• Routine screening is increasingly recommended in Canada and beyond;

• More complete clinical information - screening for concurrent disorders gives a fuller picture of a client's issues, which allows the clinician to begin to serve all the person's clinical needs; and,

• An undetected co-occurring problem can have many negative effects on a client and their family members. Clients may be repeatedly "bounced" between the substance use and mental health systems, or may frequently visit the emergency department or be hospitalized.

- More specifically, an undetected co-occurring problem can interfere with a person's ability to carry through the treatment plan.
According to researchers at CAMH, mental health services are more likely to see people with serious mental illness such as schizophrenia or bipolar disorder, while addiction service providers are more likely to see people with mood, anxiety or personality disorders. A history of trauma, and the persistence of symptoms related to the trauma, is also very common among clients with mental health or substance use issues. According to CAMH (2006), between 25% to 66% of people in treatment will have histories of trauma, though not all people who have experienced trauma will develop symptoms of post-traumatic stress disorder. For women, the experience of physical and/or sexual violence, mental health problems and substance abuse is a significant issue.

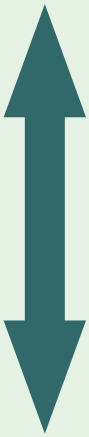
As with screening tools in general, the most useful aspects of a screening tool for concurrent disorders are:

• Brief;
• Valid and reliable; and,
• Sensitive and specific.

As opposed to using a staff rating or simple question framework, using an actual screening tool provides more objective measures of possible substance abuse or mental health problems (CAMH, 2006). More importantly screening tools can be standardized across agencies and between the mental health and substance use systems, thus helping to ensure that clients with concurrent disorders will be identified and provided appropriate services.

Screening tools for concurrent disorders can be either dimensional or diagnostic (CAMH, 2006). A 'dimensional tool' such as the Global Assessment of Individual Need – Short Screener (GAIN-SS) measures the quantity, degree or frequency of a parameter (e.g., substance use, mental health, use of treatment services). Diagnostic screening tools map onto diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders – IV (DSM- IV) and serve to indicate whether a psychiatric disorder is likely to be present or absent. An example of a diagnostic tool is the Psychiatric Disorders Screening Questionnaire (PDSQ).

CAMH (2006) has developed the following roadmaps to effectively screen and assess for concurrent disorders: The roadmap below is for use in mental health agencies (the assessment and treatment planning tools noted in the Options Column are examples only):

STEP	QUESTION/ISSUE	OPTIONS
SCREENING 	Is there evidence of a possible substance use problem that requires further investigation?	• Staff rating based on all available information • Brief substance use questions • CAGE-AID GAIN Short Screener • (GAIN-SS) • GAIN Substance Use Disorder Scale (GAIN- SUDS) • Psychiatric Disorders Screening Questionnaire (PDSQ)– alcohol/drug subscales • AUDIT (alcohol only) • Also ask about lifetime and past year use of all substances
ASSESSMENT 	Is the person in crisis or experiencing withdrawal symptoms?	• Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CiWa)
	How serious is the problem? Abuse versus dependence?	• Alcohol Dependence Scale (ADS)
	What is the extent, pattern for substance use/abuse?	• Drug History Questionnaire (DHQ) • Timeline-FollowBack • Addiction Severity Index (ASI)
	What is the effect on mental health symptoms and compliance? What is the payoff matrix? Biopsychosocial issues?	• Client History • Mueser's payoff matrix • Biopsycholosocial dimensions
	Are mental health symptoms substance-induced?	• Mental health treatment history and response to reduction in substance use
TREATMENT PLANNING	What would be the appropriate way to structure treatment?	

The roadmap below is intended for use by substance use agency providers (the assessment and treatment planning tools noted in the Options Column are examples only).

SCREENING	Is there evidence of a possible mental health problem that requires further investigation?	• Staff rating based on all available information–ABC Checklist • Brief mental health questions • GAIN Short Screener (GAIN-SS) • Modified Mini Screen • K6 • Addiction Severity Index (ASI) psychiatric subscale • Psychiatric Disorders Screening (PDSQ)
ASSESSMENT	Is the person in crisis?	Establish risk of suicide, intake history and observation
	What is the nature of the mental health problem?	Structured psychiatric interview (DSM-IV)
	How severe is the problems/symptoms?	• Symptom Check List-90 Revised (SLC-90) • Brief Psychiatric Rating Scale (BPRS) • Disorder specific tests, e.g., Beck Depression Inventory-II
	How do the mental health symptoms interact with the substance use and related probems? Biopsychosocial issues?	• Client histories and behavioural and functional analysis • Multnomah Community Ability Scale (MCAS) • Behaviour and Symptom Identification Scale (BASIS-32/24) • Quality of life scales, e.g., Wisconsin Quality of Life Provider Questionnaire • Mueser's payoff matrix
	Are mental health symptoms substance-induced?	• Mental health treatment history and response to reduction in substance use
TREATMENT PLANNING	What would be the appropriate way to structure treatment?	

The roadmaps include options that may in some contexts be considered assessment or treatment planning tools. As noted by CAMH, the focus of the roadmaps is on screening – the first step of client engagement. The second and third steps help to reinforce the role of screening in the context of the continuum of screening, assessment and treatment planning. Regardless of service provider, when using a formal screening tool, clinicians should be aware that contextual issues can affect the results, including:

- The way the client is instructed to complete the tool;
- The setting in which the screening takes place (e.g., the level of privacy);
- The trust and rapport between the client and the clinician; and,
- The client's level of distress at time of screening.

The report *Best Practices, Concurrent Mental Health and Substance Use Disorders* (Health Canada, 2002) also notes that few assessment measures have been assessed for their reliability and validity with people with concurrent disorders. Authored by CAMH, this report proposes the use of the following tools when working with clients with a concurrent disorder:

- The Addiction Severity Index (ASI) - a commonly used ; standardized assessment tool among substance use providers;

- Assessing Stage of Change and Treatment Motivation – recommended for the assessment of individuals with concurrent disorders to evaluate their motivation for change, including the stage of change and/or the individual's stage in the treatment process;

- Assessing Psychosocial Functioning - both mental health and substance use assessment must look at the broader psychosocial functioning of the person including such basic needs as housing, access to food, social supports, work, education, etc. This also includes assessment of high-risk behaviour for HIV, violence and victimization, etc. The most comprehensive protocol for the assessment and classification of social functioning is the Person-in-Environment System (PIE). Developed by the social work profession, this assessment tool is consistent with the broad bio-psychosocial perspective of addictions and mental health. The PIE complements the diagnostic-based assessment process underlying DSM-IV by focusing separately on factors related to social functioning (e.g., family, friendships, community, etc.) and environmental problems (e.g., access to food, housing, employment) and subsequently incorporating mental and physical health diagnosis. Clinician ratings of severity, duration and coping are included in the system; and,

- The Global Assessment of Functioning Scale (GAF) is another tool for determining assessment of functioning. The GAF requires a clinician familiar with a client to rate the client's overall level of psychological, social, and occupational functioning on a scale ranging from 1 to 100. The GAF can be completed with reference to varying time periods (e.g., currently, highest level of past year) and it constitutes the operationalization of Axis V of the DSM-IV multiaxial assessment.

Screening tools used with youth with concurrent disorders remain a controversial issue among many clinicians. According to Chaim and Henderson (2009), co-occurring mental health and substance use disorders in youth are associated with poor outcomes in adulthood, however effective and efficient screening, assessment and treatment approaches for youth especially are just now emerging. Despite the lack of strong tools and processes for working with youth with concurrent disorders, concerns about concurrent disorders in youth are being identified in services across sectors including child welfare, youth justice, mental health, addictions, education, health care, housing and other social service agencies. In order to adequately address the issues of this population, the authors propose the use of the GAIN-SS as a screening tool. The GAIN SS is an integrated screening tool with the following characteristics:

- Screens for both substance use and mental health issues;
- It is brief (five to seven minutes to complete);
- It can be self-administered; paper and pencil or computer;
- The GAIN-SS has been validated for 10+ years (including adult); and,
- It is low cost: $100 for a 5 year license that can include multiple agencies.

It is important to note however, that conclusions reached regarding the use of the GAIN-SS, the ethnic distribution of youth who participated in the study included only 5.1% who identified as Aboriginal (inclusive of urban and not specific to First Nation or Band affiliation).

Suggested NNADAP/NNYSAP Basket of Screening and Assessment Tools

The following suggested screening and assessment tools have been selected based on an extensive literature review as well as feedback from the *Summary Findings of Summary Findings from NNADAP/YSAP Community & Treatment Centre Screening & Assessment Tools Questionnaires* (2012) and members of the NNAPF's Community of Practice. The purpose of developing this 'basket of tools' is to provide a standardized package of tools for use by NNADAP and NNYSAP staff at both the community and treatment centre-level. The implementation and use of standardized screening and assessment tools across the NNADAP/NNYSAP system will encourage the use of a common language for service delivery and treatment, thus providing a more cohesive and seamless client-centered continuum of care.

Screening Tools for Consideration

Adolescent Alcohol and Drug Involvement Scale (AADIS)

The AADIS is a 14-item screening tool that measures and evaluates adolescent drug and/or alcohol misuse. The AADIS takes 5-15 minutes to complete by self-report or during a clinician interview. The instrument is in the public domain and can be accessed at: http://goo.gl/tSiGC

The ASSIST

The ASSIST is an 8-item questionnaire designed to be administered by a health worker using paper and pencil and takes about 5-10 minutes to administer. The ASSIST was designed to apply across a variety of cultures to screen for use of:

- tobacco products
- alcohol
- cannabis
- cocaine
- amphetamine-type stimulants (ATS)
- sedatives and sleeping pills (benzodiazepines)
- hallucinogens
- inhalants
- opioids
- 'other' drugs

The ASSIST determines a risk score for each substance which is used to start a discussion (brief intervention) with clients about their substance use. The score obtained for each substance falls into a lower, 'moderate' or 'high' risk category which determines the most appropriate intervention for that level of use ('no treatment', 'brief intervention' or 'referral to specialist assessment and treatment' respectively). The ASSIST obtains information from clients about lifetime use of substances, and use of substances and associated problems over the last three months. The tool can identify a range of problems associated with substance use including acute intoxication, regular use, dependent, or 'high risk' use and injecting behaviour.

The ASSIST comprises the following questions:

Question 1 asks about which substances have ever been used in the client's lifetime.

Question 2 asks about the frequency of substance use in the past three months, which gives an indication of the substances which are most relevant to current health status.

Question 3 asks about the frequency of experiencing a strong desire or urge to use each substance in the last three months.

Question 4 asks about the frequency of health, social, legal or financial problems related to substance use in the last three months.

Question 5 asks about the frequency with which use of each substance has interfered with role responsibilities in the past three months.

Question 6 asks if anyone else has ever expressed concern about the client's use of each substance and how recently that occurred.

Question 7 asks whether the client has ever tried to cut down or stop use of a sub-stance, and failed in that attempt, and how recently that occurred.

Question 8 asks whether the client has ever injected any substance and how recently that occurred.

Population Groups:

Validated for use in adults between 18 and 60 years of age. The authors state that the ASSIST tool has shown good cross-cultural neutrality and is feasible for use with adolescents (World Health Organization, 2010). The authors further note that 'the style and content of the current instrument as well as the cut-off scores that determine whether a client is 'lower', 'moderate' or 'high' risk may not be appropriate for use with adolescents' (World Health Organization, 2010).

Administration:

The ASSIST can be completed in about 5-10 minutes and can be incorporated into a normal primary care and/or general intake consultation. Alternatively, it may be administered by another staff member while the client is waiting to see the health worker.

The AUDIT - Alcohol Use Disorders Identification Test

The AUDIT is a 10-item questionnaire that screens for hazardous or harmful alcohol consumption.

Population Groups:

The AUDIT has been used with a variety of populations, including adult men and women, students, psychiatric clients, emergency room patients and people involved with the legal system. It has also been used in a variety of countries and has been deemed suitable for use with a range of cultural groups, including Aboriginal clients.

Administration, scoring and interpretation

The AUDIT can be administered by frontline and primary health care professionals. The World Health Organization states that even though a score of 8+ indicates an alcohol use disorder, psychometric measures suggest that a lower cut-off score of 4+ would be appropriate for women as, according to the authors, women experience alcohol-related damage at lower levels than men. A lower cut-off score is also appropriate for adolescents.

Website

The AUDIT manual, The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, can be downloaded at: http://www.who.int/substance_abuse/publications/alcohol/en/

CAGE-AID

The CAGE-AID is a four-item screening tool:

- Have you ever thought you ought to ***cut down*** on your drinking or drug use?

- Have people ***annoyed*** you by criticizing your drinking or drug use?

- Have you felt bad or ***guilty*** about your drinking or drug use?

- Have you ever had a drink or used other drugs first thing in the morning (***eye-opener***) to steady your nerves, get rid of a hangover or get the day started?

The CAGE-AID was adapted from the original CAGE (designed to detect problem drinking). The CAGE-AID asks about lifetime use.

Population Groups:

- The CAGE-AID is appropriate for use with adults and adolescents over 16 years of age.

Administration, scoring and interpretation

- The CAGE-AID can be administered by an interviewer, self-administered in pencil-and-paper format or computer administered

- Takes two minutes or less to administer

- Does not require prior training

- A score of two or more "Yes" answers indicates that the client may be using substances at harmful or hazardous levels and needs a more comprehensive assessment.

Website

For more information about the CAGE-AID, go to: http://lib.adai.washington.edu/instruments/

Drug Abuse Screening Test (DAST)

The DAST is a 20-item screening instrument designed to identify individuals who have had a drug abuse problem (excluding alcohol) in the past 12 months. It includes some features of the dependence syndrome such as inability to abstain, withdrawal symptoms, and a range of social and emotional problems associated with drug misuse.

Population Groups:

DAST is based on the Michigan Alcoholism Screening Test. The tool has had limited use with Aboriginal (Australian) individuals.

For further Information:

For more information on the DAST and cost, please go to The Centre for Addiction and Mental Health's website at:
http://goo.gl/9UoM4

Or, visit The European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) website for a more detailed description of the tool and sample forms:
http://www.emcdda.europa.eu/html.cfm/index3618EN.html

Drug-Taking Confidence Questionnaire (DTCQ-8)

The DTCQ-8 measures a client's confidence in their abilities to cope in situations that are high-risk for substance use. The tool yields information about client strengths and needs in the area of relapse potential. The tool allows for exploration of a client's relapse potential by not only identifying potential high-risk situations for that person, but also by exploring his or her level of confidence in being able to cope with a particular high-risk situation.

The eight high-risk situations of high-risk for relapse fall into two major classes of situations:

- Personal states; and,
- Situations involving other people.

The category 'personal states' refers to internal states, both physical and emotional (thoughts and feelings) and includes five situations:

- Unpleasant emotions;
- Physical discomfort;
- Pleasant emotions;
- Testing personal control; and,
- Urges and temptations.

The other category, 'Situations involving other people,' refers to challenging situations that involve others:

- Conflict with others;
- Social pressure to drink; and,
- Pleasant times with others.

Some people find one class of situations more challenging than the other.

Population Group:

- Adults

Administration

The DTCQ-8 has separate questionnaires for alcohol and other drugs. During the assessment, up to three substances can be recorded on separate forms. The drug types are:

- Alcohol
- Cannabis
- Cocaine
- Hallucinogens
- Heroin
- Sedatives
- Hypnotics
- Solvents
- Stimulants
- Tranquillizers
- Other narcotics

If the substances of concern are drugs, the DTCQ-8 for Drugs provides a line for the counsellor to insert the name of the drug. The instructions at the top of the page direct the counsellor to ask the client to "imagine yourself as you are right now in each of these situations." The sentence that precedes each of the statements is shown just above the rating scales. Clients say to themselves, "I would be able to resist the urge to drink heavily if I (were in such and such a situation]" and then choose the level of their confidence for this statement. It is the client who defines "heavy" drinking.

Regarding Treatment Planning

Initial assessment

- The counsellor needs to provide sufficient interpretation of the DTCQ-8 results to the client and other members of the treatment team so that the information can be used to develop the most appropriate treatment plan.

- For some clients, the global Self-Efficacy Score is all they need to understand their risk of relapse. For other clients, considering risk of relapse as a situation-specific phenomenon is a new way of thinking. With these clients, it might be helpful to go into more detail when discussing the results of the DTCQ-8.

- This may be the first time a client has thought about relapse as a process she or he is able to comprehend and perhaps grapple with in treatment. Understanding more about personal high-risk situations may be a motivating factor for a client to enter treatment.

Regarding treatment service

The results of the DTCQ-8 can also be used by the treatment service to provide greater detail for an in-house treatment plan for the individual participating in treatment. The more detailed interpretations of the clinical profiles are useful in order to focus relapse prevention work on an individual client's specific high-risk scenarios.

For further information:

To learn more about the DTCQ, including cost and how to administer the tool, visit the Centre for Addiction and Mental Health's website at: http://goo.gl/ZhGxn

Drug Use Screening Inventory (revised) (DUSI-R)

The DUSI-R measures severity of problems in 10 domains:

1. substance abuse
2. psychiatric disorder
3. behaviour problems
4. school adjustment
5. health status
6. work adjustment
7. peer relations
8. social competency
9. family adjustment
10. leisure/recreation

In addition, the tool contains a lie scale and documents drug and alcohol use, preferred substance, and substance with which they report the greatest problem. The output is in the form of two profiles: (1) a profile indexing absolute severity of disorder (0 to 100 percent); and (2) a relative problem index ranking the order of severity in the 10 domains. An overall problem density score, ranging from 0 to 100 percent, documents severity of maladjustment. The DUSI-R is used for measuring current status, identifying areas in need of prevention, and evaluating the magnitude of change after a treatment intervention.

Population Groups:

• Children over 10 years of age; adolescents and adults

• Known or suspected alcohol/drug users; matching specific treatments to specific problems; identifying youth in need of prevention

Administration:

Number of items: 159; Number of subscales: 11

Format(s):

• Pencil-and-paper self-administered
• Interview
• Observation
• Computer self-administered
• Other
• There are both Youth and Adult Versions

Also, there are three formats available:

• DQS / Quick Screen (3 min) FREE
• Short Assessment (8 min)
• Full Assessment (20 min)

Time required for administration is 20 minutes.
Can be self-administered or completed with a counsellor during an interviewer. No training required for administration.
Self-report version requires fifth grade reading level.

Cost:

• The DUSI-R is copyright
• Cost: Paper version $3.00 a copy; computer administration and scoring $495.00

For further information:

• YourHealthCheck at:
http://www.yourhealthcheck.org/organization/dusi

• The Centre for Addiction and Mental Health's website at:
http://goo.gl/NSXsy

GAIN Short Screener (GAIN-SS)

The GAIN-SS is designed to identify people who are likely to have a mental health disorder (and should have a full assessment). Since the GAIN-SS includes a subscale that screens for substance use disorders, it is now often included in substance use screening tools lists as well as those for mental health screening tools. The GAIN Substance Use Disorder Scale provides more detailed information about substance use problems.

The GAIN-SS has four subscales:

1. Internal disorders (somatic, depression, suicide, anxiety, trauma);

2. Behavioural disorders (attention deficit hyperactivity disorder, conduct disorder);

3. Substance abuse disorders (abuse, dependence); and,

4. Behavioural crime/violence (interpersonal violence, property crime, drug-related crime).

Population Groups:

The GAIN-SS can be used with adolescents and adults.

Administration, scoring and interpretation

• The GAIN-SS is designed for self-administration using paper and pencil or a computer.

There is a fee for use. Cost and further information on the GAIN tool can be found at: http://www.gaincc.org/

GAIN Substance Use Disorder Scale (GAIN-SUDS)

The GAIN-SUDS is a 16-item scale based on DSM-IV criteria for:

1. substance abuse (consequences of use)
2. substance dependence (tolerance, withdrawal, inability to control use)

The GAIN-SUDS is part of the Global Appraisal of Individual Needs. The substance abuse/dependence scale asks about both alcohol and other drug use.

Population Groups:

It can be used with adolescents and adults.

Administration, scoring and interpretation

Administration can be self-reported, paper-and-pencil, or computerized, and takes five to 10 minutes. A license agreement is required to use any of the GAIN family of instruments.

Cost:

There is a fee for use.

Website:

For further information on costs and the tool, go to: www.chestnut.org/LI/gain/index.html

Indigenous Risk Impact Screen (Australia)

Inclusion of the IRIS screening tool was meant only to demonstrate an example of an Aboriginal-designed screening tool that, if deemed appropriate and warranted, could be used to design a similar tool for First Nations and Inuit clients.

INDIGENOUS RISK IMPACT SCREEN (IRIS)

Please circle the answer that match's your situation.

1. In the last six months have you needed to drink or use more to get the effects you want?

No Yes Yes, a lot more

2. When you have cut down or stopped drinking or using drugs in the past, have you experienced any symptoms, such as sweating, shaking, feeling sick in the tummy/vomiting, diarrhea, feeling really down or worried, problems sleeping, aches and pains?

Never Sometimes when I stop Yes, every time

3. How often do you feel that you end up drinking or using drugs much more than you expected?

Never/Hardly ever Once a month Once a fortnight
Once a week More than once a week Most days/Every day

4. Do you ever feel out of control with your drinking or drug use?

Never/Hardly ever Sometimes Often Most days/Everyday

5. How difficult would it be to stop or cut down on your drinking or drug use?

Not difficult at all Fairly easy Difficult I couldn't stop or cut down

6. What time of the day do you usually start drinking or using drugs?

At night In the afternoon Sometimes in the morning As soon as I wake up

7. How often do you find that your whole day has involved drinking or using drugs?

Never/Hardly ever Sometimes Most days/Everyday

8. How often do you feel down in the dumps, sad or slack?

Never/Hardly ever Sometimes Most days/Everyday

9. How often have you felt that life is hopeless?

Never/Hardly ever Sometimes Most days/Everyday

10. How often do you feel nervous or scared?

Never/Hardly ever Sometimes Most days/Everyday

11. Do you worry much?

Never/Hardly ever Sometimes Most days/Everyday

12. How often do you feel restless and you are not able to sit still?

Never/Hardly ever Sometimes Most days/Everyday

13. Do past events in your family still affect your wellbeing today, (such as being taken away from family)?

Never/Hardly ever Sometimes Most days/Everyday

Source: *Schlesinger, CM., Ober, C., McCarthy, M.M., Watson, J.D., ^ Seinen, A. (2007). The development and validation of the Indigenous Risk Impact (IRIS): A 13-item screening instrument for alcohol, drug and mental risk. Drug and Alcohol review, 26, 109-117.*

MAST - Michigan Alcoholism Screening Test

The MAST is a 24-item screening instrument designed to identify and assess alcohol abuse and dependence. The MAST has been demonstrated to have adequate sensitivity and specificity with a cut-off score of 13 in identifying individuals meeting diagnostic criteria for alcohol abuse and dependence. Shortened 13-item (SMAST) and 10-item versions (Brief MAST) of the MAST can reliably be used as self-administered screening instruments.

Population Groups:
- Adults
- Adolescents over 16 years of age

Cost:
- No copyright
- $40.00 for copy, no fee for use

Further information:
Melvin L. Selzer, M.D.
6967 Paseo Laredo
La Jolla, CA 92037

Download the following document that contains information on various screening tools, including the MAST:
http://www.ncsacw.samhsa.gov/files/SAFERR_AppendixD.pdf

Modified Mini Screen

The Modified Mini Screen is a set of 22 items derived from a structured psychiatric interview. It is designed to identify people who should have a mental health assessment. The Modified Mini Screen covers three categories of mental health problems:

- Mood disorders;
- Anxiety disorders; and,
- Psychotic disorders.

Some questions ask about problems over a specified time period (the period varies from two weeks to two years), while others ask questions about lifetime occurrences of problems.

Population Groups:
Adults

Administration, scoring and interpretation
The Modified Mini Screen takes about 15 minutes to administer. The client responds yes or no to each question, and each yes response scores 1. Scores range from 1 to 22. Scores in the mid-range of 6 to 9 indicate a moderate likelihood of a mental disorder such that the client should seriously be considered for referral for a diagnostic assessment. Scores of 10 or more indicate a high likelihood of a mental disorder, and clients should definitely be referred for a diagnostic assessment. Positive responses to the question related to suicidality and both the trauma-related questions also indicate that a referral for further evaluation is needed, regardless of the total score on the Mini.

Cost:
Can be reproduced without cost.

For further information:
Visit the Centre of Addiction and Mental Health's website at:
http://goo.gl/2JHzY

PDSQ - Psychiatric Diagnostic Screening Questionnaire

The PDSQ is a self-report instrument that screens for 13 DSM-IV Axis I psychiatric disorders, including:

- Substance use disorders
- Major depressive disorder
- Generalized anxiety disorder
- Panic disorder
- Posttraumatic stress disorder
- Alcohol abuse/dependence
- Drug abuse/dependence
- Psychosis
- Bulimia/binge-eating disorder
- Somatization disorder
- Obsessive-compulsive disorder
- Social phobia
- Hypochondriasis

Population groups:
- Widely used in outpatient mental health settings
- Appropriate for adults 18 years of age and over

Administration and scoring:
Cut-off scores, critical items and follow-up interview guides are provided for each disorder

Website
The PDSQ is distributed by the commercial assessment test publisher Western Psychological Services (WPS).
For more information on purchase costs, go to:
http://goo.gl/6g12q

Substance Abuse Subtle Screening Inventory (SASSI)

The SASSI is a short, one-page self-report screening tool for chemical dependency. It can be objectively scored and plotted by support staff in 1 minute and has objective decision rules to classify individuals as chemically dependent (CD) or non-chemically dependent (non-CD). It is available in paper form, computer disk, and optical scanning form for both adults and adolescents. It is especially effective in identifying early stage CD individuals who are either in denial or deliberately trying to conceal their chemical dependency pattern. SASSI has a 93 question screening inventory, 67 of which are true/false question. A client may take 15 minutes or less to complete the survey and it can be interpreted in only a few minutes.

Cost:
- Starter kit with 25 tests, manual, scoring key
- $75.00; additional tests: less than $2.00 each

Visit the SASSI Institute's website for further information:
http://www.sassi.com

The SOCRATES - *Stages of Change Readiness and Treatment Eagerness Scale*

The SOCRATES provides information on client strengths and needs in the areas of treatment readiness. The name of the tool implies the areas being measured: Stages of Change Readiness and Treatment Eagerness Scale. The SOCRATES tool is designed to provide a general measure of the motivation of problem drinkers and drug users to enter treatment. The current tool consists of a brief 19-item version. The six stages of change measured by this tool include:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Termination

The 19-item version of the SOCRATES tool does not determine the client's specific 'stage of change' but provides scores on three scales–Recognition, Ambivalence and Taking steps–which measure the client's general level of motivation:

- Recognition: This scale provides information about the client's level of awareness or consciousness of and acknowledgement of the link between substance use and current problems.

- Ambivalence: This scale provides information about whether the client is certain or uncertain that he or she has or doesn't have a problem. The scores are neither good nor bad; they simply indicate the amount of energy the client is spending in thinking about the change process or in debating the pros and cons of change.

3. Taking steps: This scale considers evidence that a client is starting to take steps, or has already taken some steps, to change behaviour.

Population Groups:

- Problem drinkers –NOTE that SOCRATES has been tested in the United States for both male and female adult clients across several cultural groups, including Native Americans

- Intended for clients over 19 years of age (not youth).

Administration

- There are two forms, one for alcohol and one for other drugs

- The counsellor completes the one for alcohol and at least one copy of the form for other drugs if the client is using alcohol and one or more other drugs

- The counsellor must determine if issues such as culture, diversity, language and literacy may impact on self-administration. The forms can be used as homework assignments, and can be used in groups or individual sessions.

For further information on the SOCRATES and other screening tools, visit the University of New Mexico's website at: http://casaa.unm.edu/inst.html

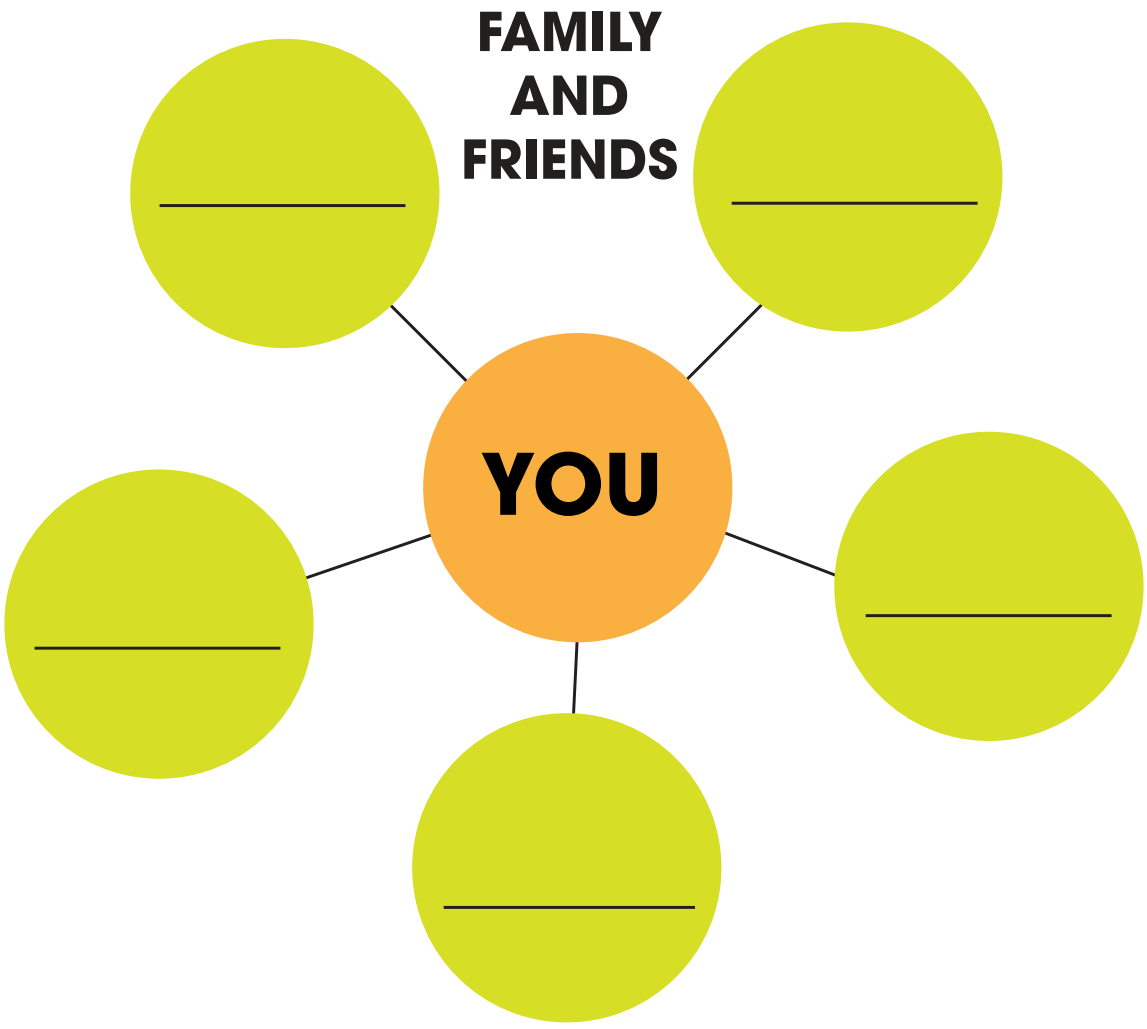
HRN:

NAME _____ DATE: _____
MONTH DAY YEAR

DATE OF BIRTH: _____
MONTH DAY YEAR

STAY STRONG PLAN

Step 1
People that help to keep me strong (family, friends, elders, carers)

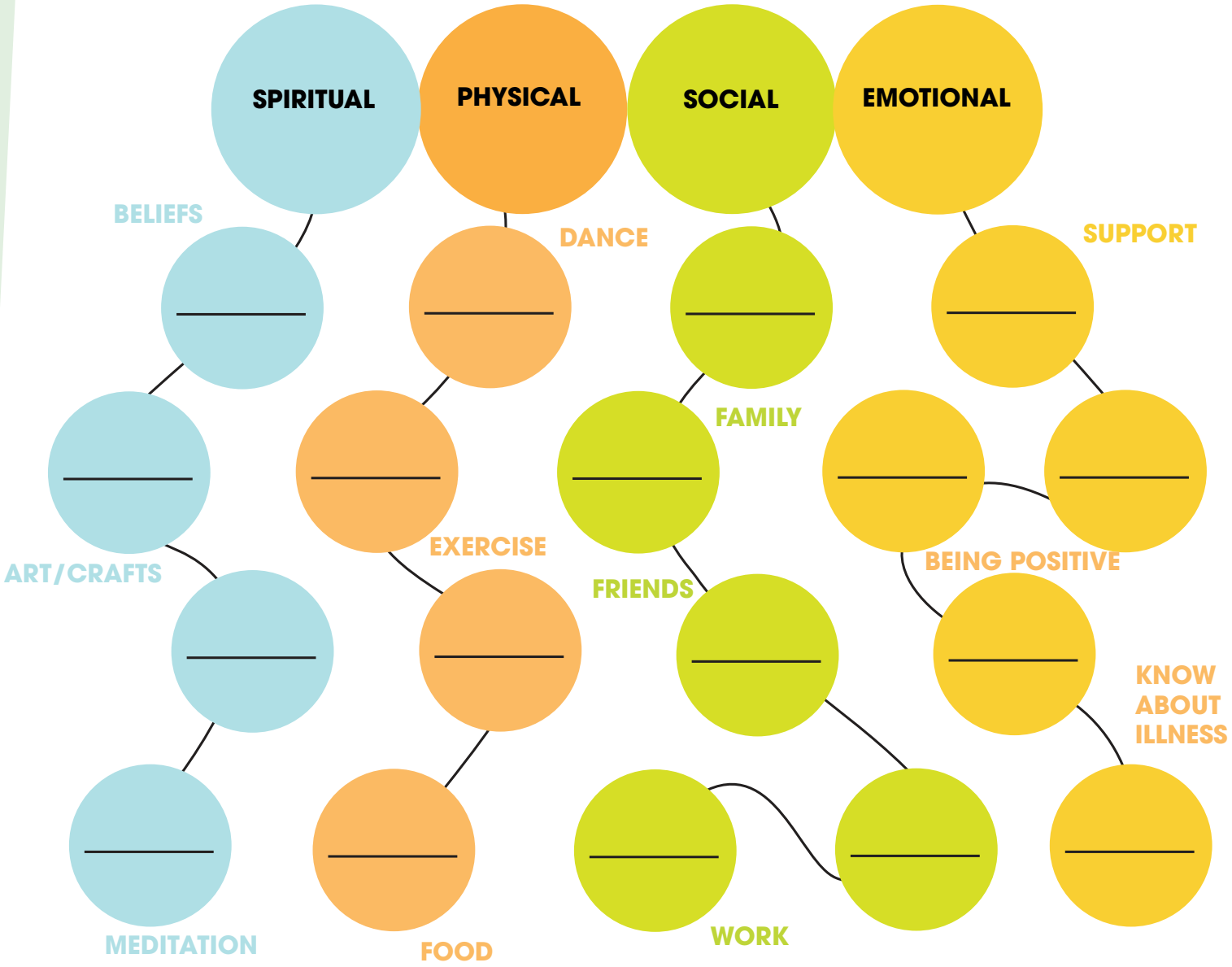


I trust this person to give advice about my treatment: _____

What keeps us strong?

Step 2

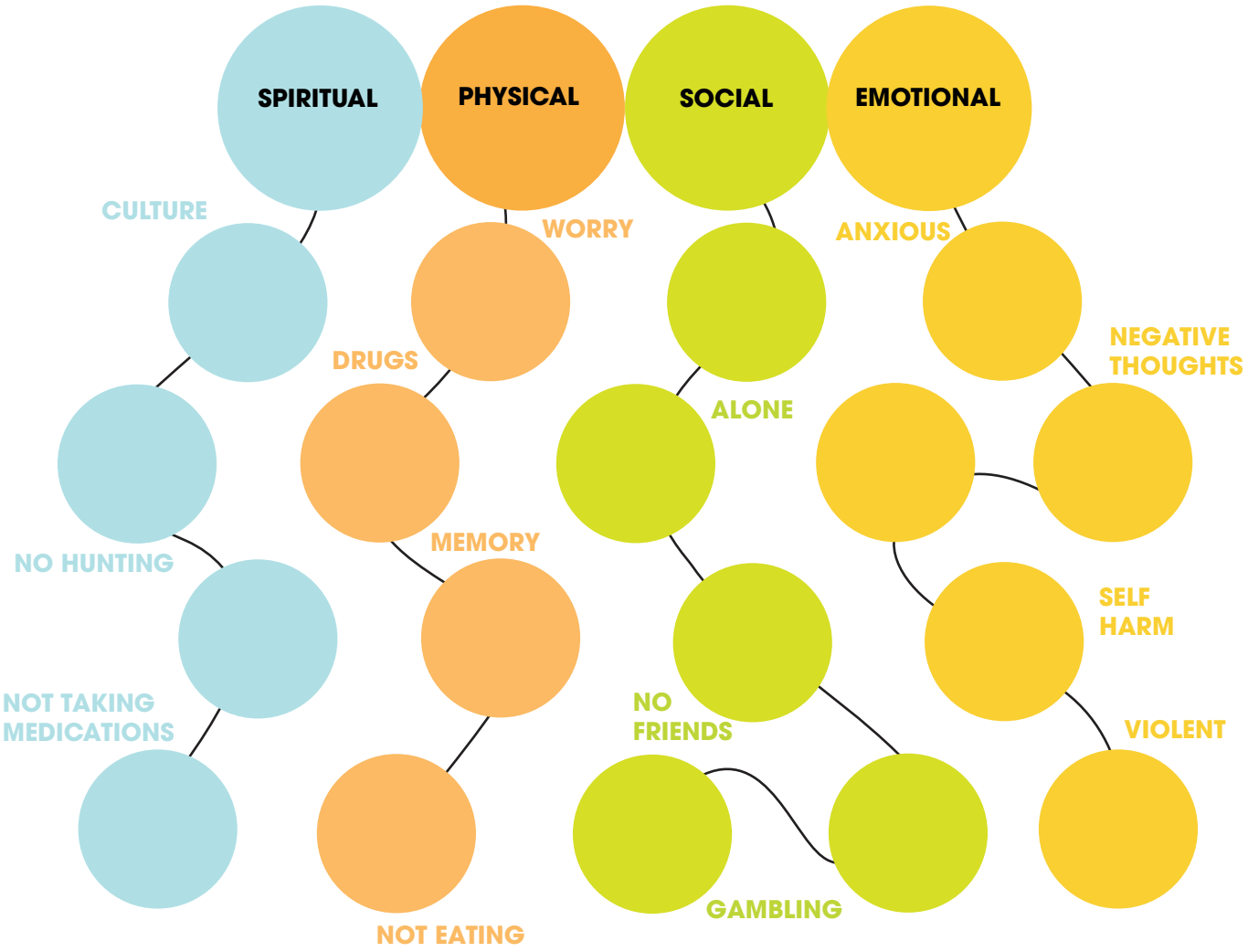
Things that help to keep me strong (spiritual, cultural, physical, family, social, mental and emotional.) Write in strengths.



Worries that take my strength away:

Step 3

Things that make me feel weak, write them in the circles.



Step. 4. Setting goals

a) Goals I have for changing my worries:

Goal one:

Step 1

Step 2

Step 3

Goal two:

Step 1

Step 2

Step 3

b) Other things to do that help :

1.

2.

3.

4.

Good things about these goals for change are:

My early warning signs of getting sick again are:

YSAC RESILIENCY SCALE - YOUTH COPY From: YSAC Youth resiliency Scale, Version 4, January 2007
Please read each statement and circle the number that best fits - 5 being always and 1 being never. Never 2- Occasionally 3, Sometimes 4- Often 5-Always. **Answer the statements using your feelings today.**

Name_____ Date _____

I feel like I know a good thing is about to happen	1	2	3	4	5
I make friends easily	1	2	3	4	5
I have things I am good at	1	2	3	4	5
I am sure things will be better for me later in life	1	2	3	4	5
I like to do things for people	1	2	3	4	5
I feel good about myself when I am helping others	1	2	3	4	5
I am comfortable when I am alone	1	2	3	4	5
I have healthy hobbies or activities that I can do by myself	1	2	3	4	5
I have healthy ways I can separate myself from bad situations	1	2	3	4	5
I feel like I know a bad thing is about to happen	1	2	3	4	5
I do things without being reminded	1	2	3	4	5
I believe in myself and my ability to meet my goals	1	2	3	4	5
I am able to connect with others	1	2	3	4	5
I have someone that encourages, supports or helps me	1	2	3	4	5
I get along with others	1	2	3	4	5
I am good at getting things started	1	2	3	4	5
I understand what a "spiritual connection" is	1	2	3	4	5
I am the first one to have an idea about a game	1	2	3	4	5
I can think of something positive to do when I am bored	1	2	3	4	5
I have ways I can think of to earn money (babysitting, helping out, etc.)	1	2	3	4	5
I believe in god, creator or something like it	1	2	3	4	5
I see a future for myself	1	2	3	4	5
I have a spiritual connection in my life.(church, elders, ceremonies, sweat lodge and other cultural activities)	1	2	3	4	5
When someone calls me a name, I become upset	1	2	3	4	5
I believe life has a greater meaning	1	2	3	4	5
I can see the funny side of things	1	2	3	4	5
I like it when people use jokes to teach me something	1	2	3	4	5
If I saw someone drop money I would give it back	1	2	3	4	5
If I saw a night staff sleeping I would tell someone	1	2	3	4	5
If my friend told me they were going to commit suicide, I would tell someone	1	2	3	4	5
If other youth were getting high or drinking I would tell a staff person	1	2	3	4	5
I feel good about the kind of person I am	1	2	3	4	5

Staff Instructions:Copy results onto the interpretation guide and save in central resiliency file.

Assessment Tools for Consideration
Addiction Severity Index (ASI)

Description:

The Addiction Severity Index (ASI) assesses the type and severity of addictions/substance use disorders in seven different areas of a client's life17. The ASI can be used as a pre-treatment assessment to determine appropriate interventions and treatment programs or as a measure of progress during and following program completion.

The ASI-NV is a specific version designed for use with Native Americans.

All versions of the ASI are in the public domain and are free.

Population Groups:

The ASI was designed for use with adults, but has been used with adolescents as well. The youth version of the ASI is the Teen-ASI (T-ASI) and was designed specifically for use with adolescent clients.

Addiction Severity Index (ASI) – psychiatric subscale

Description:

The psychiatric subscale of the ASI (see note below) contains 14 questions for the client, as well as three questions to be answered by the interviewer. The ASI timeframe is the previous 30 days for some items and lifetime for other items.

Population Groups:

The ASI is appropriate for use with adult men and women who report substance use as their major problem. It has also been used with people with psychiatric problems, pregnant women and people who have committed criminal offences.

Administration, scoring and interpretation

Information about administration and scoring is available on the TRI website (see below).

Website

For more information about the ASI (including downloadable manuals), see the Treatment Research Institute website: http://www.tresearch.org/resources/instruments.htm

Note: The ASI is a semi-structured interview designed to assess seven potential problem areas in people with substance use problems:

- medical status
- employment and support
- alcohol use
- drug use
- legal status
- family and social status
- psychiatric status.

The ASI has been used for treatment planning and outcome evaluation.

The ASI generates two sets of scores:

- Interviewer's severity rating of the client's need for treatment

- Composite scores of problem severity during the prior 30 days.

Application for Addictions Services – Needs Assessment - First Nations Quebec and Labrador Health and Social Services Commission

Sample Form:

DATE OF THE APPLICATION: _____/_____/_____ FILE NUMBER: _____
DAY MONTH YEAR

IDENTIFICATION OF THE APPLICANT

NAME: _____ _____FIRST NAME: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ MALE FEMALE
DAY MONTH YEAR

CHECK √

FIRST LANGUAGE: O FRENCH O ENGLISH O ABENAKI O ALGONQUIN O ATIKAMEKW
O CREE O MI'GMAQ O MOHAWK O INNU O NASKAPI
O INUKTITUT O OTHER, PLEASE SPECIFY_____

LANGUAGE OF USE: O FRENCH O ENGLISH

HEALTH INSURANCE NO.: _____EXPIRATION: _____/_____
YEAR MONTH

RENEWAL REQUEST TO BE MADE ON: _____/_____/_____
DAY MONTH YEAR

HOME ADDRESS:_____
NUMBER STREET APARTMENT

_____ _____ _____
CITY PROVINCE POSTAL CODE

CHECK √

CIVIL STATUS: O SINGLE O MARRIED O WIDOWED O DIVORCED O COMMON-LAW

NUMBER OF DEPENDENT CHILDREN: _____ CUSTODY: O SHARED O FULL-TIME

SPECIFY THE CHILDREN'S AGES: 1 ____ 2____ 3____ 4 ____ 5_____

CHECK √

OCCUPATION: O FULL-TIME EMPLOYMENT O PART-TIME EMPLOYMENT O UNEMPLOYED
O FULL-TIME STUDIES O PART-TIME STUDIES O AT HOME

NUMBER OF SCHOOL YEARS COMPLETED: _____

MOTHER: _____ _____
LAST NAME (AT BIRTH) FIRST NAME

FATHER: _____ _____
LAST NAME FIRST NAME

SPOUSE: _____ _____
LAST NAME (AT BIRTH) FIRST NAME

Application for Addictions Services – Needs Assessment - First Nations Quebec and Labrador Health and Social Services Commission

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ TELEPHONE #: ( ) _____ - _____

CHECK √

RELATIONSHIP: ○ PARENTS ○ SIBLING ○ FRIEND ○ OTHER-SPECIFY: _____

CHECK √
APPLICANT'S AVAILABILITY: ○ AM ○ PM ○ EVENING PERSON WITH REDUCED MOBILITY: ○ YES ○ NO

HAVE YOU EVER RECEIVED ADDICTIONS SERVICES? ○ YES ○ NO

IF SO, HAVE YOU EVER BEEN IN THERAPY? ○ YES ○ NO

IF SO, DATE OF THE LAST THERAPY: _____/_____/_____

DAY MONTH YEAR

LOCATION: ○ WAPAN ○ WANAKI ○ ONEN'TO: KON ○ MIAM UAPUKUN ○ MAWIOMI

OTHER PLEASE SPECIFY:_____

HAVE YOU EVER ATTENDED A RESIDENTIAL SCHOOL? ○ YES ○ NO

IF SO, WHERE? _____

HAVE YOU EVER HAD A PERIOD OF SOBRIETY? ○ YES ○ NO

IF SO, WHICH METHOD DID YOU TRY? (E.G: AA ME):_____

BY WHO WERE YOU REFERRED? (Friend, professional, colleague, family member, etc.)

○ FRIEND ○ PROFESSIONAL ○ COLLEAGUE ○ FAMILY MEMBER
○ SCHOOL ○ HOSPITAL ○ HEALTH CENTRE ○ JUSTICE

OTHER, PLEASE SPECIFY: _____

REFERRER: _____
LAST NAME FIRST NAME

PROBLEM

○ ALCOHOL ○ DRUGS ○ MEDICATION ○ GAMBLING

DO YOU HAVE SOMEONE IN YOUR ENTOURAGE WHO IS STRUGGLING WITH ONE OF THE FOLLOWING PROBLEMS?

_____

GAMBLING:

○ SPOUSE ○ CHILD ○ FAMILY AND/OR

ADDICTION:

○ SPOUSE ○ CHILD ○ FAMILY

Application for Addictions Services – Needs Assessment - First Nations Quebec and Labrador Health and Social Services Commission

COMPLETED BY: _____ DATE: _____/_____/_____
DAY MONTH YEAR

CONSUMPTION

SUBSTANCES	FREQUENCY OVER THE PAST 3 MONTHS	FREQUENCY IN THE LAST WEEK	QUANTITY PER DAY	ADMINISTRATION METHOD	HOW LONG HAS YOUR CONSUMPTION BEEN PROBLEMATIC?
ALCOHOL					
OPIATES					
COCAINE					
AMPHETAMINES (SPEED)					
CANNABIS					
HALLUCINOGENICS					
OTHERS:					

PERIOD OF ABSTINENCE: ○ CURRENTLY ○ PREVIOUSLY ○ NONE

LEGEND:

1 ORAL
2 NASAL
3 SMOKED
4 INJECTED ○ (I.M) OR ○ (I.V.)
5 OTHERS, SPECIFY:_____

PSYCOLOGICAL STATE

IF SO, WHICH:	CURRENTLY	PREVIOUSLY	COMMENTS
EXCESSIVE TREMBLING			
STOMACH ACHE			
VOMITING			
INSOMNIA			
EXCESSIVE SWEATING			
HALLUCINATIONS			
CONVULSIONS			
ANXIETY			
STATE OF DEPRESSION			
OTHERS :			

PSYCHIATRIC OR PSYCHOLOGICAL FOLLOW-UP: ○ CURRENTLY ○ PREVIOUSLY ○ NONE

REASONS	CURRENTLY	PREVIOUSLY	COMMENTS
SUICIDAL IDEATION			
ATTEMPTED SUICIDE			
SELF-MUTILATION			
FEELINGS OF DEPRESSION			
DEEP ANXIETY			
BEHAVIOURAL PROBLEM (Aggressiveness, acting out, violence)			
LOSS OF INTEREST DEMOTIVATION			
HALLUCINATIONS			
ISOLATION			
PHOBIA			
OTHERS:			

LEGEND:

6. EVERY DAY
7. 3 TIMES AND + PER WEEK
8. ONCE OR TWICE PER WEEK
9. ON WEEKENDS
10. OCCASIONALLY

Application for Addictions Services – Needs Assessment - First Nations Quebec and Labrador Health and Social Services Commission

DO YOU HAVE A MENTAL HEALTH DIAGNOSIS? ○ YES ○ NO

IF SO, PLEASE SPECIFY: _____

DO YOU TAKE MEDICATION? ○ YES ○ NO

IF SO, PLEASE SPECIFY: _____

MEDICAL CONDITIONS TO OVERSEE?

ARE YOU PREGNANT? ○ YES ○ NO

DO YOU HAVE A CHRONIQUE DISEASE? :

CHECK √

○ HIV ○ ASTHMA ○ HEART DISORDER ○ LUNG DISORDER

○ DIABETES ○ HEPATITIS ○ EPILEPSY ○ HYPERTENSION

○ OTHERS: _____

ARE YOU BEING MEDICALLY-MONITORED? (CURRENTLY) ○ YES ○ NO

ARE YOU TAKING MEDICATION FOR PHYSICAL PROBLEMS? ○ YES ○ NO

DO YOU HAVE A FAMILY PHYSICIAN? ○ YES ○ NO

PHYSICIAN: _____IS HE/SHE AWARE OF YOUR REQUEST FOR OUR SERVICES? ○ YES ○ NO

ARE YOU EXPERIENCING TROUBLE SLEEPING? ○ YES ○ NO

IF SO, PLEASE SPECIFY: _____

_____

ARE YOU EXPERIENCING TROUBLE EATING? ○ YES ○ NO

IF SO, PLEASE SPECIFY: _____

PRIORITIZATION CRITERIA:

ORDER OF PRIORITY	ELEMENTS OF PRIORITY
○ PREGNANT WOMAN	○ IMMEDIATE ACCESS
○ PARENTS OF CHILDREN AGES 5 YEARS AND UNDER	○ HAS CUSTODY OF THE CHILD OR CHILDREN ○ IS A SINGLE PARENT ○ BOTH PARENTS HAVE ADDICTION ISSUES ○ INVOLVEMENT OF THE D.P.J. ○ ORIENTATION OF THE COURT
○ YOUTH (LESS THAN 18 YEARS OF AGE)	○ CENTRE JEUNESSE REFERRAL ○ COURT ORDER ○ SCHOOL ○ OTHER SERVICES: _____ ○ DIRECTLY REQUESTED BY THE YOUTH
○ ADULTS ○ GAMBLING	○ PARENT WITH CHILDREN AGES 7-17 YEARS ○ INJECTABLE DRUG USER ○ USER AGED 18-24 YEARS ○ USERíS REFERRER: PARTNER ○ DIRECTLY REQUESTED BY THE PERSON AGED 24 AND + ○ ENTOURAGE OF THE USER

THE CLIENT IS REFERRED: CHECK √

○ INDIVIDUAL MEETING	ANTICIPATED DATE: _____
○ NURSE	PLEASE SPECIFY: _____
○ OTHER FIRST-LINE INTERVENER	PLEASE SPECIFY: _____
○ REHABILITATION CENTRE	ANTICIPATED DATE: _____
○ EXTERNAL RESOURCES	PLEASE SPECIFY: _____

COMMENTS _____

_____

COMPLETED BY: _____ _____/_____/_____
DAY MONTH YEAR

FILE CLOSURE

DATE THE FILE WAS OPENED: _____/_____/_____
DAY MONTH YEAR

FILE CLOSURE DATE: _____/_____/_____
DAY MONTH YEAR

REASON FOR THE CLOSURE: CHECK √

- ○ CLIENT DID NOT SHOW UP FOR THREE CONSECUTIVE APPOINTMENTS
- ○ FILE INACTIVE FOR MORE THAN THREE MONTHS
- ○ CLIENT'S LACK OF MOTIVATION
- ○ RELOCATION
- ○ FOLLOW-UP COMPLETED
- ○ HOSPITALIZATION
- ○ MUTUAL AGREEMENT
- ○ ABANDONMENT
- ○ REFERRED TO OTHER SERVICES
- ○ UNKNOWN

OTHERS, PLEASE SPECIFY: _____

COMMENTS:_____

_____

COMPLETED BY: _____ _____/_____/_____
DAY MONTH YEAR

Circumstances, Motivation, and Readiness Scales (CMR Scales)

The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities. The CMR Scales consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. Items were developed from focus groups of recovering staff and clients and retain much of the original language. Clients entering substance abuse treatment perceive the items as relevant to their experience.

Population Groups:

Adults

Administration:

• The format of the tool is 18 items at approximately a third-grade reading level

• Responses to the items consist of a 5-point Likert scale on which the individual rates each item on a scale from Strongly Disagree to Strongly Agree

• Administration time is 5-10 minutes and scoring is done by reversing negatively worded items and summing the item values

• No training required for administration

Cost:

No fee for use.

Available from: George De Leon, Ph.D.,
or Gerald Melnick, Ph.D.

National Development and Research Institutes, Inc.
New York
Phone: (212) 845-4400
Fax: (917) 438-0894
E-mail: gerry.melnick@ndri.org
www.ndri.org

Giyak Moseng: The Right Path (Nipissing First Nation)

CLIENT ASSESSMENT

Relevant History:_____

_____

Primary Worker: _____ Client Name:_____

Presenting Problem (include client's view of the problems and their causes):

_____

_____

Identified Strengths:_____

Significant Losses (death, separation, an ability, security):

_____

Support Systems:_____

History of Abuse (physical, emotional, sexual, domestic violence):

_____

_____

Legal Problems:

_____

_____

Substance Abuse History:

_____

_____

Current Use (substances, amount, frequency):

_____

_____

Patterns:

○ Abstainer ○ Occasional ○ Social ○ Weekend ○ Binge
○ Daily ○ Alcoholic / Addict

History of Injection Drug Use: ○ Yes ○ No

Specify: _____

_____

CLIENT ASSESSMENT

Are you or have you ever been on a methadone maintenance program: ○ Yes ○ No

Obtain details:

_____

_____

_____

Past Use (substances, amounts, frequency):

_____

_____

_____

Family History of Substance Use:_____

_____

_____

Gambling Activities: ○ Yes ○ No

Obtain Details

_____

_____

_____

Have you ever experienced any mental health concerns?

_____

_____

_____

_____

Mental Health History:

_____

_____

_____

Have you ever been diagnosed with a mental illness such as:

○ Depression ○ Anxiety ○ Schizophrenia ○ Bipolar Disorder
○ Post-Traumatic Stress Disorder ○ Eating Disorder

Specify:

_____

_____

CLIENT ASSESSMENT

History of suicide (thoughts, attempts, family history):

_____

_____

_____

Previous Treatment (include counselling, self-help, hospitalization, spiritual help etc.):

- ○ Medical Treatment
- ○ Traditional Services
- ○ Addiction Treatment
- ○ Substance Abuse Counselling
- ○ Self Help Group
- ○ Psychiatrist/Psychologist
- ○ Mental Health Counselling
- ○ Sexual Assault Service
- ○ Family Counselling
- ○ Legal Services
- ○ Other:

Specify:

_____

_____

Employment/Education History:

Education complete:

- ○ Elementary School
- ○ High School – grade completed
- ○ Some College
- ○ College Certificate
- ○ College Diploma
- ○ Some University
- ○ University Degree B.A.
- ○ Masters Ph.D.
- ○ No Formal Education

Problem in:

Reading Writing

Did you attend residential school? ○ Yes ○ No Years Attended_____

Did any family member attend residential school? ○ Yes ○ No

Specify:

_____

_____

Work History:

- ○ Homemaker
- ○ Seasonal Employment
- ○ Employed - Part Time
- ○ Attending School
- ○ Unemployed
- ○ Disability
- ○ Employed – Full Time
- ○ Other:_____

Comments:

_____

_____

CLIENT ASSESSMENT

Spiritual Involvement:

O Traditional O Catholic O Other:_____ Level of Involvement:_____

Are you interested in accessing more traditional services? O Yes O No

Medical/Physical Problems: _____

_____

Family Physician / Healer: _____ Medication: O Yes O No

Please list:_____

_____

Do you take medication(s) as prescribed by your physician? O Yes O No

Explain: _____

_____

Workers Observation and Assessment (describe current level of functioning, strengths, problems and need(s):

_____

_____

Goals of Treatment: _____

_____

ModeofIntervention:_____

_____

_____

Evaluation Plan: _____

_____

Treatment Plan: _____

_____

_____

Client Signature:_____Date:_____

Staff Signature:_____Date:_____

Nimkee Nupigawagan Healing Centre - Clinical Assessment, Medicine Wheel

As contained in package:

RATIONAL

To develop a basic understanding of client behaviour
To develop a basic understanding of the client's environment
This understanding will include a Cultural Assessment of behaviour
The behaviour examined will be based on five (5) categories consistent with the Medicine Wheel

These five (5) categories are:

East Door –Vision
Pertaining to the client's aspirations

South Door – Relationships and Time
Pertaining to the client's familial and community relationships

West Door – Respect/Reason
Pertaining to the client's current reflections on relationships and behaviour

North Door – Movement
Pertaining to the client's understanding of his/her own behaviour with the family community.

Centre-Earth-Healing
Pertaining to a strategy of healing in the four above stated categories. The basic premise at the centre of the wheel is the belief that the first step toward healing requires the ability to listen.

Assessment Questions:

Clients must be made aware prior to the assessment interview that abuse disclosure are required to be reported under the Child and Family Services Act. Clients must also be made aware of the potential ramifications of disclosures, such as police investigations and potential family and community dynamics.

The questions utilized in this assessment tool have been designed for an adolescent Anishnabe client group who were admitted to a healing lodge. These questions were pre-tested over a four (4) month period. Changes to the assessment process were made accordingly.

The assessment tool is meant to be used as a guide for an interview process. The questions utilized in this tool can open the door to further questioning. It is recognized that some of the questions can elicit old memories and feeling of pain. The assessment process needs to allow for the discharge of painful feelings in a caring and supportive environment.

East Door – Aspirations

Why did you think you were sent to the (facility)?
What is your understanding of your problems?
Where do you hope to be in one (1) year from now?
What do you want to be doing for the rest of your teen years?
What do you want to be doing when you are an adult?

The first two questions relate to the dark side of the East Door – inferiority. The last three questions relate to the positive side of the East Door – good feelings.

South Door – Relationships and Time

Note: With your client's guidance, draw a genogram of the family system – this can include the extended family.

Describe your relationship with your family, (or care giver)?
Have you been living with your family since birth?
Are there happy times in your family?
Describe what you like the most about your family?
Describe what you least about your family?
Do you have a boyfriend/girlfriend? (Further questioning may be needed, e.g., Are sexually active?)

Questions have been designed to address the dark side – envy and the positive side (good relationships) in this door.

West Door – Respect/Reason

What would you say is positive about your community?
Is there any alcohol, drug abuse, or sniffing in your family?
Describe the good part of your family?
Describe what happens when there is alcohol, drug abuse or a party in your family?
Do you personally drink alcohol, use drugs, or sniff?
Did anyone touch you in a way that made you feel uncomfortable?

These questions have also been designed to address the positive side – respect and the dark side – resentment in this door.

North Door – Behaviour

How would you describe your own behaviour in the family?
What do you like most about yourself?
Is there something that you don't like about yourself?
Would you describe your behaviour in the family as gentle or harsh?

Describe your interaction with family when you seek to relieve your pain or hurt? (Further questioning may be needed, e.g. such as inquiries about withdrawing behaviour.)

Centre – Healing Strategy

How important is it for you to be listened to?

___Not important
___Important
___Very Important

Why is it important for you to be listened to?

Can listening help you with your feelings? Cite example – bad is using alcohol, drugs, being violent, angry.

Yes
No
Maybe

What are some of the things you must do to heal yourself from pain? (of interest are answers pertaining to the first three-(3) questions.)

Is there someone you can talk to regarding your pain? (Relates to breaking isolation – reaching out)

The positive side of the Centre is about healing. The dark side relates to jealousy.

Conclusion

We want to understand the person within the context of his/her home and community. The assessment tool attempts to implicitly define the mind, body and spirit of an individual. The document is consistent with Anishnabe culture, which attempts to define the mind, body, and spirit of individuals.

North Door – Behaviour

How would you describe your own behaviour in the family?
What do you like most about yourself?
Is there something that you don't like about yourself?
Would you describe your behaviour in the family as gentle or harsh?

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We want to understand the person within the context of his/her home and community. The assessment tool attempts to implicitly define the mind, body and spirit of an individual. The document is consistent with Anishnabe culture, which attempts to define the mind, body, and spirit of individuals.

Implications: Guiding Principles for Social Work Practice:

The Most significant application with regards to the use of the Medicine Wheel in the Assessment process is that the use of this tool shapes the nature of our intervention with clients. It specifically shapes our perception of the problem, our understanding of our role as social worker and our method of social work practice. As a result of using the Medicine Wheel in the assessment process, the primary author has formed the following principles as a guide for our practice.

Principle 1 – The Wholistic Nature of Relationship

The use of the Medicine Wheel in the Assessment process enable us to take our focus away from the 'problem which lead to referral', to view of our clients in a wholistic sense. You specifically see the person in terms of relationships. These relationships consist of his or her family, nation, and surrounding community. Implicit in this wheel of understanding, is the inter-relationship that we all share with all of Creation – our Creator, our Earth Mother, the Sun, and the Moon, the four directions, the four legged, the winged ones, those that fly, that crawl and swim. Implicit in the wheel of our understanding is our relationship to spirits, 'helpers', and 'guides' that perhaps are unseen forces, but still impact on our well being. We recognize and respect that these forces impact our lives. These forces can also be called forth to assist in the change process.

Principle 2 – Humility in Social Work Practice

The Medicine Wheel provides us with the mirror of understanding that the Creator lives in every living being. Thus the Creator lives within our clients we are serving. This serves to remind us of our humble role. We one person in the client's life. We recognize as a 'professional' relationship with the client, it is a time limited one. This impacts of our expectation in terms of intervention planning.

Principle 3 – Empowerment in Social Work Practice

Recognizing that Creation is within us, we are also reminded that the true 'healer' or the 'helper' is the clients themselves. We have respect for the healing capacity within each individual. This helps to shape our understanding of who we are in relationship to our clients. We can view ourselves, perhaps as a facilitator or a guide. However, we understand our ultimate responsibility is to help or clients uncover and 'tap' into the healing power within. This shapes our plan of care and our intervention with our clients. We help our clients pick up their own personal medicine. We thus begin to see that the Medicine Wheel is an empowerment tool. Indeed as Nabigon, (1990) indicated the Medicine Wheel could be viewed as a Cultural Paradigm for First Nations Self-Government.

Principle 4 – Respect for Non-Interference

Related to the above is the understanding that the onus is up to the individual to want to change. We recognize that our beginning role is to facilitate awareness for the need for change. (Antone, et al., 1986). We also respect the personal autonomy of each individual. We recognize that growth happens at its own natural pace. Again we are reminded of humility and respect, when interacting with those we serve.

Principle 5 – Healing is a Natural Phenomenon

The Medicine Wheel reflects natural phenomena. As indicated earlier the presents a pictorial view of our relationship to all life in the natural environment. The wheel depicts balance and harmony. Implicit in this understanding is the following factors. That is, anything that is out of balance can come into balance. The teaching of the 'Five Rascals' in the Wheel implies that it is natural to be effected by these rascals. Implicit in the understanding is the view that we all must attend to these rascals to maintain balance and harmony in our lives. In this process our change process is demystified. The natural solutions for change are reflected back in the wheel.

Principle 6 – Self Determination in Social Work Practice

The use of the Medicine Wheel in the Assessment process is intended to be used as one of the natural solutions for change. The questions utilized in the assessment tool are written with a healing intent. The questions are written specifically in a non-judgmental and accepting manner. They are designed to elicit self-awareness among the persons being interviewed. The questions ask of the clients own perceptions of the problems they are experiencing in their lives. They are designed to elicit self-determination for those who are answering the questions. As such, the assessment process is part of the intervention with a client.

Conclusion

Principle 7 – Clinical Assessment Can Be a Healing Practice

The Assessment interview can lay a very solid foundation for future intervention. This primary author has experienced the use of this tool as building a foundation for trust, sharing, honesty and caring for future work with clients. Within the context of respect and safety, clients feel free to quietly disclose many painful traumas they had experienced throughout their lives. For many, this begins the process of breaking out of isolation. It has been observed that healing can take place within the context of an initial assessment interview for more readily than when mainstream methods of Clinical Assessments are used.

SELF ESTEEM QUESTIONNAIRE

(circle the answer that applies to you)

Are there more things about you?

MAINLY GOOD MAINLY BAD BOTH GOOD AND BAD

A kid said: (I'm no good.) Do you ever feel like this?

YES NO SOMETIMES

A kid told me: "There's a lot wrong with me." Do you feel like this?

YES NO SOMETIMES

Another kid said "I'm not much good at anything." Do you ever feel like this?

YES NO SOMETIMES

How happy are you with yourself?

VERY PRETTY HAPPY HAPPY

If some kids said something bad about Native people, would you feel as if they had said something bad about you?

YES NO SOMETIMES

How do you feel about being Native?

PROUD PRETTY PROUD NOT VERY PROUD NOT PROUD

If you could be born again, would you like to be born?

NATIVE NON-NATIVE

If you could be born again, would you like to be born as?

YOURSELF A FRIEND OTHER

Do you think you would be happier if you were not Native?

YES NO MAYBE

Do you think drinking alcohol, taking drugs or sniffing can help people with their problems?

YES NO MAYBE

Do you think your mom or dad drinks alcohol or take drugs because of something you do?

YES NO MAYBE

SELF ESTEEM QUESTIONNAIRE

(circle the answer that applies to you)

Do you thing mom and dad fight/argue because of something you did?

YES NO MAYBE

Do you think it's okay to talk about your mom or dad drinking or taking drugs?

YES NO MAYBE

Do have someone you trust to go to for help?

YES NO MAYBE

Do you keep your feelings (happy, sad, angry) to yourself?

YES NO MAYBE

Can you do something to help your mom or dad stop drinking alcohol or taking drugs?

YES NO MAYBE

Do you do things that make feel good inside?

YES NO MAYBE

When you leave Nimkee, will you sniff, drink alcohol or take drugs?

YES NO MAYBE

If someone says or does things that make you really cared, should you try to forget it happened?

YES NO MAYBE

If someone show you a private part of his/her body, should you try to forget it happened?

YES NO MAYBE

When something really scary happens to you, do you think it's best to keep it to yourself?

YES NO MAYBE

If you're scared, do you think it's all right to attract attention to get help?

YES NO MAYBE

If some tries to do something that hurts your feelings or your body, should you tell someone?

YES NO MAYBE

SELF ESTEEM QUESTIONNAIRE

(circle the answer that applies to you)

Do you think kids are to blame when adults hurt them?

YES NO MAYBE

Do you think if kids tell someone that an adult is hurting them?

YES NO MAYBE

Do you think you can tell the difference between people who try to hurt kids' feelings or bodies and those people who don't?

YES NO MAYBE

Do you think you can tell the difference between people who try to really scare kids and those who don't?

YES NO MAYBE

Youth:_____**Administered at Intake by:** _____

Administered at Discharge by:_____**Date:** _____

BEHAVIOURAL ASSESSMENT

30 Day Review

Resident Name:_____ Date of Birth:_____

Primary Worker:_____Date:_____

Admission Date:_____Discharge Date:_____

Rights & Responsibilities:_____

Date Reviewed:_____ Next Review:_____Date Required:_____

People Contacted:_____Group Pie Chart Review Date:_____

Comments:_____

_____

INCIDENT CHECKLIST:	#OF INCIDENTS	COUNSELLING SESSION (Identify behaviour issues) CYW	#OF INCIDENTS
Non Compliance in group			
Non Compliant 1/11			
Instigate Behaviours			
Suicide Attempts/Threats		Role Modeling Behaviours	
Smoking		Problem Solving Skills	
incIdents		Incident Reports	
Self Abuse		Leadership Skills	
Behaviour Reports (follow up to incident reports)		Initiative	
Serious Occurrence Reports		Self Control when angry	
Escorts		Responsibility Taking	
Physical Restraints		Respect Good Effort/ Hard Work	
AWOL		Good Sportsmanship	
Threatening Others		Maturity Level	
Physical Assault		Following Program Expectations/Guidelines	
Verbal Assault			

STATEMENT OF POLICY AND PROCEDURES

Chapter:_____	NNHC No._____	Section:_____
TREATMENT POLICY_____	Issued:_____	Jan 2002_____
Subject:_____	PLAN OF CARE_____	Effective:_____
Issued to:_____	Page:_____	1 of 2_____
	Replaces:_____	
Issued by:_____	Issued:_____	

1. POLICY- PRIVATE AND CONFIDENTIAL

1.01 The main purpose of the plan of care is to ensure the youth are aware of why they are in treatment and are aware of what they can expect to receive in the treatment program – the plan of care then protects the rights of children. The POC also ensures that we are consciously and consistently aware of needs, change, and growth of the youth.

1.02 The legislation around Children's Residence Licensing requires us to complete the 1st plan of care within the first 30 days in residence. The POC at this point only reflects the presenting issues of the youth and whatever can be drawn from assessments within the first 30 days.

1.03 This POC is then updated and revised every 30 days with a discharge plan due at 150 days. The final program evaluation, self-esteem questionnaire and summary report is due at discharge.

1.04 The 30 days requirement is that the POC be completed with the client. If others are involved then this is good, but if they are not available, then the date the POC has been completed with the client, with the client signature must on the POC.

1.05 A typed copy of the POC should then be sent to the referral worker and parent. Whether or not they are involved in the development of the POC or at the telephone conference.

1.06 If several attempts have been made to include the family and community, this should be noted on the POC, but after a couple of tries it would be appreciate to copy the report and send it with a covering letter which reminds them of the next POC date and invitation of r their participation. Don't waste a lot of energy chasing parents and referral workers – but do note all attempts and reasons given for non- participation

1.07 The priority for completing the POC is with the youth.

1.08 The POC must also include Recreation info, education assessments and plans, CYW reports, re: Behaviours/ life/social skills and any other people who are involved in the treatment of youth, i.e. probation, psychological, psychiatrist, cultural assessment, health care issues.

1.09 The POC is also an opportunity to document that the rights and responsibilities of the youth have been reviewed, date when the youth completed program orientation, participation in fire drills.

STATEMENT OF POLICY AND PROCEDURES

Chapter:_____NNHCNo._____Section:_____

TREATMENT POLICY_____Issued:_____Jan 2002_____

Subject:_____PLAN OF CARE_____Effective:_____

Issued to:_____Page:_____2 of 2_____

Replaces:_____

Issued by:_____Issued:_____

2. PROCEDURE

The Primary worker shall ensure that specific dates, times and method for including guardian/parents/referral workers are established at client intake. This schedule shall be communicated orally and in writing to the client, parent and referral worker. Parent/guardian and referral worker shall also receive education by the Primary secondary worker about the Plan of Care (POC) process and shall stress the importance of parent/guardian and referral participation. The plan of Care must always be completed with the client every 30 days, even if the parent/guardian/referral worker does not participate. A copy of the Plan of Care will include the following:

- Name and date of birth of the client
- Legal guardian
- Referral worker/agency
- Date admission and discharge
- Date of present Plan of Care (POC)
- Date of last POC
- Date of next review
- Primary and secondary worker
- Treatment coordinator
- Child's advocate
- Participants at review
- Date reviewed with client
- Date reviewed with guardian
- Signature of client
- Review of clients rights and responsibilities
- Review of goals
- Education plan update

PLAN OF CARE
NIMKEE NUPIGAWAGAN HEALING CENTRE

Page_____

PRIVATE AND CONFIDENTIAL 30 - day_____ Review_____ Transfer _____

Name of Child: _____Date of Birth:_____

Legal Guardian:_____ Referring Agency & Worker:_____

Date of Admission:_____ Date Discharge:_____

Date of Present Plan of Care:_____ Date of Last Plan of Care:_____

Date: of Next Review: _____

Primary & Secondary Treatment Worker:_____

Treatment Coordinator: _____Child's Advocate: _____

Participants in Review: _____

_____

_____

_____

_____

_____

(Must include reason why legal guardian/child/CAS Worker/Probation Officer is not in Attendance)

_____

_____

_____

_____

Date Reviewed with Child:_____Date Reviewed with Guardian:_____

Review of Client Rights and Responsibilities:

_____

_____

_____

_____

Client Signature:_____

Primary/Secondary Signature:_____

Treatment Coordinator Signature:_____

REVIEW OF GOALS: State goals and programs and progress (Include GAS see attached copy)

EDUCATIONAL PLAN UPDATE:

TO ENHANCE SELF ESTEEM

A. Addressing personal values and strengths:

B. Improving your body language:

TO ENHANCE SELF ESTEEM

C. Improve self-image & personal beliefs about self:

_____

_____

_____

_____

_____

D. Address guilt and responsibility:

_____

_____

_____

_____

_____

COMMUNICATION

A. Expressing and accepting feelings:

_____

_____

_____

_____

_____

Verbal and Non Verbal:

_____

_____

_____

Improve social interaction:

_____

_____

_____

Contact with family/home community:

_____

_____

_____

SELF-AWARENESS OF EMOTIONAL SELF

Anger:

Grief:

Anxiety:

Loneliness:

Pleasure:

Empathy:

SELF-AWARENESS OF EMOTIONAL SELF

Moon Cycle (menstruation): _____ **Sexuality:** _____

Personal skills & capabilities:

_____

_____

_____

_____

_____

_____

SELF AWARENESS OF MENTAL SELF

Individual learning styles:

_____

_____

_____

_____

_____

_____

_____

Decision making ability:

_____

_____

_____

_____

_____

_____

_____

SELF-AWARENESS OF SPIRITUAL SELF

Spirit Name: _____ **Clan System:** _____

Native Identity: _____

Cultural, Religious/Language needs/goals:

_____

_____

_____

_____

_____

_____

_____

Relationship with Creation & Creator:

_____

_____

_____

_____

_____

_____

_____

PROBLEM SOLVING

Ability to make choices:

_____

_____

_____

_____

Ability to handle frustration:

_____

_____

_____

_____

Ability to adapt:

_____

_____

_____

_____

COPING SKILLS

Response to stress:

_____

_____

Behaviour:

_____

_____

Integration:

_____

_____

Vulnerability:

_____

_____

ASSERTIVENESS

Safety and protection

_____

_____

Boundaries and privacy

_____

_____

Prevention – ability to say "no" or "yes" : _____

RECOMMENDATIONS

_____

_____

_____

_____

_____

_____

PLAN OF DISCHARGE AND AFTERCARE:

_____

_____

_____

_____

_____

NIMKEE NUPIGAWAGAN HEALING CENTRE
FINAL DISCHARGE REPORT

NAME:_____ Date of Birth _____

TYPE OF TREATMENT: _____INTAKE DATE: _____

DISCHARGE DATE: _____COMPLETED: O O If NO, please state _____

_____

_____

_____

REFERRING AGENCY: _____

REFERRAL CAREGIVER: _____

COUNSELLOR WHILE IN TREATMENT: _____

SUMMARY REPORT: _____

_____

_____

_____

_____

_____

_____

_____

Medications sent home with client:

_____

_____

_____

_____

Instructions for Medication:

_____

_____

_____

_____

DATE: _____**FILE CLOSED:** _____**Program Manager** _____
(Signature)

COPY SENT TO:	**NAME:**	**DATE:**
Referral Agent		
Parent		
Probation Officer		

*Note this report and evaluation follows the aftercare plan.

NIMKEE NUPIGAWAGAN HEALING CENTRE – Discharge Evaluation

Overall comment:

_____

_____

Groups most useful to you (check those that apply):

Personal Choices

- ○ Hygiene
- ○ Consequences
- ○ Self-Esteem
- ○ Conflict
- ○ Family
- ○ Resolution
- ○ Assertiveness
- ○ Roles

Cultural

- ○ Teachings
- ○ Sexual Abuse
- ○ Depression
- ○ Anger
- ○ Sweats
- ○ Sexual Education
- ○

Full Moon

- ○ Ceremony
- ○ Living Skills
- ○ Respect/Boundaries
- ○ Education
- ○ Recreation
- ○ Learning Centre

Groups least useful to you (check those that apply):

Personal Choices

- ○ Hygiene
- ○ Consequences
- ○ Self-Esteem
- ○ Conflict
- ○ Family
- ○ Resolution
- ○ Assertiveness
- ○ Roles

Cultural

- ○ Teachings
- ○ Sexual Abuse
- ○ Depression
- ○ Anger
- ○ Sweats
- ○ Sexual Education

Full Moon

- ○ Ceremony
- ○ Living Skills
- ○ Respect/Boundaries
- ○ Education
- ○ Recreation
- ○ Learning Centre

Was six (6) months long enough for your healing? ○ Yes ○ No

Was six (6) months too long to be away from your family? ○ Yes ○ No

Did you have a home visit during the six (6) months? ○ Yes ○ No

Presentation of program by staff

Was there enough variety in the program? (Write "yes" or "no" as applicable)

_____ Lectures _____ Videos _____ Computers _____ Music _____ Play _____ Outings

_____ Art _____ Ceremonies

NIMKEE NUPIGAWAGAN HEALING CENTRE
DISCHARGE EVALUATION

PRESENTATION OF PROGRAM BY STAFF:

Was the daily program schedule of work and breaks o.k.?	○ Yes	○ No
Did staff allow you to participate in groups?	○ Yes	○ No
Did staff allow you to discuss what you needed to talk about?	○ Yes	○ No
Did you have enough one-one sessions with your counsellor?	○ Yes	○ No

COMMENTS ON PROGRAM CONTENT:

Were you able to apply group information to your to your own life? Example.

_____

_____

_____

_____

What were you hoping to get from treatment? Were you able to get this? What do you need now?

_____

_____

_____

_____

Would you be willing to participate in a two week relapse prevention program at Nimkee?

_____

_____

_____

_____

GENERAL COMMENTS:

_____

_____

_____

_____

NIMKEE NUPIGAWAGAN HEALING CENTRE

Client Satisfaction with Treatment Problems

Please rate your satisfaction with the treatment you received for the following, **please check √ the appropriate category:**

Treatment for:	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied	
Emotional Problems					
Solvent Abuse					
Leisure/ Recreation/ Free Time					
Social/ Relationship					
Expressing Self					
Drug & Alcohol Problems					
Sexual Concerns					
School					
Family Concerns/ Problems					
Medical Problems					
Violence Prevention					
Culture / Native Identity					
Work Skills					
Decision Making					

Client Satisfaction with Staff	Excellent	Very Good	Poor	Very Poor	
Knowledgeable about solvent abuse/addiction					
Respecting client rights to confidentiality & privacy					
Listening					
Caring					
Respecting clients feelings					
Being available when needed					
Helping client meet their goals					
Helping client make better choices					

Client Signature: _____Date: _____

NIMKEE NUPIGAWAGAN HEALING CENTRE

Client Satisfaction with Treatment Activities

Please rate your satisfaction with the treatment you received for the following, **please check √ the appropriate category:**

Treatment Activity:	A Lot of Help	A fair amount of Help	A little helpful	Not at all helpful
Individual Counselling				
Life Skills Groups				
Art Groups				
Cultural Groups				
Sweat Lodge Ceremony				
Other Ceremonies				
Elders Circle				
Learning Centre				
Recreation				
Special Outings				
Sharing Circle				
Play Room				
Arts & Crafts				
Social Outings				
Family Counselling				
Work Placement				

NIMKEE NUPIGAWAGAN HEALING CENTRE

Collaterals' Satisfaction with Treatment Programs

Please rate your satisfaction with the treatment you received for the following, please check √ the appropriate category:

Activities	Very Satisfied	Somewhat Satisfied	Somewhat Dissatisfied	Very Dissatisfied
Support for guardian while dealing with youth substance abuse				
Support for guardian while dealing with youth aggressive behaviours				
Helping Families with issues related to youth's substance abuse				
Getting information about healing and treatment				
Getting information about parenting skills				
Getting information about how to deal with youth aggressive behaviours				
Getting information about solvent abuse/addiction				
Getting support after youth's graduation/ aftercare				
Parent/caregiver's Satisfaction Ratings of staff	**Excellent**	**Good**	**Poor**	**Very Poor**
Being Knowledgeable of solvent abuse/addiction				
Respecting rights to confidentiality				
Listening				
Caring				
Respecting parent/caregiver's feelings				
Helping youth meet goals				
Being available when needed				

Parent/Guardian Signature: _____

Date: _____

NIMKEE NUPIGAWAGAN HEALING CENTRE

Referral Agent Satisfaction with Treatment Program & Staff

Please rate your satisfaction with the treatment you received for the following, **please check √ the appropriate category:**

Program Activities:	Excellent	Very Good	Poor	Very Poor
Individual Counselling				
Client Assessment				
Solvent Abuse education/info				
Group Counselling				
Follow-up Plan				
Treatment Plan				
School				
Recreation				
Cultural programming				
Behaviour Issues				
Life Skills				

Staff Satisfaction	Very Satisfied	Satisfied	Somewhat Satisfied	Unsatisfied
Cooperative				
Professional				
Knowledgeable				
Friendly				
Accessible				
Genuine Interest in Youth				
Caring				

Nimkee NupiGawagan Healing Centre

Client / Collateral / Referral Agent Suggestions for Improvement

Please list any suggestions for improvement & note any strengths of Program/Staff:

POSIT - Problem Oriented Screening Instrument for Teenagers

The POSIT is a multidimensional tool intended to identify adolescents needing further assessment in problem substance use and nine other functional areas. The other nine areas are:

- physical health
- mental health
- family relations
- peer relations
- educational status
- vocational status
- social skills
- leisure and recreation
- aggressive/delinquent behaviour

The POSIT is made up of 139 yes/no questions that explore current functioning. The substance use/ abuse scale has been the subject of most of the attention for criterion-related validation and other psychometric testing. It is made up of 17 items. A briefer 11-item version has been developed.

A follow-up questionnaire is also available and can be used as a descriptive measure in program evaluation.

Population Groups:

- The POSIT has been tested in substance use, mental health, corrections and medical settings

- Aimed at adolescents aged 12 to 19 - with at least a sixth grade reading level

- Can be used in a variety of settings and is useful for developing treatment and referral plans.

Administration:

Formats available include:

- self-administered (paper-and-pencil)

- self-administered (computer)

Time required - 20 to 30 minutes.

Cost:

- No charge for use

Available:

National Clearinghouse for Alcohol and Drug Information
P.O. Box 2345
Rockville, MD 20847-2345
1-900-729-6686

PDF available from the European Monitoring Centre for Drugs and Drug Addiction
http://www.emcdda.europa.eu/eib

Computerized version
PowerTrain, Inc.
8201 Corporate Drive
Suite 1080
Landover, MD 20785
(301) 731-0900

SAMPLE POSIT FORM/QUESTIONS:

Please circle the appropriate yes or no answer.

1. Do you have so much energy you don't know what to do with it?	Yes	No
2. Do you brag?	Yes	No
3. Do you get into trouble because you use drugs or alcohol at school?	Yes	No
4. Do your friends get-bored at parties when there is no alcohol served?	Yes	No
5. Is it hard for you to ask for help from others?	Yes	No
6. Has there been adult supervision at the parties you have gone to recently?	Yes	No
7. Do your parents or guardians argue a lot?	Yes	No
8. Do you usually think about how your actions will affect others?	Yes	No
9. Have you recently either lost or gained more than 10 pounds?	Yes	No
10. Have you ever been intimate with someone who shot up drugs?	Yes	No
11. Do you often feel tired?	Yes	No
12. Have you had trouble with stomach pain or nausea?	Yes	No
13. Do you get easily frightened?	Yes	No
14. Have any of your best friends dated regularly during the past year?	Yes	No
15. Have you dated regularly in the past year?	Yes	No
16. Do you have a skill, craft, trade or work experience?	Yes	No
17. Are most of your friends older than you are?	Yes	No
18. Do you have less energy than you think you should?	Yes	No
19. Do you get frustrated easily?	Yes	No
20. Do you threaten to hurt people?	Yes	No
21. Do you feel alone most of the time?	Yes	No
22. Do you sleep either too much or too little?	Yes	No
23. Do you swear or use dirty language?	Yes	No
24. Are you a good listener?	Yes	No
25. Do your parents or guardians approve of your friends?	Yes	No
26. Have you lied to anyone in the past week?	Yes	No
27. Do your parents or guardians refuse to talk with you when they are mad at you?	Yes	No
28. Do you rush into things without thinking about what could happen?	Yes	No
29. Did you have a paying job last summer?	Yes	No
30. Is your free time spent just hanging out with friends?	Yes	No
31. Have you accidentally hurt yourself or someone else while high on alcohol or drugs?	Yes	No
32. Have you had any accidents or injuries that still bother you?	Yes	No
33. Are you a good speller?	Yes	No
34. Do you have friends who damage or destroy things on purpose?	Yes	No
35. Have the whites of your eyes ever turned yellow?	Yes	No
36. Do your parents or guardians usually know where you are and what you are doing?	Yes	No
37. Do you miss out on activities because you spend too much money on drugs or alcohol?	Yes	No
38. Do people pick on you because of the way you look?	Yes	No
39. Do you know how to get a job if you want one?	Yes	No
40. Do your parents or guardians and you do lots of things together?	Yes	No
41. Do you get A's and B's in some classes and fail others?	Yes	No
42. Do you feel nervous most of the time?	Yes	No
43. Have you stolen things?	Yes	No
44. Have you ever been told you are hyperactive?	Yes	No

SAMPLE POSIT FORM/QUESTIONS:

Please circle the appropriate yes or no answer.

45. Do you ever feel you are addicted to alcohol or drugs?	Yes	No
46. Are you a good reader?	Yes	No
47. Do you have a hobby you are really interested in?	Yes	No
48. Do you plan to get a diploma (or already have one)?	Yes	No
49. Have you been frequently absent or late for work?	Yes	No
50. Do you feel people are against you?	Yes	No
51. Do you participate in team sports which have regular practices?	Yes	No
52. Have you ever read a book cover to cover for your own enjoyment?	Yes	No
53. Do you have chores that you must regularly do a at home?	Yes	No
54. Do your friends bring drugs to parties?	Yes	No
55. Do you get into fights a lot?	Yes	No
56. Do you have a hot temper?	Yes	No
57. Do your parents or guardians pay attention when you talk to them?	Yes	No
58. Have you started using more and more drugs or alcohol to get the effect you want?	Yes	No
59. Do your parents or guardians have rules about what you can and cannot do?	Yes	No
60. Do people tell you that you are careless?	Yes	No
61. Are you stubborn?	Yes	No
62. Do any of your best friends go out on school nights without permission from their parents or guardians?	Yes	No
63. Have you ever had or do you now have a job?	Yes	No
64. Do you have trouble getting your mind off things?	Yes	No
65. Have you ever threatened anyone with a weapon?	Yes	No
66. Do you have a way to get to a job?	Yes	No
67. Do you ever leave a party because there is no alcohol or drugs?	Yes	No
68. Do your parents or guardians know what you really think or feel?	Yes	No
69. Do you often act on the spur of the moment?	Yes	No
70. Do you usually exercise for a half hour or more at least once a week?	Yes	No
71. Do you have a constant desire for alcohol or drugs?	Yes	No
72. Is it easy to learn new things?	Yes	No
73. Do you have trouble with your breathing or with coughing?	Yes	No
74. Do people your own age like and respect you?	Yes	No
75. Does your mind wander a lot?	Yes	No
76. Do you hear things no one else around you hears?	Yes	No
77. Do you have trouble concentrating?	Yes	No
78. Do you have a valid driver's license?	Yes	No
79. Have you ever had a paying job that lasted at least one month?	Yes	No
80. Do you and your parents or guardians have frequent arguments which involve yelling and screaming?	Yes	No
81. Have you had a car accident while high on alcohol or drugs?	Yes	No
82. Do you forget things you did while drinking or using drugs?	Yes	No
83. During the past month have you driven a car while you were drunk or high?	Yes	No
84. Are you louder than other kids?	Yes	No

SAMPLE POSIT FORM/QUESTIONS:

Please circle the appropriate yes or no answer.

85. Are most of your friends younger than you are?	Yes	No
86. Have you ever intentionally damaged someone else's property?	Yes	No
87. Have you ever stopped working at a job because you just didn't care?	Yes	No
88. Do your parents or guardians like talking with you and being with you?	Yes	No
89. Have you ever spent the night away from home when your parents didn't know where you were?	Yes	No
90. Have any of your best friends participated in team sports which require regular practices?	Yes	No
91. Are you suspicious of other people?	Yes	No
92. Are you already too busy with school and other adult supervised activities to be interested in a job?	Yes	No
93. Have you cut school at least 5 days in the past year?	Yes	No
94. Are you usually pleased with how well you do in activities with your friends?	Yes	No
95. Does alcohol or drug use cause your moods to change quickly like from happy to sad or vice versa?	Yes	No
96. Do you feel sad most of the time?	Yes	No
97. Do you miss school or arrive late for school because of your alcohol or drug use?	Yes	No
98. Is it important to you now to get or keep a satisfactory job?	Yes	No
99. Do your family or friends ever tell you that you should cut down on your drinking or drug use?	Yes	No
100. Do you have serious arguments with friends or family members because of your drinking or drug use?	Yes	No
101. Do you tease others a lot?	Yes	No
102. Do you have trouble sleeping?	Yes	No
103. Do you have trouble with written work?	Yes	No
104. Does your alcohol or drug use ever make you do something you would not normally do like breaking rules, missing curfew, or breaking the law?	Yes	No
105. Do you feel you lose control and get into fights?	Yes	No
106. Have you ever been fired from a job?	Yes	No
107. During the past month, have you skipped school?	Yes	No
108. Do you have trouble getting along with any of your friends because of your alcohol or drug use?	Yes	No
109. Do you have a hard time following directions?	Yes	No
110. Are you good at talking your way out of trouble?	Yes	No
111. Do you have friends who have hit or threatened to hit someone without any real reason?	Yes	No
112. Do you ever feel you can't control your alcohol or drug use?	Yes	No
113. Do you have a good memory?	Yes	No
114. Do your parents or guardians have a pretty good idea of your interests?	Yes	No
115. Do your parents or guardians usually agree about how to handle you?	Yes	No
116. Do you have a hard time planning and organizing?	Yes	No
117. Do you have trouble with math?	Yes	No
118. Do your friends cut school a lot?	Yes	No
119. Do you worry a lot?	Yes	No
120. Do you find it difficult to complete class projects or work tasks?	Yes	No

SAMPLE POSIT FORM/QUESTIONS:

Please circle the appropriate yes or no answer.

121. Does school sometimes make you feel stupid?	Yes	No
122. Are you able to make friends easily in a new group?	Yes	No
123. Do you often feel like you want to cry?	Yes	No
124. Are you afraid to be around people?	Yes	No
125. Do you have friends who have stolen things?	Yes	No
126. Do you want to be a member of any organized group, team, or club?	Yes	No
127. Does one of your parents or guardians have a steady job?	Yes	No
128. Do you think it's a bad idea to trust other people?	Yes	No
129. Do you enjoy doing things with people your own age?	Yes	No
130. Do you feel you study longer than your classmates and still get poorer grades?	Yes	No
131. Have you ever failed a grade in school?	Yes	No
132. Do you go out for fun on school nights without your parents' permission?	Yes	No
133. Is school hard for you?	Yes	No
134. Do you have an idea about the type of job or career that you want to have?	Yes	No
135. On a typical day, do you watch more than two hours of TV?	Yes	No
136. Are you restless and can't sit still?	Yes	No
137. Do you have trouble finding the right words to express what you are thinking?	Yes	No
138. Do you scream a lot?	Yes	No
139. Have you ever had sexual intercourse without using a condom?	Yes	No

REFERENCES

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GLOSSARY OF TERMS

References for the Glossary of Terms can be found at the end of this section

Addiction (the term) is most commonly used to refer to the problematic use of alcohol and other drugs. Individuals also engage in other potentially addictive behaviours such as gambling, internet gaming and shopping, etc. For the purposes of this report, addiction is, which is use (or behaviour) that has become habitual and compulsive despite negative health and social impacts.

The behaviours of primary focus are the use of psychoactive substances (alcohol and other drugs), and gambling. It is important to note that these behaviours occur along a continuum and do not always result in addiction. The spectrum of psychoactive substance use, as outlined below, also applies to other behaviours such as gambling:

• Beneficial use, which has positive health or social impacts (e.g., medical psycho- pharmaceuticals, coffee to increase alertness, etc.)

• Casual/non-problematic use, which is recreational or other use that has negligible health or social impacts

• Problematic use, which is use that begins to have negative consequences for individuals, friends/family, or society (e.g., impaired driving; binge consumption; harmful ways in which drugs are taken)

• Chronic dependence, which is use that has become habitual and compulsive despite negative health and social impacts.

Best Practices Systematically developed statements to assist practitioner and patient decisions about appropriate care for specific clinical circumstances (Health Canada, 2001, p. 24) or activities or programs that are in keeping with the best available evidence regarding what is effective (US Department of Health and Human Services, 2001, p.196)

Community Day/Evening Treatment Services refers to a structured, scheduled program of treatment activities typically provided five days or evenings per week (e.g., 3-4 hours per day) while the client resides at home or in another setting, including residential supportive treatment services, to assist the individual to develop skills to manage substance abuse/gambling and related problems.

Case Management Services is a process which includes the designation of a primary worker whose responsibilities include the ongoing assessment of the client and his/her problems, ongoing adjustment of the treatment plan, linking to and coordination of required services, monitoring and support, developing and implementing the discharge plan, and advocating for the client. Case management services are offered regardless where the individual is in the system.

Community Medical/Psychiatric Treatment Services refers to a specific non-residential service to meet the needs of individuals with concurrent disorders. This service may be offered either through a structured day/evening program or community treatment. These services are usually part of broader hospital services and employ physicians, nurses and staff specializing in the treatment of concurrent disorders.

Community Treatment Services is often a 1-2 hour sessions in group or individual format, typically once a week or less often, while the client resides elsewhere in the community. Community counselling/treatment includes brief intervention, lifestyle and personal counselling to assist the individual to develop skills to manage substance abuse/gambling and related problems, and/or maintain and enhance treatment goals. Such activities as relapse prevention, Guided Self-change, family intervention, follow-up and aftercare are included here. Care may be provided with or without medical/ psychiatric treatment. Frequency and length of sessions may vary depending on client need and program format. It may be offered in a variety of settings including outreach to the client's home, school, an addiction agency or other service setting. Outreach includes activities such as early intervention but not prevention, education or public relations activities.

Community Withdrawal Management Services Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. Clients may be simultaneously accessing residential support services, or they may be residing in their home, the home of a significant other or in another community setting, supervised or unsupervised. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Service is provided at three levels. .

Concurrent disorders applies to people who have been diagnosed with both a mental illness and an addiction. People experiencing a combination of mental / emotional / psychiatric problems with the abuse of alcohol and/or other psychoactive drugs. In diagnostic terms refers, to a combination of mental health and substance use disorders as defined (for example) on either Axis I or Axis II of DSM-IV (Health Canada, 2001, p.7). People having a combined or concurrent substance use and mental health problems are said to have a concurrent disorder (CAMH).

Dual diagnosis applies to people diagnosed with a developmental disability and a serious mental illness.

Entry (Intake) refers to activities and decision-making steps that underlie the process by which someone obtains information about and/or enters the addiction treatment system. Including:

• **Inquiry Contact** (a request for information about agency programs, the treatment system, or other issues, made by a person from the community, a staff member from another agency, or another professional)

• **Intake** (contact with a person to determine whether he or she is eligible for agency services, to register the client into the agency, and to orient the client to services available at the agency)

GLOSSARY OF TERMS

• **Screening** (a brief process that collects information in only enough detail to determine the client's immediate needs and to provide direction for next steps in the assessment/treatment process. The screening process can also provide information to clients, which assists clients in clarifying their own position regarding next steps. Screening may occur in an individual or group format.)

• **Outreach** (to take proactive steps to identify and connect with potential clients in the client's environment; to engage people who are at risk or have substance abuse or gambling problems (e.g., schools, high risk neighbourhoods, raves, shopping malls)

• **Crisis** (immediate response to people in crisis through easy access that provides practical substance abuse and/or problem gambling assistance, support, advice or attention to urgent medical, psychosocial and/or basic needs)

The various **Entry** activities may occur by telephone, Internet, or face to face, and may be conducted in one or more sessions, in one or more locations, and individually or in a group.

Evidence-based Programs or interventions that have undergone scientific evaluation and have proven to be effective (Adapted from US Department of Health and Human Services, 2001, p. 198).

Harm Reduction is both a philosophy and a set of practices that are pragmatic, evidence-based, and rooted in the intention to reduce harm. Harm reduction strategies embrace a long-term view of intervention and change, and place an emphasis on immediate, achievable and protective approaches to positive change.

Health Promotion is the process of enabling people to increase control over and to improve their health.

Initial Assessment/Treatment Planning Services

The initial assessment is a process involving mutual investigation or exploration that provides the clinician with more detailed information for the purpose of determining specific client needs, goals, characteristics, problems and/or stage of change. Assessments vary in length according to the client's situation, and comprehensive assessments may be reserved for clients with more complicated histories and problems. This assessment forms the basis for initial treatment planning, a process of negotiation based on feedback from the assessment results, the client's strengths, prioritized problem areas, clinician judgment, client preferences and readiness for change, and the identification of potential barriers to treatment entry. This culminates in the development of a clear plan of action, including referrals as appropriate.

Mental Health According to the WHO there is no "official" definition of mental health. However, most experts agree that mental health and the absence of mental illness is not the same thing; the absence of a recognized mental disorder is not the only indicator for mental health. Therefore, mental health can be understood as a resource that:

• Enables individuals and communities to control their subjective well-being and to cope with adversity and change

• Supports meaningful and inclusive participation in social environments.

Mental Health and Addictions Systems

The term "mental health and addictions systems" is used throughout this report to refer to specialized health treatment, services and supports for people with mental illness, problematic substance use and gambling. However, people with mental health or addiction issues may also interact with many other general health, social and community based services, including primary care, long-term care, home care, income support, police, justice and corrections, housing, and schools.

Recovery

There is significant divergence around the word recovery and its interpretation differs among many groups. In this paper, we endorse a broad vision of recovery that involves a process of restoring or developing a positive and meaningful sense of identity apart from one's condition, and a meaningful sense of belonging while rebuilding a life despite or within the limitations imposed by that condition. A recovery oriented system of care identifies and builds upon each individual's assets, strengths, and areas of health and competence to support achieving a sense of mastery over his or her condition while regaining a meaningful and constructive sense of membership in the broader community.

Residential Treatment Services is a structured, scheduled program of treatment and/or rehabilitation activities provided while the client resides in-house, to assist clients to develop and practice the skills to manage substance use and related problems. In addition to the scheduled program activities, clients have 24 hour access to support and the residential treatment milieu.

Residential Medical/Psychiatric Treatment Services is often a structured, scheduled program of addictions treatment and/or rehabilitation activities provided for clients whose biomedical, emotional and/or behavioural problems are severe enough to require individualized medical/ psychiatric care, while the client resides in-house. The treatment and/or rehabilitation is intended to assist the individual in stabilizing and managing his/her medical/ psychiatric problems, while also addressing the addiction problem per se, or to allow for referral to appropriate substance abuse/gambling treatment. In addition to the scheduled program of addictions treatment and rehabilitation activities clients have 24 hour access to support and the residential treatment milieu.

Residential Supportive Treatment Services

• **Level I:** Housing and related recovery/support services such as lifestyle counselling, coaching for activities of daily living, community reintegration, vocational counselling and mutual aid, provided to clients who require a stable, supportive environment prior to, during, or following treatment, which is accessed elsewhere.

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• **Level II:** Housing/accommodation in alcohol/drug-free setting. Addiction services are not offered on-site or as part of the housing service.

Residential Withdrawal Management Services
Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. This care is provided in a Withdrawal Management (detoxification) Centre, or on an inpatient basis in a hospital. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Service is provided at three levels (the following apply to both community and residential withdrawal management services):

Level I

• Client symptoms can be safely monitored by staff who are not medically trained.

• Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after-hours clinic/health centre/hospital emergency department.

• Client/staff ratios do not permit high intensity symptom monitoring.

• In consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication:

Medications for medical problems

Medications for diagnosed psychiatric problems

Pain medications only for acute injuries or recent surgery

Level II

• Client symptoms can be safely monitored by staff who are not medically trained.

• Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after-hours clinic/health centre/hospital emergency department.

• Routine medical consultation and sufficient staff resources are available to consider management of the following medications/situations:

All medications as listed in Level I

Clients on methadons

Clients being tapered from benzodiazepines or narcotics

Level III

• Client symptoms require monitoring by medically trained staff

• Medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations:

All medications as listed in Level I

Circumstances as listed in Level II

Medically- assisted withdrawal

Screening can be done using various methods to identify whether a person may have a mental health or substance abuse issue that warrants more comprehensive methods. The screening process is used to determine the appropriateness and eligibility of a client for admission to a particular program. Through the screening process, the counsellor and client (and often family members) determine the most appropriate initial course of action given the client's needs and characteristics and available services and supports in the community.

Serious Mental Illness The three categories used to identify people with serious mental illness are:

• Disability

• Anticipated duration and/or current duration

• Diagnoses

The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to a diagnosable disorder.

Disability refers to the fact that some individuals lack the ability to perform basic living skills such as eating, bathing, or dressing; maintaining a household, managing money, getting around the community and appropriate use of medication; and functioning in social, family and vocational-educational contexts.

Anticipated Duration/Current Duration: Evidence may indicate that a person's problem may be ongoing in nature. This does not mean that the problems are continuous; there may be intermittent periods of full recovery or enduring long-term recovery, and some can fully recover.

Diagnoses: For example, schizophrenia, mood disorders, organic brain syndrome, and paranoid and other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included.

Stigma is attached to people or groups who are viewed as different from society's norms, mainstream behaviours or identities. In effect, stigma is often used as a way of discrediting, isolating and ultimately attempting to control people who fall within a stigmatized group. It is a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation.

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Substance Use Problem is a broad term describing a wide range of social, personal and/ or physical problems as a result of the use of alcohol or other drugs, but where use has not yet resulted in substance dependence.

Substance Use Disorders is a diagnostic term that refers to a habitual pattern of alcohol or illicit drug use that results in significant problems related to aspects of life such as work, relationships, physical health, financial well-being etc. There are two mutually exclusive subcategories – substance abuse and substance dependence. In some cases, the use of substances per se (as distinct from abuse or dependence) negatively impacts people with mental health problems (Health Canada, 2001, p. 8).

Suicidality is a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide (US Department of Health and Human Services, 2001, p. 203).

System Integration refers to the development of enduring linkages between service providers or treatment teams within or across multiple systems to facilitate the provision of services to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/ support workers working for different treatment units or services providers. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan (Health Canada, 2001, p16).

Trauma-informed Services take into account the impact of trauma and integrate this knowledge into the services being provided. A trauma informed perspective views the behaviours as a response or coping mechanism of past or current abusive/traumatic experiences. Trauma informed services do not require that the issue be disclosed; rather, it is the understanding that trauma may have an impact in an individual's life and be prepared to work in ways that will support the individual across the continuum of services. In trauma-informed services, all staff are trauma trained and understand the impact of trauma on the lives of those who are seeking help.

Treatment Integration occurs when mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.

GLOSSARY OF TERMS REFERENCES

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ENDNOTES

[i] From: Navigating Screening Options for Concurrent Disorders (CAMH, 2006):

• The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders): The DSM is used in North America to diagnose mental health disorders. The fourth and most recent edition, the DSM-IV, organizes mental disorders into 16 major diagnostic classes—for example, mood disorders and substance-related disorders. Within these diagnostic classes, disorders are further broken down—for example, depressive disorders and bipolar disorders are included in the mood disorders class. For each disorder, the DSM-IV lists specific criteria for making a diagnosis.

• Reliability: The stability of measurements across time.

• Sensitivity: Correct identification of people who meet the criteria for a particular diagnosis or problem.

• Specificity: Correct identification of people who do not meet the criteria for a particular diagnosis or problem.

• Validity: The degree to which a test measures what it is intended to measure.

[ii] Admission and Discharge Criteria and Assessment Tools ("ADAT") is a comprehensive package to be used by professionals to determine the most appropriate level and intensity of care that a client needs. The clinical assessment tools included in the package are DHQ, Adverse Consequences, Health Screening Form, SOCRATES, TEQ, PSS, DTCQ-8, BASIS-32 and Clinical Profile Form. Six of the eight tools that make up the ADAT suite of tools are owned by CAMH. CAMH does not own the other two tools (BASIS-32 and SOCRATES); they are not part of this Agreement. DATIS is the sole Canadian licensor for BASIS-32. There is a license fee associated with its use. Depending on the agency's status with the Ministry of Health & Long Term Care, this fee might have been already covered by exiting agreements. For further details, please contact DATIS at datis_staff@camh.net). The SOCRATES is in the public domain and may be used without cost or permission. This Licensing Agreement grants permission only for those tools owned by CAMH. Any reference throughout this Agreement to ADAT will mean only those tools to which CAMH has ownership.

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Limitation of Liability

The main purpose of ADAT is to help determine the most appropriate level and intensity of care that a client needs at a point in time. ADAT is designed to be administered by a qualified healthcare provider (including, but not limited to addiction or mental health workers, other clinicians, counsellors, or nurses). ADAT was designed to be used in combination with standard clinical evaluation and interview to collect information that will help a provider determine treatment recommendations that best fit the client at that time, within the system of care in their particular environment/geographical location. ADAT is not designed to replace a clinical evaluation; accordingly, a provider should fully evaluate any client and not rely solely on ADAT results to make diagnostic or treatment-related decisions. The information contained and generated in these materials is not intended nor implied to be a substitute for medical diagnosis or treatment or for professional medical advice. CAMH shall not be liable to the Licensee, or any client of the Licensee or any third party for any damages arising out of the Licensee's use of ADAT.

Governing Law

This Agreement shall be interpreted according to the substantive laws of Ontario, regardless of the choice of law rules of any jurisdiction, and the Licensee agrees to submit to the jurisdiction of Ontario courts. This Agreement expresses the complete understanding of the parties with respect to the subject matter and supersedes all prior representations and understandings.

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nnapf
national native addictions partnership foundation

fanpd
Fondation autochtone nationale de partenariat pour la lutte contre les dépendances