ADAPT
HALTON ALCOHOL, DRUG and GAMBLING
ASSESSMENT PREVENTION & TREATMENT SERVICES

Problem Gambling Day Treatment Program

Information and Referral Package

(January 2017)

Dear Colleagues and Clients:

Thank you for your interest in the ADAPT Problem Gambling Day Treatment Program. This 5-day program runs Monday through Friday, 9:30am to 3:30pm. It is available to any resident of Ontario.

Our program is facilitated by professional counsellors, who specialize in the treatment of problem gambling. Funded by the Ontario Ministry and Health and Long-Term Care, all services are fully confidential and provided at no fee to the participant.

We encourage participation in the program for individuals who are. . .

- Beginning treatment for problem gambling and would like to establish a solid foundation for ongoing recovery.
- Beginning treatment for problem gambling and would like to stabilize the gambling by accessing a full week of support in a safe setting.
- Trying to reduce or stop his/her gambling and are struggling to meet those goals through outpatient/community counselling.
- Working to stop or reduce gambling, but have had a relapse and would like to intensify recovery efforts.
- Attending other programs and would like to learn and apply new skills and strategies that will further strengthen recovery.
- wanting to attend a gambling recovery program in his/her local community, but does not feel safe in doing so because of concerned about privacy/anonymity.
- Wanting to attend a residential recovery program, specific to gambling, but cannot afford more than a week off work to meet this goal.

The ADAPT Problem Gambling Day Treatment Program also offers a “Family and Friends” workshop for those close to the problem gambler to gain information, education and support. Information will be provided during the day treatment cycle.

We thank you for your interest in this program. Please do not hesitate to call our toll free Intake Line for enquiries or referrals. The number to call is **1-866-783-7073.** We look forward to hearing from you.

Sincerely,

Jackilyn Alberton
Program Manager
Problem Gambling & Behavioural Addictions
905-691-0231
jalberton@haltonadapt.org

Intake Continued

Referral Requirements

In order for our program to deliver the best services possible to each client, we ask that the following information be included at the time of the referral. If possible, our staff will develop specialized programming, based on the needs of the participants. Your assistance in helping us to have a clear understanding of the client's needs, goals and challenges is instrumental in enabling the program to best meet the client's needs.

Please include the following documents with your referral:

1) CATALYST Client Profile and Admission Information **OR** ADAPT Client Information form (provided in this package)
2) CATALYST OSAB Required Gambling Data Form **OR** OSAB form (provided in this package)
3) A signed consent to release and disclose information between referring agency and ADAPT (included in this package)
4) A signed consent to allow the ADAPT Day Treatment Program to contact the client directly (included in this package)
5) Safety and Special Needs form (included in this package)

Completed packages can be sent by fax:

905-639-6880
Attention: Jackilyn Alberton

Should you have questions, please contact Jackilyn Alberton at 1-866-783-7073.

Intake Continued

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Consent to the Collection, Use and Disclosure of Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

All employees of ADAPT are mandated under law to protect the personal health information/clinical records of every client. Signing this form will allow consent for the sharing/disclosure of your personal health information between the parties noted. This consent/authorization may be withdrawn, upon request, at any time.

I _____ **(D.O.B.** _____ **),**
Print full name dd/mm/yy

of _____, **hereby authorize**
Address of client

_____**To disclose personal health**
Name of person/agency disclosing information

information to _____**.**
Name of person/agency receiving information

This consent applies to information in the records of:

_____ _____
Client name (printed) Date of birth (dd/mm/yy)

_____ _____
Client signature Today's date

_____
Signature of witness

NOTES: This section includes any explicit restrictions/instructions pertaining to the information to be disclosed under this consent.

Problem Gambling Day Treatment Program Referral, Participation and Discharge Planning.

Consent for ADAPT to Contact Program Participant Directly

I _____, **(D.O.B**_____**),**
Print Full Name dd/mm/yy

Hereby authorize ADAPT to contact me directly with the following restrictions:

Contact by PHONE:

- ☐ **Do not contact me by phone.**
- ☐ **Contact me at the following phone numbers only:** _____
  _____
- ☐ **Never leave a phone message.**
- ☐ **Leave a phone message, and identify ADAPT in the message.**
- ☐ **Leave a phone message, but do not identify ADAPT in the message. Leave your name only.**
- ☐ **Leave a phone message, but do not identify ADAPT. Identify yourself as** _____.

Contact by EMAIL:

- ☐ **Do not send anything to me by email.**
- ☐ **Send email to the following address:** _____

This consent applies to information in the records of:

_____ _____
Client Name (Printed) Date of Birth (dd/mm/yy)

_____ _____
Client Signature Today's Date

_____
Signature of Witness

OTHER INSTRUCTIONS FOR CONTACT:

Intake Continued

ADAPT Problem Gambling Day Treatment Program
Safety and Special Needs

It is important that your participation in the ADAPT Problem Gambling Day Treatment Program is a safe and enjoyable experience. Please assist us in ensuring your safety and comfort by completing the following form.

Are you presently taking medications to be taken in case of emergency? (e.g. asthma medications, EpiPens, Nitro-Glycerin, etc.)?

Please list any emergency medications you may require and will have with you during the program.

_____

_____

_____

_____

Do you have any food allergies and/or have a restricted diet due to personal, religious or medical reasons?

Please list any food restrictions you have.

_____

_____

_____

_____

ADAPT
HALTON ALCOHOL, DRUG and GAMBLING ASSESSMENT PREVENTION & TREATMENT SERVICES

ADAPT Client Information Form

Name: _____ _____
(First) (Last) (Here before? Y/N)

D.O.B: _____ **Gender:** _____ **Last Name at Birth:** _____
D M Y

Principle ☐ **Collateral** ☐ **Client Type (A D G):** _____ **Adult/ Youth/ Family Member**

Referring Source: _____ **Referring Agency:** _____

Language: _____ **Ethnicity:** _____

Address _____

City: _____ **Postal Code:** _____ **Country of Res:** Canada

Address Effective Date: _____

Home Phone:	_____	**Call?** ☐	**Msg?** ☐	**ADAPT name?** ☐
Work Phone:	_____	**Call?** ☐	**Msg?** ☐	**ADAPT name?** ☐
Cell Phone	_____	**Call?** ☐	**Msg?** ☐	**ADAPT name?** ☐
Family Contact:	_____	**Call?** ☐	**Msg?** ☐	**ADAPT name?** ☐

Notes/ Substance Used: _____

Intake Continued

ADAPT
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Name: _____ **Client Number:** _____
(First) **(Last)**

Client Information

In order to provide the best possible care, we ask that you complete the following questions.

Client type:

- ☐ Client
- ☐ Family Member
- ☐ Non-Ministry Client
- ☐ Non-Ministry Family Member

Issues concerning:

- ☐ Alcohol
- ☐ Drugs
- ☐ Alcohol & Drugs
- ☐ Gambling

Are you required to attend? If yes please indicate.

- ☐ Parole and Probation
- ☐ Family
- ☐ Child Welfare Authority
- ☐ Employer
- ☐ Education
- ☐ Unknown
- ☐ Diversion
- ☐ Safe Schools
- ☐ Other _____
- ☐ No

What is your current legal status?

- ☐ On Probation or Parole
- ☐ Waiting Trial/Sentence
- ☐ None
- ☐ Unknown

What is your current relationship status?

- ☐ Married/ Partner/C Law
- ☐ Unknown
- ☐ Separated/ Divorced
- ☐ Widow/Widower
- ☐ Single (Never married)

What is your current employment status?

- ☐ Full Time
- ☐ Unemployed
- ☐ Part Time
- ☐ Student
- ☐ None
- ☐ Retired
- ☐ Disabled
- ☐ Unknown

What is the highest level of education completed?

- ☐ No Formal Schooling
- ☐ Some College
- ☐ Some Primary
- ☐ Completed College
- ☐ Completed Primary
- ☐ Some University
- ☐ Some High School
- ☐ Completed University
- ☐ Completed High School
- ☐ Unknown

What is your current income source?

- ☐ Employment
- ☐ Family Support
- ☐ Ontario Works (OW)
- ☐ Disab. Ins. (ODSP)
- ☐ Employment Insurance
- ☐ Retirement Income
- ☐ Other _____
- ☐ None

Please check any boxes that apply at this time.

Presenting Issues at Admission:

- ☐ Substance Use
- ☐ Emotional
- ☐ Anger/ Violence
- ☐ Educational/ Employment
- ☐ Child Welfare Involvement (CAS)
- ☐ Concurrent Disorder
- ☐ Accommodations
- ☐ Not Applicable
- ☐ Legal Issues
- ☐ Financial
- ☐ Physical Health
- ☐ Parenting/ Child

Intake Continued

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HALTON ALCOHOL, DRUG and GAMBLING ASSESSMENT PREVENTION & TREATMENT SERVICES

Name: _____ **Client Number:** _____
(First) **(Last)**

Substance Use History

Using the list below, please list presenting problem substances and frequency of use within the PAST 30 DAYS.

Presenting Problem Substance(s)	**Frequency of Use (Within Last 30 Days) - Use Letter Code**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Letter Codes

A. Did Not Use
B. 1-3/ Month
C. 1-2/ Week
D. 3-6/ Week
E. Daily
F. Binge
G. Unknown

Please check the substances you have used within the PAST 12 MONTHS.

Substances Used in Last 12 Months: (Check all that apply)

- ☐ Alcohol
- ☐ Cocaine
- ☐ Crack
- ☐ Ecstasy
- ☐ Cannabis (i.e.: Marijuana, Hash, Hash Oil)
- ☐ Glue/ Inhalants (i.e.: Glue, Gas, Ether, Nail Polish etc…)
- ☐ Heroin/ Opium
- ☐ Methamphetamine (i.e.: Crystal Meth)
- ☐ Over The Counter Codeine
- ☐ Prescription Opioids
- ☐ Steroids
- ☐ Tobacco
- ☐ Other Psychoactive (i.e.: Anti-Depressants, Anti-Psychotics, Dilantin, Prozac, Lithium, Tranquilizers, Robaxin, Sleeping Pills, Zoloft etc…)
- ☐ Amphetamines/ Stimulants (i.e.: Speed, Ritalin, Wake-Ups, Pseudoephedrine)
- ☐ Barbiturates (i.e.: Downers, Florinal, Seconal, Tuinal etc…)
- ☐ Benzodiazepines (i.e.: Ativan, Clonazepam, Diazepam, Valium, Xanax)
- ☐ Hallucinogens (i.e.: LSD, Angel Dust, Magis Mushrooms, Mescaline, Salvia, GHB, Ketamine)
- ☐ Other Please Specify: _____
- ☐ Unknown
- ☐ None

Gambling History

Gambling identified as a problem? _____ **Y/ N/ Unknown**

Refer to Gambling Counsellor? _____ **Y/ N/ Unknown**

Please check the activities you have participated in within the PAST 12 MONTHS.

Gambling Activities in the Last 12 Months : (Check all boxes that apply)

- ☐ Bingo
- ☐ Slot Machines
- ☐ Gaming Machines (other than slots)
- ☐ Card/ Table Games – Casino
- ☐ Informal/ Illegal Types of Gambling
- ☐ Horse Races
- ☐ Sport Betting
- ☐ Lottery Tickets
- ☐ Instant Win/ Scratch Tickets
- ☐ Internet Gambling
- ☐ Gambling with Stock Market/ Real Estate
- ☐ Betting on Games of Skill
- ☐ Betting on Outcome of Events
- ☐ None

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HALTON ALCOHOL, DRUG and GAMBLING
ASSESSMENT PREVENTION & TREATMENT SERVICES

Name: _____ **Client Number:** _____
(First) (Last)

Physical Health Status

Visual Impairment: ☐ Yes ☐ No ☐ Unknown **Hearing Impairment:** ☐ Yes ☐ No ☐ Unknown

Mobility/ Physical Impairment: ☐ Yes ☐ No ☐ Unknown **Pregnant:** ☐ Yes ☐ No ☐ Unknown

Have you ever injected drugs? ☐ Yes ☐ No ☐ Unknown **If yes:** ☐ Prior to one year ago ☐ Within 12 months

Have you been admitted to the hospital overnight within the past 12 month for a physical ailment? ☐ Yes ☐ No ☐ Unknown **If yes:** _____ **times**

Mental Health Status

Have you been diagnosed with mental health problems? **Within last 12 months** ☐ Yes ☐ No ☐ Unknown

Diagnosis #1 _____ **In your lifetime** ☐ Yes ☐ No ☐ Unknown

Diagnosis #2 _____

Have you been hospitalized for mental health problems? **Last 12 months** ☐ Yes ☐ No ☐ Unknown

Lifetime ☐ Yes ☐ No ☐ Unknown

Have you received counseling/ support/testing for mental/emotional/behavioral/psychological problems? **Currently** ☐ Yes ☐ No ☐ Unknown

Last 12 months ☐ Yes ☐ No ☐ Unknown

Lifetime ☐ Yes ☐ No ☐ Unknown

Have you received prescribed medication(s) for mental health problems? **Currently** ☐ Yes ☐ No ☐ Unknown

Prescription #1 _____ **Last 12 months** ☐ Yes ☐ No ☐ Unknown

Prescription #2 _____ **Lifetime** ☐ Yes ☐ No ☐ Unknown

Other health conditions? (e.g. Diabetes etc…) ☐ Yes ☐ No ☐ Unknown **If yes, please list:** _____

Family Doctor: _____ **Methadone/ Opioid Substitute Prescribed?** ☐ Yes ☐ No ☐ Unknown

CATALYST OSAB GAMBLING DATA FORM
Page 1

1. Are you seeking help for:

___ Your own difficulties related to a family member/significant other's gambling. STOP HERE

___ Your own gambling problem. PLEASE CONTINUE

___ Both. PLEASE CONTINUE

2. Looking back now, for how many years has your gambling affected your life in negative ways?

Years ____ Months ____

3. Please indicate how long it has been since you last gambled:

Years ____ Months ____ Weeks ____ Days ____

4. Please indicate whether:

___ You came to this agency specifically for gambling treatment

___ Your gambling problem surfaced in the course of other treatment

CATALYST OSAB GAMBLING DATA FORM
Page 2

5(a) Please indicate how often you engaged in each of the following gambling activities in the past 12 months:

Did not gamble in the past 12 months: ___

		Did not gamble	Less than 1x/month	1-3x/ month	1-2x/ weekly	3-6x/ weekly	Daily	Unknown
1	Played cards							
2	Played Mah-jong							
3	Played live KENO							
4	Played Roulette							
5	Bet on horses, dogs, or other animals							
6	Bet on sports							
7	Bet on dice games (e.g. craps)							
8	Bought lottery tickets							
9	Bought scratch tickets							
10	Bought tear-open tickets							
11	Played bingo							
12	Played stock options/commodities market							
13	Played VLT's							
14	Played slots or other non-VLT's							
15	Internet gambling							
16	Played pool/golf or other game of skill							
17	Sports pools							
18	Bet on random events/informal bets							
19	Other							

5 (b) Please indicate the top three types of gambling problems, using the activity members in 5(a):

Major _____ 1st other _____ 2nd other _____

CATALYST OSAB GAMBLING DATA FORM
Page 3

6(a) Please indicate how often you gambled in each of the following locations in the last 12 months:

		Did not gamble	Less than 1x/month	1-3x/ month	1-2x/ weekly	3-6x/ weekly	Daily	Unknown
1	Commercial casino							
2	Charity gaming club							
3	Bingo hall							
4	Race track							
5	Off-track betting location							
6	Internet							
7	Television							
8	Telephone							
9	Lottery kiosk/outlet							
10	Family/friends setting							
11	Social club							
12	Restaurant/ bar							
13	School setting							
14	Work setting							
15	Senior's centre/home							
16	Custody facility							
17	Somewhere else in the community							

6 (b) Please indicate the top three locations for gambling, using the numbers in question 6(a):

Major _____ 1st other _____ 2nd other _____

7. Thinking about the times you gambled in the past 12 months, what percent were:

(a) in Ontario _____ %

(b) In another province _____%

(c) Outside of Canada _____%

(numbers should add up to 100%, zeros not necessary)

PLEASE GIVE TO CLIENT

Important Program Information

Dear Program Participant:

Thank you for your interest in the ADAPT Problem Gambling Day Treatment Program. Our staff looks forward to meeting you and to working with you. We are committed to ensuring the program provides a safe and supportive environment for all participants. Please review this document. It contains some key information to help you prepare for participation in the program. If you have any questions or concerns, please do not hesitate to call the Program Manager at 905-691-0231 or toll free at 1-866-783-7073.

Food and Refreshments:
Our program believes that good nutrition is important to a healthy lifestyle. We encourage all program participants to eat a healthy breakfast each day before coming to the program. The program will provide coffee and tea each morning and lunch will be served at noon each day. All food and beverages are provided at no cost to the participants.

Food Allergies / Restrictions:
Program participants will be screened for food allergies and/or food restrictions based on medical, religious or personal needs. We will do everything possible to ensure that the food provided contains no ingredients identified as causing concern. Despite such precautions, some participants may choose to provide their own lunch. We ask that you please inform the program staff if you plan to bring food to the program site, to ensure that no products are brought into the site that may cause risk to other participants.

Clothing and Dress Code:
It is important that you are comfortable during the program. We recommend that participants wear a sweater or jacket to ensure that they can be comfortable if the room temperature fluctuates.
Please do not wear any clothing with beer/alcohol logos, drug references, or gambling references or symbols.

Medications:
Participants who are taking medications for physical or mental health issues may continue to use these medications, as prescribed, during the program. It is the responsibility of each participant to ensure that they have all of their required medications for the day.
Under no circumstances should a participant accept or distribute medications from or to other participants.
If recent changes in your medications are causing notable issues with lethargy or concentration, please contact the program manager to discuss these concerns prior to the program start date.
If you have any emergency medications (Epipens, nitro-glycerin etc.), please bring these with you, and inform the program staff of any special instructions related to the use of these medications.

Substance Use
During the five days of the program, all participants are asked to abstain from all alcohol and/or drug use, including abuse of prescription medications. If you feel this will be a difficult condition for you to meet, please contact the program manager to discuss the issue prior to the program start date.

Gambling while in Program:
All program participants are encouraged to abstain from ALL forms of gambling during the course of the program. Even where abstinence may not be your long-term goal, we ask that abstain during the program week in order to stay focused on the program material that is provided.

Perfumes and Fragrances:
Some participants are sensitive or allergic to certain perfumes and fragrances. We ask that all participants refrain from the use of perfumes and fragrances during the program.

Sharing Personal Information:
We strongly recommend that you do not share personal contact information (i.e. phone numbers, addressed, e-mail addresses, etc.) with other program participants. Many models of treatment encourage group members to share their contact information in the hope that they can provide or gain support. In early recovery, however, the sharing of such information can increase your levels of personal stress and anxiety. In some cases, the sharing of personal contact information can increase relapse risk and threaten recovery.

Transportation:
The program does not provide transportation to and from the treatment site. All participants are responsible for arranging their own transportation. We strongly recommend that participants do not offer to provide transportation to other program participants. This recommendation is made for your own protection from potential liability and/or lawsuits.

Health Card:
The program does NOT require your Health Card Number. However, we ask that all participants have their Health Card with them at all times, in case of a medical emergency or accident that requires services through the local hospital.

Other Special Needs:
Please inform our staff if you have any other special needs. This will help to ensure that your involvement in the program is safe and comfortable.

Thank you for your consideration of these guidelines. We look forward to working with you in a safe, healthy and mutually respectful environment.