CONNECTIVE

Northern BC Therapeutic Community (NBCTC)

The Northern BC Therapeutic Community (NBCTC) operates within an adaptive therapeutic community model, where substance use and mental health care overlap within a supportive community. NBCTC believes this community offers a pathway to positive change and enhances their individual psychotherapeutic work.

Within NBCTC, residents make collective decisions, work together to build a community, and take an active role in their well-being; ultimately, residents are able to develop new relationships with themselves.

The therapeutic community encourages:

- Group Responsibility
- Personal responsibility
- Citizenship
- Democracy
- Empowerment

NBCTC is located about 30 km southwest of Prince George, BC. The large, remote property allows residents to grow food and interact with various livestock. Our unique community offers a safe, healing space where men can focus on reclaiming their physical, emotional, mental, and spiritual well-being.

Minimum length of stay: 6 Months.

Recommended length of stay: 9 months

The program is broken up into three parts:

1. Introduction (to the community and your authentic self): 0-3 Months
2. Transformation (into self and wellness): 3-6 Months
3. Reunification (taking ownership of your new life in society): 6-9+ Months.

APPLICATION INFORMATION

NBCTC does not currently take direct or self-referrals. Approved referrals can come from:

- Community Addictions Counsellors
- Community support workers
- Registered Social Workers
- Mental Health Professionals
- Provincial detox centers
- All outpatient programs funded by any of the provincial Health Authorities
- Social Workers in the Ministry of Housing and Social Development Offices
- Correction Services Canada authorized staff
- Probation Officers
- Physicians

Once you have been referred, the next step is to complete this application package with the help of a community service professional.

If you need help completing the application, please contact us. We will connect you with a community service that can assist you.

Email: admissions.nbctc@connective.ca

PLEASE CONSIDER THE FOLLOWING BEFORE MOVING FORWARD WITH THE APPLICATION:

- The community is only able to manage low-to-moderate withdrawal symptoms. Anyone experiencing more extreme symptoms will be required to visit a medical detox facility before accessing NBCTC.
- Potential applicants must have the capacity to participate fully in the program (cognitively and physically).
- The community is not currently accessible in wheelchairs.
- The success of this model requires a commitment to a long-term stay.
- Applicants must have approved funding in place before joining.
- Applicants must be of adult legal age in B.C. – 19 years.
- Applicants must have approved Medical Services and medication coverage. Out-of-province coverage may not directly align with BC coverage.
- Successful applicants must bring a two-week supply (or fax prescriptions

before they arrive) for any medication(s) ordered by a physician.

When you have completed your application, please email it to admissions.nbctc@connective.ca (Attention: Intake Coordinator). Our Intake Coordinator will get back to you as soon as possible and help you through the application process.

Once your application has been received, it will be reviewed by the Application Referral team. If approved, the next and final step will be a question-and-answer call with selected community members. After the call, the community members will submit an evaluation, and this will inform final acceptance.

This process helps ensure that you are a good fit for the program and will fit in with the existing community.

Updated Note:
We now have publicly funded beds available for clients who do not have access to other sources of funding.

While these beds cover the cost of the program, we strongly recommend that applicants have some personal funding available to purchase essential items sold on-site. These may include:

- Cigarettes or vape products
- Hygiene supplies
- Small convenience food items

By applying for a publicly funded bed, applicants acknowledge that they are responsible for any personal expenses not covered by the program.

RESIDENT INFORMATION & APPLICATION FORM

Referral Date: _____

How did you learn about NBCTC? Check any that apply:
☐Website ☐ Word-of-mouth ☐Online Search ☐Previous Referral ☐Friend/Family ☐Professional

Applicant Information:
First Name:_____Middle Name(s):_____Last Name: _____

Preferred Name:_____

Home Phone: _____ Cell Phone: _____

Alternative phone: _____

Mailing Address: _____City:_____Province:_____

PHN Number: _____ SIN#:_____

Date of Birth: Month_____Day_____Year_____

Highest Level of Education Completed
☐High school ☐ Some high school grade ☐ Trade School

Post-Secondary: ☐Certificate ☐ Diploma ☐ Degree

Emergency Contact Name
Name:_____Relationship:_____Contact Number: _____

Alternate: _____

Referral Agent's Name: _____Organization: _____

Address: _____Telephone: _____Email: _____

Psychiatrist/Family Physician: _____

Telephone: _____ Fax:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

With my signature below, I consent to the sharing of information between NBCTC and the following individuals (Physician, Psychiatrist, Mental Health Teams, Referral Agent/Case Worker, Pharmanet, Friends or Family members assisting with this application, and Medical Clinicians involved in my care).

Name: _____ Organization/Relationship: _____

Contact Number: _____

This consent will expire in twelve months from the date below.

Applicant Print Name:_____

Applicant's Signature:_____

Date: Month_____Day_____ Year _____

EARLY DISCHARGE PLAN

An early discharge is when a resident leaves the therapeutic community before their planned program completion date and before transition planning has been completed. If this is required, our goal is to ensure the resident has a safe place to go, with appropriate support, in their home community.

If the resident leaves on short notice or an unplanned urgent discharge is required, the referral agent and the emergency contact will be notified immediately. We will work with both parties to discharge the resident to the below location.

Key Community Contact for the Transition Plan (Name / Relationship):	

Phone:	**Email**:
Emergency Contact and/or Next of Kin (Name / Relationship):	
Phone:	**Email**:
Community Allied Health Professional / Referral Agency:	
Phone:	**Email**:

Early Exit Location Contact Name: _____ **Relationship**: _____

Early Exit Location Address: _____

Location Phone: _____

If an early exit is home with family, are they aware?
☐Yes ☐ No

Early Exit Transportation Method:_____

By signing below, I consent to my referral agent and emergency contact being contacted if I am discharged early from the program.

If a resident is deemed not ready, willing, or able to participate in all aspects of the program, the resident and/or referring agency agree to repatriate the resident upon early discharge.

Resident Name: _____

Resident Signature: _____

Referring Agent Name (If Applicable): _____

Proof Referral Stamp

FUNDING & FEES INFORMATION

☐ Self-pay
Fee payable upon admission (please call our site to discuss this option)

☐ Employer/Insurance:_____
Contact Name:_____
Company Name/Agency: _____
Phone: _____
Fax: _____
Address: _____

☐ Mental Health and Addictions Services
Please attach the funding approval.

☐ First Nation Health Authority ☐ CPP ☐ EI
For more information on how to pay using these options, please contact us.

Daily fees for program participants are based on per-diem funding from the Ministry of Social Development and Poverty Reduction. This funding model is only accessed for the days a resident lives at the NBCTC. Residents will be informed if this funding model changes.

There are no outside fees, and no security or damage deposits needed.

Please complete this section so the Ministry of Social Development and Poverty Reduction can fund your journey at NBCTC. If you do not have an open file with the Ministry, please phone the Admissions Coordinator for further instructions.

Name:_____ Clients GA #:_____
Worker Name:_____ Agency I.D.:_____
Contact Number:_____ Date Confirmed:_____

Ministry Stamp

SUBSTANCE USE HISTORY

Substances used	Primary Substance Identified	Are you seeking support for this substance use?	Date of last use	Typical Amount	Number of times used in the last 30 days?

What is the impact of your substance use on:	Mild	Moderate	Significant
Social Environment (friends, relationships)			
Primary Support system (may include family or natural supports.)			
Employment/education			
Housing			
Health			

How can NBCTC support your current needs in psychosocial functioning and medication assistance?

Substance Use Treatment History

Service Accessed	Dates	Service Provider	Program Completed Y/N
Withdrawal Management (Detox)			
Outpatient Services or Counselling			
OAT (Opioid Agonist Treatment)			
iOAT (Injectable Opioid Agonist Treatment)			
Recovery Based Housing			
Intensive Bed-Based Treatment			
Peer Support Groups (AA/NA/SMART/Life Ring)			

MENTAL HEALTH HISTORY

Do you currently have a diagnosed mental illness/ disorder for which you are receiving mental health services?

☐ Yes ☐ No

If yes, please provide the Diagnostic Category/Primary focus below.

Axis 1a DSM-IV TR Clinical Disorder

Axis 1b Other conditions that may be the focus of clinical attention

Axis 2a Personality Disorders and Cognitive Disabilities

Axis 4. Psychosocial and Environmental Concerns

Mental Health Clinician/Psychiatrist Contact Name:

Phone: _____

Email: _____

Have you experienced any of the following in the past six months?

☐ Non-accidental self-injury
☐ Suicide attempts/chronic ideation
☐ Psychosis (paranoid or delusional)
☐ Certification under the Mental Health Act

Did substance use bring on any of these experiences? If so, which ones?

Have there been any hospital admissions for mental health reasons over the past six months? If yes, please provide details (e.g., admission date, location, rationale, and duration of stay).

LEGAL

Are you currently reporting to a Probation Officer or Bail Supervisor?

☐ Yes

☐ No

If yes, please disclose the:

Name of Bail/PO Officer:_____Office Ph:_____

Do you have any upcoming court dates?

☐ Yes

☐ No

If yes, please provide details (e.g. transportation required, technological requirements):

Have you ever been convicted of Arson, Sexual Assault?

☐ Yes

☐ No

If yes, please provide the date and location of the offence(s):

Are there any conditions we need to know to support your stay?

I, _____, consent to Connective releasing and exchanging any relevant information about my legal history with any legal agencies associated with me (e.g., lawyer, probation officer, etc.)

Signature: :_____Date: :_____

Additional Information

Why is this therapeutic community being considered at this time?

Are there any spiritual or religious practices/ceremonies that will support your wellness while in the therapeutic community?

WHAT YOU WILL NEED FOR YOUR STAY

Plan for NBCTC to be your home for the time you are here. Feel free to bring comfortable things to make your room yours, such as a pillow and photographs.

- Your personal health#/card
- A 2-week supply of any prescription medication or a prescription.
- Casual, comfortable/warm clothing
- Running shoes/ boots, shower sandals
- Alarm clock/radio
- Toiletries
- Musical instruments if you play and hobby/crafts you enjoy
- Books, if you enjoy reading
- A covered mug (travel mug) to use while you are here.
- NBCTC encourages a "scent-free" environment.
- Residents are responsible for their clothing. They are expected to bring appropriate clothing for all seasons (from a below-zero winter to a hot and dry summer).
- Pens, paper, and journal
- Free time activities such as books, art supplies, musical instruments, etc.
- MP3 player with no camera capacity

All meals, laundry facilities, bedding and towels are provided.

By signing below, I consent to the following:

- This referral is being submitted for consideration to the Northern BC Therapeutic Community
- The information in this referral and any supporting documentation being released and shared between my Community Care Team and the NBCTC

This consent will expire 6 months from the date below.

Resident Name:_____ **Date:**_____

Signature:_____

Authorized Referral Agent Name Signature:_____

Date:_____

PRE-ADMISSION MEDICAL EVALUATION / INFORMATION

A Physician must complete the Pre-Admission Medical Evaluation forms.

Does this person require supervised medical withdrawal management services?

☐ Yes ☐ No

If yes, is medically supervised withdrawal management scheduled?

☐ Yes ☐ No

If yes, what date is withdrawal management expected to be completed?

_____

Does the person have mobility challenges?

☐ Yes ☐ No

If yes, please indicate: _____

_____

Does the person have vision or hearing impairments?

☐ Yes ☐ No

If yes, please describe:_____

_____

Does this person require assistance with physical hygiene care?

☐ Yes ☐ No

If yes, please describe:_____

_____

Does the person have chronic pain?

☐ Yes ☐ No

If yes, please describe:_____

_____

Please list all current medications (attach MAR or separate document if needed).

Be sure to include the medication name, dosage, length of time on medication and prescribing doctor.

Medication & Dosage	Date Started	Prescribing MD	Administration Method

Medical Concerns	Date(s) (If Applicable)	Treatment or Hospitalization Details
☐ Cardiovascular ☐ Respiratory		
☐ Surgeries ☐ Infection (MSSA, MRSA)		
☐ Brain Injury (TBI,ABI) ☐ Cognitive Impairment ☐ Seizures		
☐ Hepatitis ☐ HIV ☐ Diabetes (Specify Type)		

☐ Dental		
☐ Other (Please Specify)		

Is the individual currently on long-acting injectable antipsychotic medication?
☐ Yes ☐ No

If yes, please note the frequency: _____

Does the individual have any allergies to food or medications?
☐Yes ☐No

If yes, please describe:_____

Is the individual currently on Opioid Agonist Therapy (OAT)?
☐Yes ☐No

If yes, please check: ☐ Methadone ☐Suboxone ☐Kadian ☐ Sublocade
What is the current OAT dose?_____
Prescribing OAT Physician:_____
Phone:_____**Fax:**_____**MSP#:**_____

Please be prepared to supply the resident with 2 weeks of prescriptions upon admission to the community.

Today's Date:_____**Patient's Name:**_____
Physician Name:_____**Signature:**_____
CPSBC #:_____**MSP License #:**_____

Doctor stamp