

# **A Guide for Referral Services**

The Catalyst Program is a structured non-residential program offered by ReGen Alcohol and Other Drugs (AOD) Treatment and Education Agency.

The Catalyst Program is a statewide service for people over 18 years who reside in Victoria. It is for people with problematic alcohol or substance use, either as the drug of choice or as part of a pattern of poly substance use. The program is for people who have completed a withdrawal program and who have made a decision to stop alcohol or substance use. The program operates from Monday to Friday. Most activities are scheduled between 9.30am and 3.30pm. The program incorporates evening activities. Up to 15 people participate in the program at any one time.

The period following withdrawal is a vulnerable time in which the potential for relapse is significant. The program provides intensive post withdrawal support. The aim is to help people develop coping skills and maintain the motivation to change their drinking or substance use behaviour at a time when it is very challenging to stay on track. We do not impose sanctions on people who lapse; however, people cannot attend the program if substance intoxicated. Prescribed medications and pharmacotherapies for any drug are recognised as acceptable treatment interventions.

The Catalyst Program is a six-week non-residential structured program. It incorporates one to one motivational enhancement therapy, group work, recreation and social activities. Assessment, goal setting and coordinated service linkages are core components of the program. Where indicated, families or significant other involvement is encouraged.

### **Eligibility Criteria**

* A recent withdrawal treatment completed prior to Catalyst start date.
* Commitment to abstinence from alcohol or other substances for the duration of the program.
* Stable accommodation to facilitate attendance.
* Stable mental health.
* Basic English literacy skills.
* Client must not have a significant intellectual or cognitive impairment that would prevent program participation.

### **Information Required from Referral Source**

* Copy of Alcohol and Other Drug Comprehensive Assessment no older than three months.
* Copy of Victorian AOD Intake Tool no older than three months.
* Copy of Self-Completion Form no older than three months.
* List of current supports and contact information.
* Consent to Release Information with Catalyst Program and other key service providers.
* Development of a withdrawal and interim support plan in collaboration with the client.

### **What is an Interim Support Plan?**

The plan is likely to include things like:

* Identifying key support people, e.g., family member/partner, AA sponsor, counsellor, friend, telephone support services, etc.
* Referral options for family and significant others if indicated, e.g., ReGen Family and Friends Group.
* Possible referral to a Post Withdrawal Support Worker who can provide support for up to six weeks post withdrawal. This might include linkage to other services the client may need.
* Preparation of things that need to be organised before starting the Catalyst Program, e.g., medical appointments, transport, assessments, childcare, rescheduling of appointments or time off work.

### **How to Make a Referral**

**Contact the Catalyst Intake Team on 0481 912 554 between 9.00 am – 3.30 pm, email referral form, AOD assessment, Intake Tool, Self-Completion Form and release of information to Catalyst\_Intake@regen.org.au or fax to 03 9383 6705, attention Catalyst Team.**

**We encourage you to call the team to discuss a referral prior to sending the paperwork.**

# **Catalyst – Community Rehabilitation Program**

## Referral Form

### **Referrer details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of referral** | Click or tap to enter a date. | **Service** | Click or tap here to enter text. |
| **Referrer’s name** | Click or tap here to enter text. | **Telephone** | Click or tap here to enter text. |

### **Client details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client name** | Click or tap here to enter text. | **Date of birth** | Click or tap to enter a date. |
| **Gender identity** | [ ] Male  | [ ]  Transgender male  | [ ] Non Binary / Indeterminate  |
| [ ]  Female  | [ ] Transgender female | [ ]  Intersex  | [ ] Decline to answer  |
| **Pronoun Preference** | Click or tap here to enter text. |  |
| **Aboriginal or Torres Strait Islander** | [ ] Aboriginal  | [ ] Both Aboriginal and Torres Strait Islander |
| [ ]  Neither Aboriginal nor Torres Strait Islander  | [ ] Decline to answer  |
| **Address** | Click or tap here to enter text. | **Post code** | Click or tap here to enter text. |
| **Telephone** | Click or tap here to enter text. | **Permission to leave message** | [ ] Yes | [ ] No |
| [ ]  Discretion required |
| **Please indicate whether the client has basic English literacy skills** | [ ] Yes | [ ] No |
| **Emergency contact** | Click or tap here to enter text. | **Phone** | Click or tap here to enter text. |
| **Relationship to client** | Click or tap here to enter text. |

### **Withdrawal details/Pharmacotherapy information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of clinical review** | Click or tap to enter a date. | **Clinical consultant** | Click or tap here to enter text. |
| **If non-residential withdrawal, please tick which catchment area** | [ ]  IN | [ ]  N | [ ]  NW |
| [ ] IE | [ ] SW | [ ] B |
| **Withdrawal service and plan and interim withdrawal plan** |
| Click or tap here to enter text. |
| **Pharmacotherapy type** | Click or tap here to enter text. | **Dose** | Click or tap here to enter text. |
| **Commencement date** | Click or tap to enter a date. | **Prescribing doctor** | Click or tap here to enter text. |

### **Mental health**

|  |  |  |
| --- | --- | --- |
| **Does the client have a history of involvement with mental health services?** | [ ] Yes | [ ] No |
| **Is the client currently receiving mental health treatment?** | [ ] Yes | [ ] No |
| [ ] Depression | [ ] Anxiety |
| [ ]  *Mild* | [ ]  *Moderate* | [ ]  *Severe* | [ ]  *Mild* | [ ]  *Moderate* | [ ]  *Severe* |
| [ ]  Bi Polar | [ ]  PTSD | [ ]  Psychotic Disorder | [ ]  Eating disorder | [ ]  ABI |
| [ ]  Personality Disorder | [ ]  Intellectual Disability | [ ]  Other | *Details*:Click or tap here to enter text. |
| **If a box has been ticked, please provide recommendations from treating team if Catalyst program is suitable for client:** |
| Click or tap here to enter text. |
| **Please provide details regarding diagnosis, symptoms, insight, hospitalisation and treatment:** |
| Click or tap here to enter text. |

### **Client’s Stage of Change regarding substance use**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  **Pre-contemplative**Not aware of having problem | [ ]  **Contemplative**Considering change behaviour | [ ]  **Active**Ready to take action now or have done so recently | [ ]  **Maintaining**Looking for strengths to maintain changed behaviour | [ ]  **Relapse**Resuming AOD use after a period of abstinence |

### **All medical, health and welfare professionals involved in client’s care**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Role** | **Service** | **Contact details** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

### **Risk issues**

|  |
| --- |
| **Please comment on history of suicidal ideation/behaviour; harm to self or others; and/or any physical health risks:** |
| Click or tap here to enter text. |
| [ ] None stated |

### **Check list**

|  |  |  |
| --- | --- | --- |
| [ ] Withdrawal completed or planned | [ ] Mental state stable | [ ] Accommodation stable |
| [ ] Committed to abstinence for duration of program | [ ] Basic English literacy skills |
| [ ] No significant cognitive impairment |
| **Documents needed to activate referral** |
| [ ] AOD Comprehensive Assessment | [ ] Intake Tool | [ ] Self-Completion Form |
| [ ] Release of Information | [ ] IVO (if applicable) |