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 9.30 am and 3.30 pm. The program incorporates evening activities. Up to 15 people will be participating 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 medication and pharmacotherapies for any drug are recognised as acceptable treatment interventions.

The Catalyst Program is a 6 week non residential structured program. It incorporates 1:1 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 state.
- 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 Drug Assessment
- Copy of Self Complete Initial Screen for Alcohol and Other Drug Problems
- 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, GP, friend, telephone support services etc.
- Referral options for family and significant others if indicated eg. ReGen Family and Friends Group.
- 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 ReGen Intake Team on 1800 700 514 between 9.00 am – 3.30 pm or fax referral form, AOD assessment, screener and release of information to 03 93836705 attention Catalyst Team.
Catalyst- Community Rehabilitation Program

Referral Form

Referrer Details

Date of Referral: ____________
Referrers Name: _______________ Service: ___________________ Ph: ________________

Client Details

Name: ___________________________ DOB: _____ Gender: ☐ M ☐ F
Ethnicity: _______________________ Email address: _____________________________
Address: _________________________ Postcode: ____
Telephone: _____________________ Message O.K : ☐ Yes ☐ No ☐ Discretion Required

Please specify any special dietary requirements: ________________________________

Please indicate whether the client has basic English literacy skills: ☐ Yes ☐ No

Emergency Contact: _____________________ Ph: _______________________

Relationship to Client: _________________________________________________

Withdrawal Details / Pharmacotherapy Information:

Date of clinical review: ________________ Clinical consultant: ________________
If Non-residential withdrawal please tick which catchment area: ☐ SW ☐ IN ☐ N ☐ NW ☐ IE ☐ B

Withdrawal Service & plan and interim Withdrawal Plan:

__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

Pharmacotherapy Type & Dose: ___________________________________ ☐N/A

Commencement Date: ____________ Prescribing Doctor: _____________________
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

- Mild
- Moderate
- Severe

Anxiety

- Mild
- Moderate
- Severe

- Bi Polar
- PTSD
- Psychotic Disorder
- Eating disorder
- Personality Disorder
- ABI
- Intellectual Disability

If a box has been ticked please provide recommendation from treating team if Catalyst program is suitable for client:

__________________________________________

Please provide details regarding diagnosis, symptoms, insight, hospitalisation and treatment:

__________________________________________

Please indicate Client’s Stage of Change regarding their substance use:

<table>
<thead>
<tr>
<th>Pre-contemplative</th>
<th>Contemplative</th>
<th>Active</th>
<th>Maintaining</th>
<th>Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not aware of having</td>
<td>Considering</td>
<td>Ready to take</td>
<td>Looking for</td>
<td>Resuming AOD use</td>
</tr>
<tr>
<td>problem</td>
<td>change</td>
<td>action now</td>
<td>strengths to</td>
<td>after a period of</td>
</tr>
<tr>
<td></td>
<td>behaviour</td>
<td>or have done</td>
<td>maintain changed</td>
<td>abstinence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>recently</td>
<td>behaviour</td>
<td></td>
</tr>
</tbody>
</table>

Please list all medical, health and welfare professionals involved in the client’s care:

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Contact Details</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

Risk Issues: Please comment on history of suicidal ideation/behaviour; harm to self or others and/or any Physical Health risks:

__________________________________________

__________________________________________

- 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
- AOD assessment attached
- Release of information
- Screener attached

- If AOD Assessment, screener and Release of Information are not provided, the referral will not be activated.