

# Working On Program

**Working On is a partnership between Mercy Family Services and Brisbane City Council  
with funding from the Queensland Government**

## Criteria

Applicants are:

- to be aged between 17 and 35
- to be in recovery from substance abuse - clean and sober
- to be living in stable accommodation
- to be willing to commit to continuing Drug and Alcohol counselling
- likely to have recovery enhanced through employment
- not in full-time permanent work.

## Undertaking

In submitting this referral, I understand that:

- I have agreed the information supplied in this referral is correct;
- I am clean and sober and ready to be considered for participation in the Working On program;
- I have consented to program staff obtaining additional information from my referring agency or other agencies as per the 'Authorisation for Exchange of Information' form on page 7.

## Confidentiality

**ALL** information in this Referral is kept confidential and used only for purposes relating to the application for the Working On program.

## Applicant

**Complete pages 2 – 7**

## Case Manager/ Clinician

**Complete pages 8 – 9**

## Returning the completed Referral

Fax the completed Referral and Authorisation for Exchange of Information to:  
**Senior Project Officer  
Brisbane City Council  
Fax: 3334 0081**

## Working On Program Referral – Applicant to complete

**1** Applicant details

Last or family name

First or given name/s

Male  Female 

Address

  
  
 Postcode

Phone number

Mobile number

E-mail address

**2** How long have you lived at the above address?Years  Months **3** Do you share this accommodation with other people?No  **Go to 5**Yes  **Go to next question****4** Do they use any substances?No Yes **5** What is your country of birth?**6** What is your date of birth?**7** Are you an Australian citizen?No Yes **8** Are you of Aboriginal or Torres Strait Islander descent?No Yes **9** Are you of Culturally and Linguistically Diverse (CALD) descent?No Yes **10** Are you of Australian South Sea Islander (ASSI) descent?No Yes **11** Do you have a disability?No Yes  **Give details**
  
  

**12** Emergency contact details

Name of person to contact in an emergency

Relationship to you

Address

  
  
 Postcode

Home phone number

Work phone number

Mobile phone number

**13** Is this person aware of your substance use history?No Yes

**Questions 14 to 16 relates to assistance you may receive through Centrelink.**

**14** Do you receive income support through Centrelink?

No  Go to **17**

Yes  Go to **next question**

**15** What type of support do you receive?

**Tick ALL that apply**

New Start

Youth Training Allowance

Disability Support Pension

Sickness Allowance

Parenting Benefit

Special Benefits

Carer's Benefit

**16** Are you being assisted through **Specialist Employment Services?** (For example: Health/Disability Support, Commonwealth Rehabilitation Service)

No

Yes  Name of Specialist Employment Provider

Name of consultant

Contact phone number

**17** How long have you been unemployed?

Less than 12 months

12 to 24 months

Greater than 24 months

**18** Are you being assisted through a **Job Services Australia Provider?**

No  Go to **20**

Yes  Name of agency

Job Seeker ID Number

**19** What level of assistance do you receive?

Stream One (Limited)

Stream One

Stream One Work Experience Phase

Stream Two

Stream Three

Stream Four

**Questions 20 to 25 relate to your family and friends.**

**20** What family do you have?

  
  
  

**21** What contact do you have with your family?

No contact

Some contact

Frequent contact

**22** Are your family aware of your substance history?

No

Yes

**23** Do your family support you when you seek assistance?

No

Yes  How do they support you?

  
  
  
  

**24** Do you have friends who are non users?

No

Yes

**25** Do your friends support you when you seek assistance?

No

Yes



**35** What did/would you do if feeling tempted to lapse or relapse?


**36** Have you discussed a relapse management plan with your counsellor?

No

Yes  What is your plan?


**37** What substance/s are you receiving treatment for?


**38** Do you attend counselling?

No  Go to **41**

Yes  Name of counselling service

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Name of your counsellor

--

Counsellor's phone number

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**39** How often do you meet with your counsellor?

Weekly

Fortnightly

Monthly

Other  How often?

--

**40** How long have you been seeing a counsellor?

Less than 1 month

1 to 3 months

6 to 12 months

More than 12 months  How long?

--

**41** Are you currently receiving treatment through any of the following?

**Tick ALL that apply**

Psychiatrist

Psychologist

General Practitioner

Narcotics Anonymous

Alcoholics Anonymous

Residential Rehabilitation

Detox

Other  Give details

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**42** Are you currently taking medication?

No

Yes  List type of medication and dosage you are on

Type of medication	Dosage
1.	
2.	
3.	
4.	

**43** Do you have any other medical conditions?

No

Yes  Give details


**44 PAST TREATMENT**

In the table below, please indicate past treatments you have undertaken in your recovery.

Type of treatment	When did you have this treatment? (e.g. 2009)	Where did you go for this treatment?	How long were you engaged in this treatment?
Psychiatrist			
Psychologist			
General Practitioner and/or other			
Counselling			
Narcotics Anonymous			
Alcoholics Anonymous			
Medication (e.g. Methodone, Subutex)			
Residential Rehabilitation			
Detox			

**45 ONGOING TREATMENT**

What ongoing treatment or programs are you required **by law** to participate in? (For example: Drug Court and what phase, Crime Prevention Workshops, Community Service, reporting to Probation Officer)

Type of treatment program	Number of hours required	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

# Working On Program

## Authorisation for Exchange of Information



### Authorisation for Exchange of Information – Applicant to complete

I authorise the following individuals and/or agencies to release information to and obtain information from 'Working On' program staff which is relevant to maintaining my place on this program.

Centrelink  Name of Branch  Jobseeker ID Number

Job Services Australia Provider  Name of Provider

Counselling Service  Name of Service

Medical Practitioners  Name of Medical Practitioner/s

Other  For example: accommodation services, support person other than counsellor

#### Applicant authorisation

Name of applicant

Signature

Date

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# Working On Program

## Referral Agency Information

### Referral Agency Information – Case Manager or Clinician to complete

#### Suitability Statement

This program is not suitable for young people currently engaged in dependent/regular drug use or at high risk of relapse. Employers and mainstream workplaces who choose to participate in the program by offering work are not able to respond adequately to relapse issues.

In referring young people it is important that they are considered as low risk of relapse. It is expected that you have observed them and have adequate evidence of their reliability, commitment and responsibility to participate in this employment program.

#### 1 Name of organisation

Address

  
  


Postcode

Name of practitioner

Profession

Phone number

Fax number

Mobile number

E-mail address

#### 2 Is this organisation a specialist Drug and Alcohol Counselling Service?

No  Go to **next question**

Yes  Go to **4**

#### 3 What type of services are provided?

  
  


#### 4 How long have you known the applicant?

Less than 1 month

1 to 3 months

3 to 6 months

More than 6 months  How long?

#### 5 How many sessions has the applicant attended during this time?

Assessment only

1 to 3 sessions

3 to 5 sessions

More than 5 sessions

#### 6 What are you treating the person for?

  
  


#### 7 Please provide an outline of the treatment.

  
  
  


#### 8 What sort of contact has the applicant maintained?

Stable contact with treatment services

Irregular contact with treatment services

#### 9 Does the applicant have a diagnosed mental health condition?

Don't know

No

Yes  Give details

**10** Has a Job Capacity Assessment been undertaken?

Don't know

No

Yes  Give details


**11** Is the applicant engaged with any other treatment/support services?

Don't know  Go to **13**

No  Go to **13**

Yes  Go to **next question**

**12** Provide details of the additional treatment/support the applicant has engaged.

Psychiatrist	Name _____
	Phone No. _____
Psychologist	Name _____
	Phone No. _____
General Practitioner	Name _____
	Phone No. _____
Drug and Alcohol Counsellor	Name _____
	Phone No. _____
Specialist Job Agency	Name _____
	Phone No. _____
Disability Agency	Name _____
	Phone No. _____
Counsellor (other than Drug and Alcohol)	Name _____
	Phone No. _____

**13** What is your plan for the case management/care of this applicant?


**14** Are you able to refer the applicant to a drug and alcohol counselling service if you are **not able** to provide regular drug and alcohol counselling/support for a period of approximately 15 months?

No

Yes  Name of service

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**15** Describe your assessment of the applicant's readiness for work? (*Comment on reliability, punctuality, health and any other demonstrated qualities*).


**16** Have you discussed potential work related issues with the applicant?

No

Yes  Give details


**17 Case Manager/Clinician Statement**

I understand that in submitting this document I am acknowledging my responsibility in referring this person as suitable for the 'Working On' program.

Signature

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Date

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