Twenty second Annual Report

2010-2011

Drug and Alcohol Multicultural Education Centre

Contents

NSW HEALTH DEPARTMENT

DAMEC is an initiative wholly funded by the NSW Department of Health

Chairperson's Annual Report

This has been another successful year for DAMEC as it continues to develop the clinical service through quality improvement activities and prepares for accreditation in 2012. This year Rachel Rowe has stepped into Connie Donato-Hunt's role in the research position and has very successfully led the internal process evaluation of the counseling service. The DAMEC Counselling Services aim to address some of the gaps in AOD service provision to CALD communities by providing culturally sensitive outpatient counselling that addresses alcohol and other drug (AOD) use and co-occurring mental health issues. In 2010, the service expanded to include family counselling. From 2008 to 2009 DAMEC's *Vietnamese Transitions Project* began engaging Vietnamese participants in AOD counselling as part of a broader casework program to address recidivism. That program recommenced again in 2011 and will continue until mid-2012. Also in 2011, DAMEC Counselling expanded its reach to Auburn, where the counselling in Arabic and English is now offered from new premises at the Auburn Centre for Community.

This evaluation aimed to gain understanding about the client demographic attending the service, to identify the referral sources and intake patterns at the service, and to explore the characteristics and developments within DAMEC's model of counselling over the 30-month evaluation period. The final report provided a practical insight about the counselling approach at DAMEC and the extent to which the counselling model has been implemented. It identified some difficulties in application of Brief Solution Focused Therapy in this context and identified significant access barriers for CALD clients as they often do not have a thorough understanding of the counselling process. As a result, the 12 session format has been modified to include 2 sessions on psych-educational information on counselling and models of intervention. Further DAMEC is now using concepts of motivational interviewing and client centered therapy modified to be culturally appropriate. The final report is available at the DAMEC website and we look forward to incorporating routine collection of treatment outcome measures to facilitate further service improvements.

At the organisational level, DAMEC is undertaking external accreditation through the Australian Council of Health Standards. This process is not only reviewing our direct counselling service but all aspects of governance, administration and DAMEC business processes. Although DAMEC was well structured prior to accreditation preparation, this process has allowed us to identify and address any weaknesses. I would like to take the opportunity to thank Karen Redding for taking on this challenging task with such enthusiasm and skill.

DAMEC has been recognised twice throughout the year for our exceptional work. The innovative and important work of the Vietnamese Transitions Program received a Crime Prevention Award. This program has made a positive impact on the lives of Vietnamese Offenders with AOD issues and reduced significantly the recidivism rate of these offenders. The second award recognized DAMEC's Health Promotion Campaign by the Multicultural Marketing Awards. *Using Ice Seek Advice* is an innovative website providing a portal for young people from a CALD background to access information on amphetamines. Congratulations to the staff involved in these terrific projects.

I would like to thank Kelvin Chambers for his excellent leadership of the organisation throughout 2011. I also acknowledge the support I continually receive from my fellow Board members. They are skilled professionals from a range of sectors of service who guide DAMEC in its important work. DAMEC will be making a significant contribution to the clinical knowledgebase in alcohol and other drug service delivery to CALD communities and we look forward to the next 12 months of achievement.

Prof. Jan Copeland
Chairperson

CEO's Report

DAMEC has continued to deliver quality outcomes throughout the year. This has been in no small part due to the work of our dedicated and highly skilled staff team. I need to make mention of the work they do on an ongoing basis and the high quality of outcomes they deliver for CALD communities across NSW. In particular DAMEC' administration, project and research staff based at Redfern and our counselling team at Liverpool that have all contributed to meeting DAMEC's objectives.

DAMEC saw in 2010/11 for the first time having to develop a waiting list for the counselling service. I don't know if this is a good thing overall as demand rises or a reflection of the high reputation our services are now held in. It makes a difference from the Offices at Cabramatta where the clients were a dumping ground for Probation & Parole. In many real senses we are delivering better outcomes for our communities.

In 2010 a change of State Government occurred. DAMEC looks forward to working with new administration. There have been changes in terms of administration and the way Health delivers services across the State but overall DAMEC continues to fulfill its objectives and goals.

DAMEC lost our Clinical Services Manager this year Mr. Max Brettargh. Although Max was only with us for a relatively short period of time, his work was fundamental in developing the counselling service we have today. I thank Max for his work and wish him success at Drug Health at Central Sydney Local Health Network.

DAMEC embraced accreditation this year and has delivered a more robust and quality service. Apart from strengthening our systems, accreditation is delivering quality outcomes for our clients in enhanced assessment protocols and treatment models. I like to thank Karen Redding in particular for all the effort she has applied.

As I look towards another year I see so many more challenges on the horizon. The Day clinic proposal, new premises for administration and the new treatment grants funding. All in all an exciting 2012.

Kelvin Chambers
CEO

DAMEC Mission

Reduce the harm associated with the use of alcohol and other drugs within culturally and linguistically diverse (CALD) communities in New South Wales.

DAMEC Objectives

Working within a multi-sectoral framework and adopting a Health Promotion approach DAMEC will:

Deliver culturally sensitive specialist AOD interventions for individuals and families from a culturally and linguistically diverse (CALD) background;

Understand the prevalence and impact of AOD amongst CALD communities;

Build the capacity of CALD communities to understand and address AOD issues;

Enhance the accessibility of drug and alcohol services for people from CALD background.

DAMEC Activity

Quality Improvement

DAMEC has a contract with The Australian Council on Healthcare Standards for accreditation. The purpose of this process is to manage Quality Improvement within the organisation. In July 2011 DAMEC moved from Equip 5 to the Equip 5 for Day Procedure Centres. This product is a better fit for DAMEC as the counseling arm of DAMEC is outpatient.

Equip 5 for Day Procedure centres has 26 criteria that DAMEC is in the process of gathering evidence of how we meet the standards. There has been progress and new procedures being developed by all staff. DAMEC staff are all involved in this process.

DAMEC counseling is still a relatively new part of the service and has experienced a clinical file audit and skills audit which was most useful. DAMEC has some six community languages as part of the skill set of clinical staff. Training and development will continue into 2012 with DAMEC working with trainers to meet the specific needs of our staff and client group.

DAMEC continues to be supported by NADA in this process and has been working with other NGOs especially Manly Drug Education and Counselling Centre who have been generous with their time and support.

NSW Dug Council

DAMEC continues to be represented at the NSW Alcohol and other Drugs Program Council. DAMEC has contributed to significant debate throughout the year ensuring the needs of CALD communities continue to be advocated to the Department of Health. DAMEC also co-chairs the Health Promotion Subcommittee of the council. The work has been significant and a new Strategic Plan has been developed proposing the way forward for NSW Health in regard to health promotion and prevention work. The strategies for CALD communities were considerable in this plan, with clearly articulated aims and objectives with identified CALD performance measures.

NADA

DAMEC is represented with the NADA Health Promotion Sub committee. DAMEC has provided input onto collective responses on the National Health Reform consultation, the NSW Health Drug and Alcohol Health Promotion Plan and various other submission. DAMEC continues to ensure that CALD issues are responded and action where appropriate.

DAMEC Projects

This has mostly been a year of consolidation of recent DAMEC projects. The web-site for the "Using Ice? Seek Advice" amphetamines project was finalised and continues to be maintained. The associated USB wristbands were disseminated, receiving a very positive response. This project won the trophy for Best Non-Government Website over $5000 at the 2011 NSW Multicultural Communications Awards, presented at Parliament House.

The Vietnamese Transitions project recommenced with funding from the Commonwealth Attorney-General's Department under Proceeds of Crime and has continued to run smoothly, thanks to a strong partnership with Corrective Services NSW. This project won a 2010 Australian Crime and Violence Prevention Award which was presented at NSW Police Headquarters.

(pictured L to R Assistant Commissioner John Hartley,, CEO of DAMEC Kelvin Chambers, Thanh Nguyen Transitions Worker, Helen Sowey Project Officer, . The Hon. Mike Gallagher Minister fir Police)

Several of DAMEC's recent projects have been presented at conferences in the past year, including Creating Synergy in Wollongong, APSAD in Canberra, and internationally at "Working within the Forensic Paradigm" in Prato, Italy.
A new project commenced this year with funding from NADA's Practice Enhancement Project. This project involves the translation of the SMART Recovery program into Vietnamese, with relapse prevention groups being piloted in corrective services settings.

This year also saw the updating and reprinting of the Vietnamese "FACT" booklet ("Families and carers affected by the drug and alcohol use of someone close"), since the original print run had been exhausted.

DAMEC has maintained involvement in several CDATs – St George, where DAMEC has supported a project to provide drug education to newly arrived young people at Intensive English Centres, and Auburn, where an easy-to-read alcohol resource for new arrivals is nearing completion. DAMEC has also provided information and staff at Community Information Days or-

ganised by the Liverpool CDAT. DAMEC continues to chair the Liverpool CDAT

DAMEC has also played an active role on several state-wide interagency groups, including the NADA Health Promotion Subcommittee, the Multicultural Youth Affairs Network, the Refugee Health Improvement Network, as well as supporting the Ethnic Communities Council in the establishment of the Greater Sydney Multicultural Interagency.

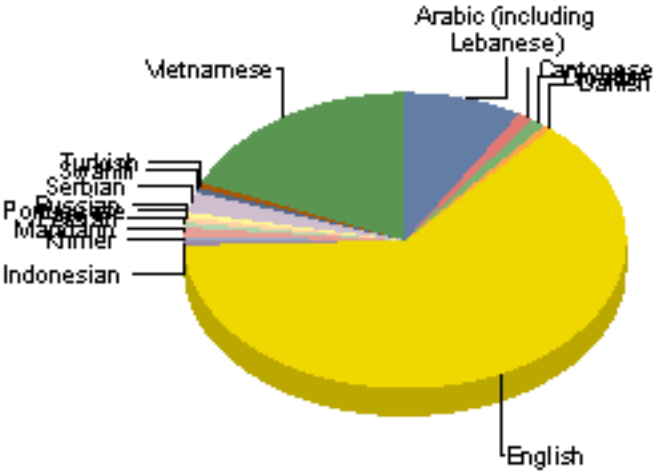
DAMEC Counselling (Liverpool Auburn)

The five funding streams for the DAMEC counselling service are the Commonwealth Improved services grants, NGO treatment grants project (TGP) NSW Health Carers for people with disabilities Non-Government Organisation Grant Program a one-off grant for a support program CALD carers and the core funding from NSW Health MHDAO.

DAMEC Counselling is delivered at two sites Liverpool and Auburn Community Center. DAMEC also provides outreach services in Miller near Liverpool.

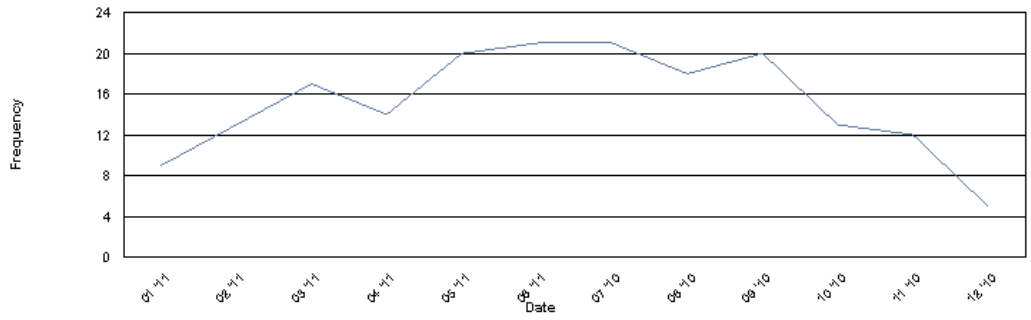
DAMEC has seen 183 clients over the 12 month period. Of that number 69% were from a non English Speaking background.

Preferred Language

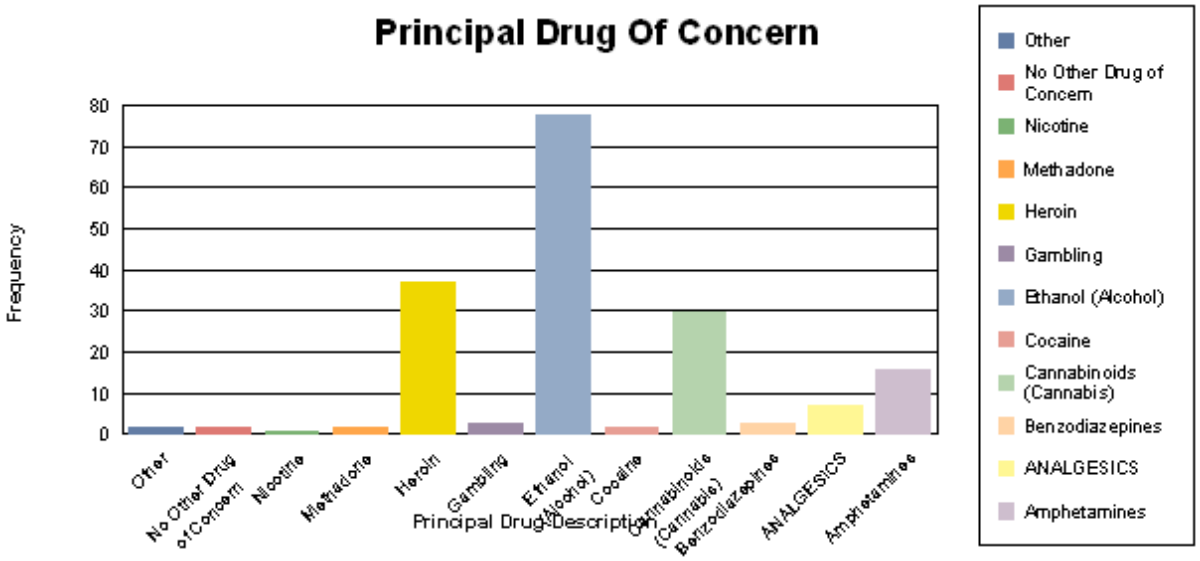


Arabic (including Lebanese)	8.7%
Cantonese	1.1%
Croatian	1.1%
Danish	0.5%
English	62.8%
Indonesian	0.5%
Khmer	0.5%
Mandarin	1.1%
Persian	0.5%
Portuguese	0.5%
Russian	0.5%
Serbian	2.2%
Swahili	0.5%
Turkish	0.5%
Vietnamese	18.6%
Total:	100.0%

Admission Report



Principal Drug Of Concern



Other DAMEC Activity

Interagencies, committees and working groups attended

St George - Sutherland Multicultural Advisory Committee
Auburn Humanitarian Network
Fairfield Migrant Interagency
Holroyd-Parramatta Multicultural Network
Blacktown Migrant Interagency
Blacktown Emerging Communities Action Planning (BECAP)
Multicultural Youth Issues Network - NSW
Youth Peer Education and Mentoring Network
Department of Education and Training refugee Student Support Group
Network of Trainers in Diversity Health
Meeting of Workers with the Sudanese community
African Settlement Needs Network
Refugee Health Improvement Network
Harm Reduction Interagency
Auburn CDAT
Holroyd-Parramatta CDAT

ABN 28 959 252 950

Edward D. Chahoud B.Bus., CPA
CERTIFIED PRACTISING ACCOUNTANT

Edward D. Chahoud is a CPA Practice

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BELMORE, N.S.W. 2192

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INDEPENDENT AUDIT REPORT

TO THE MEMBERS OF
DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED

We have audited the financial report, being a special purpose financial report , of **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED** which comprises the Balance Sheet as at **30 June 2011**, the Income statement for the year ended **30 June 2011** and notes to the accounts.

The committee is responsible for the preparation and presentation of the financial statements and the information they contain and has determined that the accounting policies used and described in Note 1 to the financial statements which form part of the financial report are appropriate to meet the requirements of the Associations Incorporations Act (NSW) 2009 and are appropriate to meet the needs of the members.

We have conducted an independent audit of this financial report in order to express an opinion to the members of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED** on the preparation and presentation there of.

The financial report has been prepared for the members of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED** . We disclaim any assumption of responsibility, for any reliance on this report or on the financial statements prepared to any person other then the members of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED**, or for any purpose other than for which it was prepared.

Our audit has been conducted in accordance with Australian Auditing Standards to provide reasonable assurance whether the financial report is free of material misstatement. Our procedures include examination, on a test basis, of evidence supporting the amounts and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Australian accounting concepts and standards

The audit opinion expressed in this report has been formed on the above basis.

AUDIT OPINION

In my opinion the accompanying Financial Statements of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED**, which have been prepared under the historical Cost convention are properly drawn up:-

a) So as to give a true and fair view of the state of affairs of the Centre as at **30 June 2011** and of the results of the Centre for the year ended on that date: and

b) Are in accordance with Statements of Accounting Concepts and Applicable Accounting Standards.

E. Chahoud 9/9/11

E.CHAHOUD CPA Reg No.841305

Liability limited by a Scheme approved under the Professional Standards Legislation

DRUG AND ALCOHOL MULTICULTURAL EDUCATION
CENTRE INC.
ABN 44 792 123 447

FINANCIAL REPORT
FOR THE YEAR ENDED
30 JUNE 2011

Liability limited by a scheme approved under
Professional Standards Legislation

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

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DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

BALANCE SHEET
AS AT 30 JUNE 2011

	2011 $	2010 $
MEMBERS' FUNDS		
Accumulated Surplus	140,412	262,623
TOTAL ACCUMULATED FUNDS	140,412	262,623
Represented by:		
ASSETS		
CURRENT ASSETS		
Petty Cash	250	750
Westpac Grant a/c 032 023 17-9301	(10)	398
Westpac Cash Management a/c 032 023 22 9154	170,294	102,337
Westpac Cash Management a/c 032 023 21 3603	-	58,942
Westpac cheque a/c 032 023 22 9146	32,232	73,549
Westpac cheque a/c 032 023 22 9162	191	15,550
Westpac Debit Card a/c 032 023 24 2500	10,396	2,978
Sundry Debtors	99	362
Trade Debtors	3,741	44,000
Input Tax Credits	11,033	10,386
TOTAL CURRENT ASSETS	226,226	309,254
NON CURRENT ASSETS		
Fixed Assets		
Office Equipment at Cost	99,948	99,946
Less: Accumulated Depreciation	(68,644)	(59,091)
	31,302	40,855
Furniture & Fittings	45,964	45,964
Less: Accumulated Depreciation	(32,026)	(25,310)
	13,939	20,654
Office Renovation at Cost	6,929	6,929
Less: Accumulated Depreciation	(6,929)	6,929
	-	-
Total Fixed Assets	45,241	61,509
TOTAL NON CURRENT ASSETS	45,241	61,509
TOTAL ASSETS	273,467	370,763

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 782 123 447

BALANCE SHEET
AS AT 30 JUNE 2011

	2011 $	2010 $
LIABILITIES		
CURRENT LIABILITIES		
Sundry Creditors	5,103	4,032
Trade Creditors	627	-
Superannuation Payable	10,444	6,196
PAYG Withheld	5,515	8,658
GST Payable	26,180	16,299
TOTAL CURRENT LIABILITIES	46,869	35,185
NON CURRENT LIABILITIES		
Employee Entitlements	86,186	72,955
TOTAL NON CURRENT LIABILITIES	86,186	72,955
TOTAL LIABILITIES	133,055	108,140
NET ASSETS	140,412	262,623

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2011

	Note	2011 $	2010 $
INCOME			
OTHER INCOME			
Interest Received		3,209	4,822
Income from Administration, Conference Training & NADA		21,826	32,585
Grants		1,026,786	1,029,306
Profit on Sale of Non-current Assets		-	11,603
		1,051,821	1,078,316

The accompanying notes form part of these financial statements.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2011

	Note	2011 $	2010 $
EXPENDITURE			
Auditing Fees		3,000	7,635
Accountancy Fees		2,129	3,980
Advertising		858	3,833
Annual Lunch		-	1,258
Administration Expenses		27,689	12,898
Bank Charges		1,736	1,522
Backfill Sessionals		37,271	7,100
Catering Expenses		1,741	-
Cleaning		6,710	12,471
Conference		3362	2,365
Computer Expenses		20,216	27,778
Counselling Expense		11,632	510
Depreciation		16,268	-
Electricity		18,054	14,086
Holiday Pay		7,327	6,975
Insurance		10,366	6,752
Leasing Charges		17,561	14,706
Library Items		55	-
Minor Asset Purchase		-	153
Long Service Leave		6,904	28,008
Motor Vehicle Expenses		63,516	63,528
OH & S Expenses		6,503	
Postage		1,002	1,167
Printing & Stationery		8,926	2,615
Project Evaluation		12,000	-
Project Expenses		5,379	16,647
Project Expense - African		-	500
Project Expense - Vietnamese		-	1,100
Research Project Expense		291	8,681
Resource Expense		-	4,065
Rent		104,265	113,727
Repairs & Maintenance		3,798	4,597
Salaries & Wages		629,747	746,059
Security Costs		724	1,232
Staff Amenities		4,804	6,721
Staff Training		26,732	17,912
Sundries		826	-
Publication & Subscriptions		684	1,626

The accompanying notes form part of these financial statements.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2011

	Note	2011 $	2010 $
Superannuation Contributions		61,578	66,614
Telephone & Internet Charges		28,035	21,026
Travelling Expenses		6,857	6,052
Travelling Allowance		2,641	1,137
Translation Service		1,895	105
Payline Fees		2,893	3,144
Utilities		1,300	-
Workers Compensation Insurance		11,266	15,644
		1,174,032	1,252,826
Surplus/Loss for the year		(122,211)	(174,512)
Accumulated Surplus at the beginning of the financial year		262,623	278,404
Write back of GST/PAYG withholding obligations			190,531
Assets Write back to Reflect Current Valuation			(31,800)
Accumulated Surplus at the end of the financial year		140,412	262,623

The accompanying notes form part of these financial statements.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

1 Statement of Significant Accounting Policies

This financial report is a special purpose financial report prepared in order to satisfy the financial reporting requirements of the Associations Incorporation Act NSW. The committee has determined that the association is not a reporting entity.

The financial report has been prepared on an accruals basis and is based on historic costs and does not take into account changing money values or, except where specifically stated, current valuations of non-current assets

The following significant accounting policies, which are consistent with the previous period unless otherwise stated have been adopted in the preparation of this financial report.

Income Tax

The Association is exempt from income tax under S23(e) and therefore no provision for tax is required.

Property, Plant and Equipment (PPE)

Leasehold improvements and office equipment are carried at cost less, where applicable, any accumulated depreciation..

The depreciable amount of all PPE is depreciated over the useful lives of the assets to the association commencing from the time the asset is held ready for use.

Leasehold improvements are amortised over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

Provisions

Provisions are recognised when the association has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured.

Provisions recognised represent the best estimate of the amounts required to settle the obligation at reporting date.

Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, deposits held at-call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the balance sheet.

Revenue and Other Income

Revenue is measured at the fair value of the consideration received or receivable after taking into account any trade discounts and volume rebates allowed. Any consideration deferred is treated as the provision of finance and is discounted at a rate of interest that is generally accepted in the market for similar arrangements. The difference between the amount initially recognised and the amount ultimately received is interest revenue.

Interest revenue is recognised using the effective interest rate method, which for floating rate financial assets is the rate inherent in the instrument.

Revenue recognition relating to the provision of services is determined with reference to the stage of completion of the transaction at reporting date and where outcome of the contract can be estimated reliably. Stage of completion is determined with reference to the services performed to date as a percentage of total anticipated services to be performed. Where the outcome cannot be estimated reliably, revenue is recognised only to the extent that related expenditure is recoverable.

All revenue is stated net of the amount of goods and services tax (GST).

Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Tax Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense. Receivables and payables in the balance sheet are shown inclusive of GST.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2011

		2011 $	2010 $
2	**Trade and Other Receivables**		
	Current		
	Trade Debtors	3,840	44,362
	Input Tax Credits	11,033	10,388
		14,873	54,750
	The association does not hold any financial assets whose terms have been renegotiated, but which would otherwise be past due or impaired.		
3	**Property, Plant and Equipment**		
	Office Equipment at Cost	99,946	99,946
	Less: Accumulated Depreciation	(68,644)	(59,091)
		31,302	40,855
	Furniture & Fittings	45,964	45,964
	Less: Accumulated Depreciation	(32,025)	(25,310)
		13,939	20,654
	Total Plant and Equipment	45,241	61,509
	Total Property, Plant and Equipment	45,241	61,509
4	**Member Funds**		
	Accumulated Surplus at the beginning of the financial year	262,623	278,404
	Surplus (Deficit) attributable to the association	(122,211)	(15,781)
	Accumulated Surplus at the end of the financial year	140,412	262,623

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

NOTES TO THE FINANCIAL STATEMENTS
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DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

STATEMENT BY MEMBERS OF THE COMMITTEE

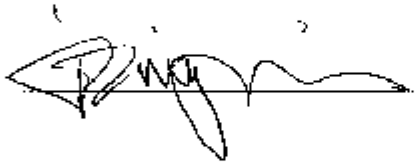
The committee has determined that the association is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.

In the opinion of the committee the financial report as set out on pages 1 to 9:

1. Presents a true and fair view of the financial position of Drug and Alcohol Multicultural Education Centre Inc. as at 30 June 2011 and its performance for the year ended on that date.
2. At the date of this statement there are reasonable grounds to believe that Drug and Alcohol Multicultural Education Centre Inc. will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the Committee and is signed for and on behalf of the Committee by:

Chairman: _____

Treasurer:  _____

Dated this **day of**

COMPILATION REPORT
TO DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

The responsibility of the committee

The committee is responsible for the information contained in the special purpose financial report and has determined that the significant accounting policies adopted as set out in Note 1 to the financial statements are appropriate to meet the needs of members.

We have compiled the accompanying special purpose financial statements of Drug and Alcohol Multicultural Education Centre Inc. which comprise the balance sheet as at 30 June 2011, profit and loss statement for the year then ended, a summary of significant accounting policies and other explanatory notes.

The specific purpose for which the special purpose financial statements have been prepared is to provide financial information to the committee of management.

The responsibility of the committee of management

The Committee of Management is solely responsible for the information contained in the special purpose financial statements and has determined that the basis of accounting adopted is appropriate to meet the needs of the committee of management for the purpose of complying with the association's constitution.

Our responsibility

On the basis of information provided by the committee of management we have compiled the accompanying special purpose financial statements in accordance with the significant accounting policies adopted as set out in Note 1 to the financial statements and APES 315: Compilation of Financial Information.

Our procedures use accounting expertise to collect, classify and summarise the financial information, which the Committee of Management provided, in compiling the financial statements. Our procedures do not include verification or validation of procedures. No audit or review has been performed and accordingly no assurance is expressed.

The special purpose financial statements were compiled exclusively for the benefit of the committee of management. We do not accept responsibility to any other person for the contents of the special purpose financial statements.

Name of Firm: GK Plus Co Accountants Pty Ltd
Chartered Accountants

Address: Level 1, 130 Waldron Road, Chester Hill NSW 2162

Dated this 15th **day of August, 2011**

DAMEC Board 2010/2011

Chairperson	Jan Copeland (PhD)
Secretary	Mr. Graeme Pringle
Treasurer	Mr. Bruce Davies
Appointed Member	Mr. Peter King (Acting Treasurer) (NSW Refugee Health Service)
Appointed Member	Ms. Nadia Garan (Transcultural Mental Health Service)
Appointed Member	Mr. Mariano Coello (STARRTS)

DAMEC Staff

CEO	Mr. Kelvin Chambers
Program Manager (Project & Research)	Ms Karen Redding
Program Manager (Clinical Services)	Mr. Max Brettargh (June10—Jan 11)
Office Manager	Ms Sarina Afa
Senior Policy Officer	Ms Helen Sowey
Senior Research Officer	Ms Connie Donato-Hunt Ms. Rachel Rowe
Intake/Information Officer	Mr Paul Robson
Drug and Alcohol Counsellor's	Mr. Hassan Darbas Ms. Sandra Evers Ms. Thi Ai Hien Nugeyen Ms. Vi Nguyen
Transitions	Mr. Thahn Nguyen
Administrative Assistant	Ms Leigh Latu

Twenty third Annual Report

2011-2012

Drug and Alcohol Multicultural Education Centre

Contents

NSW HEALTH DEPARTMENT

DAMEC is an initiative wholly funded by the NSW Department of Health

Chairperson's Annual Report

I am pleased to report that 2011/12 has once again seen a year of steady growth and successful delivery of a range of DAMEC activities. The Centre has been successful in attracting funds from a variety of bodies to further our work reducing the harm associated with alcohol and other drug use among culturally and linguistically diverse communities.

One of the key facilitators for our delivery of counseling services to CALD communities has been the provision of Commonwealth funding to supplement our core NSW Health grant. This year we successfully completed our Non Government Treatment Grants Program and Improved Services funded activities. These ran for four years and enabled DAMEC to provide bilingual counselors and enhanced our capacity to meet the needs of clients with mental health concerns.

We are very pleased to report that these grants have been awarded for another three years, with enhanced funding, to provide an additional counselor and an intake officer. This will add significant capacity to our counseling service. I wish to note the exceptional work of our counselors. This is demonstrated by an increase in referrals to DAMEC Counseling Services and a 35% increase in weekly sessions to our growing numbers of clients in treatment.

I have also been proud of the work DAMEC has done in evaluating the Counselling Service. While we believe that we do an exceptional job, it is pleasing to see this view supported via evaluation. Further I am pleased to see the adoption of outcome measures within the intervention program and I am looking forward to these results through next year.

As an academic I believe DAMEC's research agenda throughout the year has again been excellent. DAMEC staff has presented several papers and had two papers published in peer reviewed journals in 2011/12. Much of this work was led by Connie Donato Hunt, DAMEC's senior research officer and we were very sorry that she left to take up new challenges this year. Connie had spent several years with DAMEC and contributed much to the Centre's research outputs. Her work and commitment were inspiring. I wish her all the best in her career. The Centre's research program was smoothly transitioned to Rachel Rowe who filled the role whilst Connie was on leave. It was most fortunate that she agreed to take on the role full-time as she is a highly skilled and talented researcher and I look forward to her ongoing contribution.

DAMEC's staff is the most important asset of the organization. I'd like to thank them all for their continued contribution to the sector and the work they do on behalf of DAMEC. I would like to thank my fellow Board members who have provided me with support throughout my time as Chair. This year we have worked towards accreditation which has seen significant additional workload on key staff. I would like to especially acknowledge the contribution of Karen Redding to this important task and thank her for her enthusiasm and exceptional commitment and effort to assisting the Centre in the major task. My final thanks are to the CEO, Kelvin Chambers, who has continued to grow the organization and enhance our commitment to best practice, staff development and excellent client outcomes. I look forward to continuing to assist DAMEC in achieving its objectives.

Prof. Jan Copeland
Chairperson

CEO's Report

DAMEC has had another amazing year and continues to achieve significant outcomes for CALD communities across NSW. I have an incredibly easy job with a highly competent and committed staff team and supportive Board. In particular DAMEC's chair is extraordinary finding time to guide DAMEC's research work as well as support DAMEC in its objectives. I also like to thank Peter King, stepping up into an executive position is never easy. I had the opportunity this year to spend more time at DAMEC Counselling Service at Liverpool. I was stunned by the professionalism and competency of this staff team. It is a privilege to be a CEO of such an organisation.

This year DAMEC is preparing for ACHS audit as part of its quality improvement strategies. Karen Redding has been tireless in preparing DAMEC for this over the past year. I was somewhat sceptical about ACHS reviewing what we already do; in fact I thought it was an exercise in bureaucracy. However, through Karen's work I have not also seen subtle improvements but major improvements in gaps that I wasn't aware of. Special mention needs to be made of Karen Redding and all her work in driving this agenda.

I was pleased to see Connie Donata Hunt leave DAMEC to a more challenging position. Connie had done amazing work while she was here with DAMEC and to see someone move on with greater skills and more development to continue promoting CALD communities. DAMEC wishes her all the best. On a sadder note Sarina Afa left DAMEC after several years of dedicated service. Sarina has some challenges in her life and I hope they can be resolved shortly.

DAMEC completed work on our NGOTGP and ISI funding programs this year. I was pleased at the outcomes DAMEC was able to achieve. The ISI funding allowed DAMEC to expand its services to enhance support for people with mental health issues. DAMEC has tried to develop a range of working relationships with mental health services to better support our clients. At the end of this year's program it became evident that DAMEC's development of internal psych support services rather than working with other agencies was the most effective.

DAMEC's complex case presentation of clients significantly impacts the referral services we can provide. Many of DAMEC's clients need assertive case management and support. Our staff provide outpatient counselling, a therapeutic intervention, case management becomes an accessory for our staff otherwise we would not get any therapy done. This leaves a big service gap for our clients that does not seem to be met other than through Probation and Parole.

DAMEC was refunded for the NGOTGP and ISI for the next three years. This work will continue DAMEC's expansion for CALD counselling services. DAMEC has challenges for new premises, new staff and new funding opportunities. 2012/13 looks to be another great year.

Kelvin Chambers
CEO

DAMEC Mission

Reduce the harm associated with the use of alcohol and other drugs within culturally and linguistically diverse (CALD) communities in New South Wales.

DAMEC Objectives

Working within a multi-sectoral framework and adopting a Health Promotion approach DAMEC will:

Deliver culturally sensitive specialist AOD interventions for individuals and families from a culturally and linguistically diverse (CALD) background;

Understand the prevalence and impact of AOD amongst CALD communities;

Build the capacity of CALD communities to understand and address AOD issues;

Enhance the accessibility of drug and alcohol services for people from CALD background.

DAMEC Activity

Quality Improvement

DAMEC has a contract with The Australian Council on Healthcare Standards for accreditation. DAMEC has spent the past twelve months preparing for audit.

DAMEC can feel proud of its achievements over the past twelve months led by the work of Karen Redding. DAMEC now has Quality Improvement as part of its function and direction. It has many new policy and procedures in place that has delivered significant outcome to client care.

One of the major achievements has been the establishment of systems that review and evaluate DAMEC's work. This has been embedded in the Board, Sub-committees; staff planning and process. The QI process has development many of the tools that will be needed by DAMEC to deliver good quality outcome.

NADA

DAMEC continues to work with NADA as its peak on issues of importance. DAMEC has benefitted from many of the training sessions delivered to the sector. DAMEC has assisted NADA in developing responses to clinical record keeping and staff development.

DAMEC continues to share premises and resources with NADA at the Redfern Office. This model of shared resources continues to be a great example to NSW Health.

Transitions

The project goals are to prevent criminal recidivism and relapse to drug use for Vietnamese drug offenders in the South Western Sydney region.

The project provides intensive case management support for a period of 3-6 months following release from prison for 12-15 Vietnamese drug offenders and their families. This support will be provided by a Vietnamese bilingual/bicultural Transitioning Support Worker employed by the project. This worker will be based at DAMEC's treatment service located at Liverpool, and particular emphasis will be placed on linking program participants into drug treatment.

Potential program participants will be identified by the NSW Department of Corrective Services at least one month prior to their release date. The Transitioning Support Worker will have opportunities to engage with the identified prisoners prior to release and to recruit eligible volunteers into the project.

The role of the Transitioning Support Worker will include support and referrals for issues such as:

- accommodation
- drug treatment
- family issues
- psychological issues
- employment
- general health
- legal issues

Client Outcome Data

- Provide intensive case management support for prisoners post-release.
- Provide support and referrals to families of participants
- Received 32 referrals
- Opened 28 case files
- 4 clients were referred to the Transitions a very short time before they were release. They were not able to be contacted. They were lost in the transition period.
- Engage and provide transitional assistance for 28 clients
- Provided AOD counselling
- Assisted 12 clients obtained accommodations.
- Visited clients at their homes, in prisons and in Compulsory Drug Treatment Centre.
- Accompany clients to appointment and supporting them at the other services.
- Refer clients to Legal Aid or to a private legal adviser. Transport them to and from courts.
- SMART Recovery workshop in Silverwater Correctional Centre
- Work with 17 families.
- Up to date 15 files were closed

The Transitioning Support Worker, supported by the Community Restorative Centre, will also provide information and support to local Vietnamese community welfare associations to enhance their ability to support ex-offenders and their families.

Services Engaged by the Project

- Engage other services: Hume Community Housing, Housing NSW, Corrective Services NSW (prison and community P&P), Connection Project, Fairfield Drug Health, Bankstown Drug Health, Corella Log, Odyssey, Catholic Care, Centrelink, VDAP, VCA, Mental Health, and GPs.
- Engage Charity organizations: St Vincent de Paul, Chester Hill Neighbourhood

Centre, Father Chris Riley op-shop, Anglicare, Salvation Army.

- Justice Health Service at local courts

DAMEC has examined new strategies to expand this program to Arabic speaking communities and is awaiting the outcome of a grant tender. The Transitions program is scheduled to end in August 2012.

NSW Dug Council

DAMEC continues to be represented at the NSW Alcohol and other Drugs Program Council. DAMEC has been involved in a range of policy decisions as NSW Health has developed new approaches with the new Government.

Often, during this process, DAMEC has raised issues of concern regarding CALD communities and it has been difficult to raise this voice. 2011/12 was a time of budget restraints and real cuts within the Department. This has impacted in terms of support and direction by the Department.

The change to Local Health Districts and the intention to tender out more health services to the NGO sector will have impacts yet to be realised. It will continue to be an interesting year of development.

Research

This year Connie Donato-Hunt left the position of Senior Researcher and Rachel Rowe was employed in this position from June 2012.

In January, Rachel conducted a staff in-service on the findings of the (then recently completed) DAMEC Counselling Evaluation, and disseminated the summary reports widely (as per HREC approval) to health networks, mental health agencies, general practitioners in South Western Sydney.

Prior to leaving Connie was successful in her application for a Research Seeding Grant through NADA and MHCC, and unsuccessful in applications to MHDAO (Primary care study) and NSW Cancer Institute (Evaluation of the NSW Quitline).

The Research Seeding Grant allocated DAMEC funds to investigate the plausibility of a third DAMEC prevalence study of the substance use rates among major CALD groups in NSW. Over the second half of 2012, Research Subcommittee meetings and various meetings with key researchers on previous and prospective prevalence studies have been held to discuss the viability of such a project and meet grant reporting requirements.

Angela Gallard joined DAMEC on a 6-month research placement as part of her completion requirements for a social work masters from CSU, Wagga Wagga. Angela is working on a study on the treatment protocols and standards employed across AOD services in NSW. “From first contact- supporting people from CALD backgrounds in NSW AOD services” involves an online survey of workers, and is expected to culminate in a report for DAMEC and publication in academic journals in early 2013.

The most recent edition of *Mental Health and Substance Use* features an article entitled “Cultural and family contexts for help seeking among clients with cannabis, other drug and mental health issues” by Ian Flaherty and Connie Donato-Hunt. This is extended research output from their 2009 study “Finding the right help: pathways for culturally diverse clients with cannabis use and mental health issues”.

DAMEC has also played an active role on several state-wide interagency groups, including the NADA Health Promotion Subcommittee, the Multicultural Youth Affairs Network, the Refugee Health Improvement Network, as well as supporting the Ethnic Communities Council in the establishment of the Greater Sydney Multicultural Interagency

DAMEC Counselling (Liverpool Auburn)

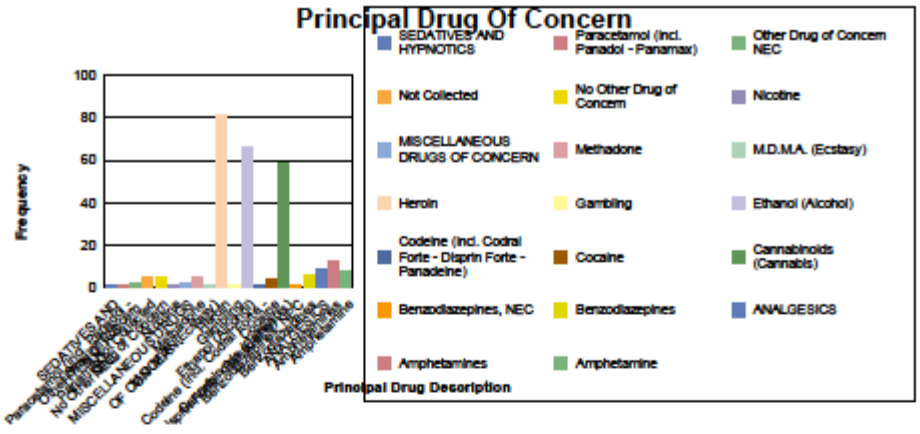
DAMEC delivers an outpatient counselling service with priority for CALD clients. DAMEC currently has on staff two Vietnamese, Arabic, Khmer & Chinese speaking counsellors. DAMEC’s majority clients still come from Probation and Parole or Community Service referrals.

DAMEC counselling service has adopted Brief Solution Focussed Therapy (BSFT) as the primary mode of counselling therapy for clients contacting the service seeking assistance. BSFT is a strength based intervention which is forward looking and highlights the journey toward solutions in preference to re-examining and reinforcing problems.

DAMEC has modified its intake and assessment procedures to be more culturally sensitive. These changes were advised from consultations with service providers. DAMEC ensures 24 hour turnaround with CALD clients as well as a narrative protocol to illicit information.

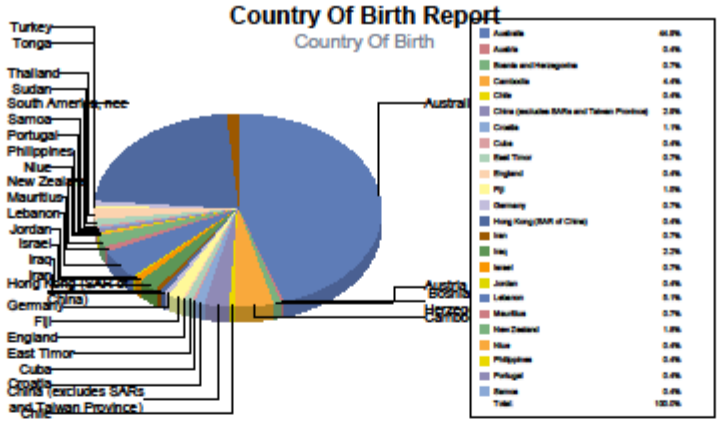
DAMEC has two ancillary services at the counselling centre. DAMEC has a Family worker (see above) that counsellors refer to when carer and family issues are identified. DAMEC has recently been using a part time psychologist to provide assistance with clients with co-occurring mental health issues. DAMEC now provides a psychological testing and diagnosis service through this position. DAMEC has found many clients referred have a coexisting mental health issue. Often clients are medicated by a GP but diagnosis was made several years ago and not reviewed. DAMEC is now providing these clients with diagnosis and mental health management plans.

DAMEC has undertaken an evaluation of the counselling service (see attached). This evaluation has shown the efficacy of the DAMEC counselling model. As a direct result of the evaluation, DAMEC has now adopted an outcome measure since May 2011. This outcome measure is managed by NADA.



29/11/2012

Principal Drug	Frequency
SEDATIVES AND HYPNOTICS	1
Paracetamol (incl. Panadol - Panamax)	1
Other Drug of Concern NEC	2
Not Collected	5
No Other Drug of Concern	5
Nicotine	1
MISCELLANEOUS DRUGS OF CONCERN	2
Methadone	5
M.D.M.A. (Ecstasy)	1
Heroin	81
Gambling	1
Ethanol (Alcohol)	66
Codeine (incl. Codral Forte - Disprin Forte - Pana	1
Cocaine	4
Cannabinoids (Cannabis)	59
Benzodiazepines, NEC	1
Benzodiazepines	6
ANALGESICS	9
Amphetamines	12
Amphetamine	8
Total	271



03/12/2012

Country Name	Frequency
Australia	123
Austria	1
Bosnia and Herzegovina	2
Cambodia	12
Chile	1
China (excludes SARs and Taiwan Province)	8
Croatia	3
Cuba	1
East Timor	2
England	1
Fiji	4
Germany	2
Hong Kong (SAR of China)	1
Iran	2
Iraq	6
Israel	2
Jordan	1
Lebanon	14
Mauritius	2
New Zealand	5
Niue	1

1

Other DAMEC Activity

Interagencies, committees and working groups attended

St George - Sutherland Multicultural Advisory Committee
Auburn Humanitarian Network
Fairfield Migrant Interagency
Holroyd-Parramatta Multicultural Network
Blacktown Migrant Interagency
Blacktown Emerging Communities Action Planning (BECAP)
Multicultural Youth Issues Network - NSW
Youth Peer Education and Mentoring Network
Department of Education and Training refugee Student Support Group
Network of Trainers in Diversity Health
Meeting of Workers with the Sudanese community
African Settlement Needs Network
Refugee Health Improvement Network
Harm Reduction Interagency
Auburn CDAT

Edward D. Chahoud is a CPA Practice

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INDEPENDENT AUDIT REPORT

TO THE MEMBERS OF
DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED

We have audited the financial report, being a special purpose financial report , of **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED** which comprises the Balance Sheet as at **30 June 2012**, the Income statement for the year ended **30 June 2012** and notes to the accounts.

The committee is responsible for the preparation and presentation of the financial statements and the information they contain and has determined that the accounting policies used and described in Note 1 to the financial statements which form part of the financial report are appropriate to meet the requirements of the Associations Incorporations Act (NSW) 2009 and are appropriate to meet the needs of the members.

We have conducted an independent audit of this financial report in order to express an opinion to the members of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED** on the preparation and presentation thereof.

The financial report has been prepared for the members of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED** . We disclaim any assumption of responsibility, for any reliance on this report or on the financial statements prepared to any person other then the members of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED**, or for any purpose other than for which it was prepared.

Our audit has been conducted in accordance with Australian Auditing Standards to provide reasonable assurance whether the financial report is free of material misstatement. Our procedures include examination, on a test basis, of evidence supporting the amounts and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Australian accounting concepts and standards.

The audit opinion expressed in this report has been formed on the above basis.

AUDIT OPINION
In my opinion the accompanying Financial Statements of the **DRUG & ALCOHOL MULTICULTURAL EDUCATION CENTRE INCORPORATED**, which have been prepared under the historical Cost convention are properly drawn up:-

a) So as to give a true and fair view of the state of affairs of the Centre as at **30 June 2012** and of the results of the Centre for the year ended on that date; and

b) Are in accordance with Statements of Accounting Concepts and Applicable Accounting Standards.

E. Chahoud 24/8/12.

E.CHAHOUD CPA Reg No.841305

Liability limited by a Scheme approved under the Professional Standards Legislation

DRUG AND ALCOHOL MULTICULTURAL EDUCATION
CENTRE INC.
ABN 44 792 123 447

FINANCIAL REPORT
FOR THE YEAR ENDED
30 JUNE 2012

Liability limited by a scheme approved under
Professional Standards Legislation

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

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DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

BALANCE SHEET
AS AT 30 JUNE 2012

	2012 $	2011 $
MEMBERS' FUNDS		
Accumulated Surplus	(93,956)	140,412
TOTAL ACCUMULATED FUNDS	(93,956)	140,412
Represented by:		
ASSETS		
CURRENT ASSETS		
Petty Cash	250	250
Westpac Grant a/c 032 023 17-9601	(10)	(10)
Westpac Cash Management a/c 032 023 22 9154	6,712	170,294
Westpac Cash Management a/c 032 023 21 3603	-	-
Westpac cheque a/c 032 023 22 9146	11,607	32,232
Westpac cheque a/c 032 023 22 9162	192	191
Westpac Debit Card a/c 032 023 24 2500	829	10,396
Sundry Debtors	1,337	99
Trade Debtors	7,277	3,741
Input Tax Credits	12,033	11,033
TOTAL CURRENT ASSETS	40,221	228,226
NON CURRENT ASSETS		
Fixed Assets		
Office Equipment at Cost	109,846	98,946
Less: Accumulated Depreciation	(77,356)	(68,644)
	32,590	31,302
Furniture & Fittings	45,964	45,964
Less Accumulated Depreciation	(38,550)	(32,025)
	9,414	13,939
Office Renovation at Cost	6,929	6,929
Less: Accumulated Depreciation	(6,929)	6,929
	-	-
Total Fixed Assets	42,004	45,241
TOTAL NON CURRENT ASSETS	42,004	45,241
TOTAL ASSETS	82,225	273,467

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

BALANCE SHEET
AS AT 30 JUNE 2012

	2012 $	2011 $
LIABILITIES		
CURRENT LIABILITIES		
Sundry Creditors	5,985	5,103
Trade Creditors	25,474	627
Superannuation Payable	9,729	10,444
PAYG Withheld	6,787	5,515
GST Payable	8,350	25,180
ATO - Tax Clearing Account	16,818	
TOTAL CURRENT LIABILITIES	73,143	46,869
NON CURRENT LIABILITIES		
Employee Entitlements	105,038	86,196
TOTAL NON CURRENT LIABILITIES	105,038	86,196
TOTAL LIABILITIES	178,181	133,065
NET ASSETS	(95,959)	140,412

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2012

	2012 $	2011 $
INCOME		
OTHER INCOME		
Interest Received	3,186	3,209
Income from Administration, Conference Training & NADA	29,024	21,836
Grants	913,630	1,026,796
Profit on Sale of Non-current Assets	-	-
	945,840	1,051,821

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2012

	2012 $	2011 $
EXPENDITURE		
Auditing Fees	3,045	3,000
Accreditation Costs	3,630	-
Accountancy Fees	5,145	2,129
Advertising	250	958
Administration Expenses	-	27,989
Bank Charges	1,467	1,736
Backfill Sessional	-	37,271
Catering Expenses	1,783	1,741
Cleaning	8,875	6 710
Conference	5,025	3,362
Computer Expenses	9,971	20,215
Counseling Expense	5,160	11,332
Depreciation	13,236	16,268
Electricity	15,529	18,354
Holiday Pay	(20,994)	7,327
Insurance	4,444	10,368
Leasing Charges	9,009	17,561
Library Items	-	55
Long Service Leave	39,646	5,904
Motor Vehicle Expenses	58,424	63,516
OH & S Expenses	-	5,603
Postage	1,265	1,002
Printing & Stationery	5,533	6,926
Project Evaluation	5,295	12,000
Project Expenses	23,408	5,379
Research Project Expense	1,864	291
Rent	122,537	104,265
Repairs & Maintenance	2,146	3,798
Salaries & Wages	702,631	629,747
Security Costs	1,131	724
Staff Amenities	10,943	4,804
Staff Training	3,088	25,732
Sundries	69	826
Publication & Subscriptions	6 466	624
Superannuation Contributions	59,957	61,578
Telephone & Internet Charges	29,311	29,035
Travelling Expenses	3,702	6,857
Travelling Allowance	291	2,641
Translation Service	13,752	1,898
Payline Fees	2,982	2,893

The accompanying notes form part of these financial statements.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2012

	2012 $	2011 $
Utilities	-	1,300
Workers Compensation Insurance	13,192	11,255
	1,182,208	1,274,032
Surplus/Loss for the year	(236,368)	(122,211)
Accumulated Surplus at the beginning of the financial year	140,412	262,623
Write back of GST/PAYG withholding obligations		
Assets Write back to Reflect Current Valuation		
Accumulated Surplus at the end of the financial year	(95,956)	140,412

The accompanying notes form part of these financial statements.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2012

1 Statement of Significant Accounting Policies

This financial report is a specia purpose financial report prepared in order to satisfy the financial reporting requirements of the Associations Incorporation Act NSW. The committee has determined that the associatinn is not a reporting entity.

The financial report has been prepared on an accruals basis and is based on historic costs and does not take into account changing money values or, except where specifically stated, current valuations of non current assets.

The following significant accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report.

Income Tax

The Association is exempt from income tax under S23 (e) and therefore no provision for tax is required.

Property, Plant and Equipment (PPE)

Leasehold improvements and office equipment are carried at cost less, where applicable, any accumulated depreciation.

The depreciable amount of all PPE is depreciated over the useful lives of the assets to the association commencing from the time the asset is held ready for use.

Leasehold improvements are amortised over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

Provisions

Provisions are recognised when the association has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured.

Provisions recognised represent the best estimate of the amounts required to settle the obligation at reporting date.

Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, deposits held at-call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the balance sheet.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2012

Revenue and Other Income

Revenue is measured at the fair value of the consideration received or receivable after taking into account any trade discounts and volume rebates allowed. Any consideration deferred is treated as the provision of finance and is discounted at a rate of interest that is generally accepted in the market for similar arrangements. The difference between the amount initially recognised and the amount ultimately received is interest revenue.

Interest revenue is recognised using the effective interest rate method, which for floating rate financial assets is the rate inherent in the instrument.

Revenue recognition relating to the provision of services is determined with reference to the stage of completion of the transaction at reporting date and where outcome of the contract can be estimated reliably. Stage of completion is determined with reference to the services performed to date as a percentage of total anticipated services to be performed. Where the outcome cannot be estimated reliably, revenue is recognised only to the extent that related expenditure is recoverable.

All revenue is stated net of the amount of goods and services tax (GST).

Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Tax Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense. Receivables and payables in the balance sheet are shown inclusive of GST.

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

NOTES TO THE FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2012

		2012 $	2011 $
2	**Trade and Other Receivables**		
	Current		
	Trade Debtors	7,277	3,840
	Input Tax Credits	12,033	11,033
		19,310	14,873
	The association does not hold any financial assets whose terms have been renegotiated, but which would otherwise be past due or impaired.		
3	**Property, Plant and Equipment**		
	Office Equipment at Cost	109,946	93,946
	Less: Accumulated Depreciation	(77,356)	(62,644)
		32,590	31,302
	Furniture & Fittings	45,964	45,964
	Less: Accumulated Depreciation	(36,550)	(32,025)
		9,414	13,939
	Total Plant and Equipment	42,004	45,241
	Total Property, Plant and Equipment	42,004	45,241
4	**Member Funds**		
	Accumulated Surplus at the beginning of the financial year	140,412	262,623
	Surplus (Deficit) attributable to the association	(236,368)	(122,211)
	Accumulated Surplus at the end of the financial year	(95,956)	140,412

DRUG AND ALCOHOL MULTICULTURAL EDUCATION CENTRE INC.
ABN 44 792 123 447

STATEMENT BY MEMBERS OF THE COMMITTEE

The committee has determined that the association is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements

In the opinion of the committee the financial report as set out on pages 1 to 9:

1. Presents a true and fair view of the financial position of Drug and Alcohol Multicultural Education Centre Inc. as at 30 June 2011 and its performance for the year ended on that date.
2. At the date of this statement, there are reasonable grounds to believe that Drug and Alcohol Multicultural Education Centre Inc will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the Committee and is signed for and on behalf of the Committee by:

Chairman: _____

Treasurer: _____

Dated this 11th **day of** September 2012

DAMEC Board 2011/2012

Chairperson	Jan Copeland (PhD)
Secretary	Mr. Graeme Pringle
Treasurer	Mr. Bruce Davies
Appointed Member	Mr. Peter King (Acting Treasurer) (NSW Refugee Health Service)
Appointed Member	Ms. Nadia Garan (Transcultural Mental Health Service)
Appointed Member	Mr. Mariano Coello (STARRTS)

DAMEC Staff

CEO	Mr. Kelvin Chambers
Psychologist Program Manager (Project & Research)	Ms Karen Redding
Office Manager	Ms Sarina Afa (resigned Feb 2012)
Finance Administrator	Mr Sathees Jeyaraj
Senior Policy Officer	Ms Helen Sowey
Senior Research Officer	Ms Connie Donato-Hunt Ms. Rachel Rowe
Intake/Information Officer	Mr Paul Robson (resigned Feb 2012)
Drug and Alcohol Counsellor's	Mr. Hassan Darbas
	Ms. Sinatt Cheng
	Ms. Vi Nguyen
Psychologist	Ms. Sandra Evers
Transitions	Mr. Thahn Nguyen
Administrative Assistant	Ms Elizabeth Opoku

Evaluation of DAMEC Counselling Services

Rachel Rowe
November 2011

This report was prepared for the Ministry of Health and Commonwealth Department of Health and Ageing by Ms Rachel Rowe, Research Officer at the Drug and Alcohol Multicultural Education Centre (DAMEC).

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Executive summary

Drug and Alcohol Multicultural Education Centre (DAMEC) Counselling Services aim to address the need for AOD service provision to CALD communities in South-western Sydney, by providing culturally appropriate outpatient counselling that addresses alcohol and other drug (AOD) use and co-occurring mental health issues. In 2008, the Liverpool based service received funding from the Department of Health and Ageing Non-Government Treatment Grants Programme (NGO TGP), to establish and maintain a counselling service in which two assigned workers could undertake counselling in Vietnamese and Arabic. In 2010, the service expanded to include family counselling. From 2008 to 2009 DAMEC's *Vietnamese Transitions Project* began engaging Vietnamese participants in AOD counselling as part of a casework program to address recidivism. That program recommenced in 2011 and will continue until mid-2012. Also in 2011, DAMEC Counselling expanded its reach to Auburn, where counselling in Arabic and English is now offered from new premises at the Auburn Centre for Community.

While the interim evaluation of DAMEC Counselling Services (2010) assessed if organisational objectives were being met and if enhanced standards were in place; the aims of this final evaluation were to gain understanding about the client demographic attending the service, to identify the referral sources and intake patterns at the service, and to explore the characteristics and developments within DAMEC's model of counselling. A process evaluation was deemed the most effective way to respond to these criteria. To conduct this evaluation, an attempt to contact all of the clients admitted to the service from April 1st 2011 until September 30th 2011 was made. Interviews were conducted in September and October 2011 with 24 clients, composing just under half of the clients attending the service over the aforementioned period. Furthermore, in-depth interviews were conducted with every counsellor at the service, and the services' Minimum Data Set (MDS) figures from April 1st 2009 until September 30th 2011 were analysed to identify patterns and trends in client intake, referral sources and also to cross-examine the qualitative data sets. This report presents the results: a practical insight about the counselling approach at DAMEC and the extent to which the counselling model has been implemented.

This evaluation highlighted numerous effective practices employed at DAMEC Counselling Services in the context of growing client admissions, including notable increases in clients referred through the criminal justice system, family counselling and Vietnamese speaking clients. Effective practices related to counsellors' attributes, culturally informed practices and multilingual capacity, family counselling, approaches to coerced clients and warm referral techniques. This evaluation identified a need to systematise aspects of these practices, such as case file review and mental health diagnostic processes. Furthermore, the findings indicate that inter-agency referrals, mental health diagnosis and cultural information are not adequately reflected in the services' MDS and as such, standard reporting criteria across DAMEC Counselling Services should be

implemented to enhance treatment objectives. In this vein, strategic efforts to develop stronger relationships with mental health services, local GPs and CALD community groups are also recommended. To meet NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines (2008), this report recommends providing clients with basic information about the particular psychosocial interventions used in their counselling. Section 7 of this evaluation presents an examination of the counselling model from which the scope of interventions used at DAMEC is reported. Finally, the findings with regards to clients' own perceptions of the impacts of counselling underpin the recommendation that two outcome measures are implemented across the services.

Acknowledgements

The evaluator wishes to sincerely thank all those who gave their time to participate in this evaluation, both clients and staff at DAMEC Counselling Services. Thanks also to the members of DAMEC Research Subcommittee, Jan Copeland (NCPIC), John Howard (NCPIC), Robert Stirling (NADA), Ian Flaherty (MSIC), Tricia O'Riordan (NSW Health) and Kelvin Chambers (DAMEC), for their generous feedback on the evaluation protocol and report. This project would have been difficult to undertake without the support and encouragement of all the staff at DAMEC. Finally, the evaluator recognises the contribution of DAMEC Counselling Services' key funding bodies, the Ministry of Health and Commonwealth Department of Health and Aging.

Ethics approval for the evaluation of DAMEC Counselling Services was obtained from the NSW Population and Health Services Research Ethics Committee.

Contents

1 Background

In 2008 the Drug and Alcohol Multicultural Education Centre (DAMEC) received funding under the Department of Health and Ageing (DoHA) Non-Government Organisation Treatment Grants Programme (NGO TGP). The funding received was to be used to provide counselling for Arabic and Vietnamese speakers, largely in South Western Sydney. To this end, a counsellor who spoke Arabic and one who spoke Vietnamese were employed to work for DAMEC from an office in Liverpool, South Western Sydney. In 2011 DAMEC Counselling Services opened at the Auburn Centre for Community, an Arabic/English counselling service now operates part time from this site. In 2010, a family counselling role was incorporating into DAMEC Counselling Services. The Vietnamese Transitions Project received its first grant to operate from 2008 to 2009 and a second grant to operate from 2011 to 2012. The program offers casework and counselling to Vietnamese clients upon discharge from prison, and as such the program employs a bilingual and bicultural worker.

In 2008, the intended objectives of DAMEC Counselling Services were to:

1. Provide bilingual drug and alcohol counselling services to Arabic and Vietnamese speaking clients in South Western Sydney;
2. Provide bilingual family support to families of Vietnamese and Arabic speaking clients in South Western Sydney;
3. Provide a consultation service to drug and alcohol workers in NSW regarding CALD clients;
4. Pilot an variety of culturally appropriate treatment models for Vietnamese and Arabic speaking background clients;
5. Continuously improve the DAMEC programme by regularly evaluating its effectiveness against each stated objective;
6. Continuously improve the DAMEC Arabic and Vietnamese Drug Treatment programme by regularly evaluating its effectiveness against each stated objective;
7. Develop an evaluation model for the programme.

1.1 Results from the interim evaluation:

While this evaluation is not a direct extension of the interim evaluation conducted in 2010, the interim evaluation's methodology and findings were influential in developing this final evaluation's aims and intended outcomes. The preliminary evaluation was both summative and formative, in that it made several recommendations to improve the service and developed documents and procedures to implement these recommendations. The interim-evaluation collected client satisfaction surveys, however these were inconclusive. The interim evaluation looked into the existing literature and organisational structures needed to implement Brief Solution Focused Therapy with CALD clients. In 2010, this was followed up with 6-months of

training in this psychosocial intervention for all counselling staff. These developments influenced the decision to enhance the qualitative component of the current evaluation, and reflect on the ongoing development of the counselling model in more detail.

2 Introduction

This process evaluation employed quantitative and qualitative methods to satisfy the following aims. It forecast several intended outcomes, some of which can be met by an evaluation process, while others are the anticipated product of organisational developments resulting from implementing evaluation recommendations.

2.1 Aims of the evaluation:

1. To identify referral sources and intake patterns at DAMEC Counselling Services over a 2-year period from April 1 2009 to September 30 2011.
2. To gain insight about the complex needs of DAMEC clients, including CALD clients with criminal justice issues and/or with co-occurring mental health issues.
3. To explore what the counselling approach comprises from the perspectives of clients and practitioners.

2.2 Intended evaluation outcomes

1. Understanding of the extent to which CALD clients and other complex needs clients are receiving treatment from DAMEC Counselling Services.
2. Incorporation of consumer and practitioner feedback in developments of the therapeutic approach currently being piloted at DAMEC Counselling Services.
3. Documentation of the level of implementation of the therapeutic approach.
4. Recommendations regarding the implementation of the therapeutic approach.
5. Identification of short-term and immediate impact measures.
6. Accountability requirements set by funding bodies met.

3 Evaluation methodology

3.1 Data collection tools

In response to each aim of the study, the evaluation methods involved a quantitative assessment of client records and flow patterns; and qualitative interviews with service clients and staff. The first approach involved the review of the Minimum Data Set (MDS) collected at DAMEC from April 1st 2009 until September 30th 2011. The second approach involved in-depth interviews with two participant groups: active DAMEC clients from May 1st until August 30th; and DAMEC counselling staff.

3.2 Recruitment and consent

On May 1st 2011, DAMEC Counselling Services implemented a General Consent Document (Appendix I) which was designed to inform clients about DAMEC's research and evaluation practices in general, as well as to enable DAMEC researchers to contact clients with their full and informed consent. The completed forms were passed on to the evaluator, from which a list of potential interview participants was generated. The evaluator contacted clients using the numbers that clients had provided when signing the General Consent Document. For the initial phone call, a non-clinical staff member witnessed each client's verbal expression of consent to participating in an interview. She then withdrew from the room in order for the interview to commence. The evaluator asked all clients for permission to audio-record the interview, and audio-recorded or took notes according to each client's wishes.

3.3 Ethics

The full protocol for this evaluation was reviewed and approved by the NSW Population and Health Services Research Ethics Committee in July 2011 (Appendix II). The evaluator sought ethical approval to conduct the evaluation to ensure that the highest level of ethical rigour was obtained for interviews with the vulnerable client sample. Since the evaluation sought to collect data regarding the implementation of psychosocial interventions with CALD clients, an area where little current literature exists, this ethics approval enables the results from this evaluation to be published by DAMEC in other forms, as pre-approved by the Committee. A limitation associated with the ethics review process was a reduction in the time available for participant recruitment.

3.4 Data sets

3.4.1 Quantitative data collection and analysis: Minimum Data Set (MDS)

The quantitative data from the services' MDS records has been analysed over the whole evaluation period. The data was also divided into 5 periods, of 6 months duration each. This enabled the evaluator to compare periods and identify trends. The quantitative data obtained has been employed to describe gross figures and trends regarding DAMEC's scope in terms of client demographic and duration of treatment episodes between April 2009 and September 2011. No further analysis or experiments were run on this data.

3.4.2 Qualitative data collection: counsellor interviews

Interviews with all 6 DAMEC counsellors were conducted on October 5th, 12th and 13th 2011. It should be noted that counsellors' roles at the services vary from working on specific programs (Vietnamese Transitions Project), family and carer support, to primarily working with clients who speak Vietnamese or Arabic (although other languages are spoken by the counselling team, grant funding exists specifically for Vietnamese and Arabic counselling roles). Interview questions for this group are included in Appendix IV.

3.4.3 Qualitative data collection: client interviews

Regarding clients of DAMEC Counselling Services, 56 clients consented to being contacted for research and evaluation projects from May 1st 2011. These clients, representing all but one client admitted to the DAMEC over the period, were subsequently telephoned and invited to participate in this service evaluation. During this period, counsellors distributed information brochures about the evaluation in English, Vietnamese and Arabic. As anticipated, a large number of the services' clients were difficult to contact over the phone but those who were contacted showed high retention rates. NAATI accredited interpreters were contacted and trained in verbal consent, confidentiality protocols and interviewing. Interpreters for Arabic, Cantonese, Khmer, Mandarin and Vietnamese received this training and conducted the interviews in the presence of the Evaluator. Audio recordings and detailed notes were then transferred to the Evaluator for data analysis. Interview questions for client participants are included in Appendix V.

The language groups represented in the interviews correspond with the languages spoken by DAMEC's clients as shown in the MDS over the same period. See table below.

Total clients consented to be contacted for the purposes of research/evaluation from May 1 - August 30, 2011: 56	**Total clients consented to interview for evaluation of DAMEC Counselling: 29**

Total client intake over this period: 57	
Total clients consenting and participating in interview: 24 English speaking clients: 16 Vietnamese speaking clients: 5 Mandarin speaking clients: 2 Arabic speaking client: 1	**Clients unavailable: 32** No answer: 18 Wrong number: 3 Disconnected service: 2 Residential rehab: 1 Hospital: 1 Consented to interview, but unable to schedule due to competing commitments (e.g. work): 5 Withdrawal: 1 Not-eligible (assessed but not suitable for admission): 1
Languages in which interviews were conducted: 4 English: 16 (66.7%) Vietnamese: 5 (20.8%) Arabic: 1 (4.2%) Mandarin: 2 (8.3%)	**Top 6 languages at DAMEC Counselling:** English: 63.2% Vietnamese: 21% Arabic: 3.5% Mandarin: 3.5% Cantonese: 3.5% Khmer: 1.7%

When were clients in the interview sample admitted to DAMEC?

Eighteen of the clients interviewed had been admitted to DAMEC Counselling Services this year, with 5 clients carrying over from 2010 and one client first attending counselling in 2009.

Gender composition of the sample

Fifteen interviewees were identified as men, with 9 identified as women. This reflecting a moderate over-representation of female interview respondents (37.5%, n=9), where the services' MDS shows 25% of clients admitted during the same period were women. Two of the women interviewed had attended counselling in relation to a family member's alcohol or drug use, of the entire client sample, these were the only respondents who had not attended counselling for any AOD issues of their own.

Referral sources among this sample

The respondents reported a range of referral sources to DAMEC, the scope reported reflects the elements collected in the MDS. Fifty-eight per cent of clients interviewed had been referred to counselling through the Criminal Justice System. Seven clients had been referred to DAMEC by Probation and Parole, 2 through Forum Sentencing, 1 through the Magistrates Early Referral into Treatment (MERIT) Program and another 4 reported also being referred through the courts. This group composed 58.3% of total client sample. Additionally, 3 clients had been referred on from Uniting Care Burnside in Cabramatta when its AOD counselling program was closed in 2011. Two clients had found out about DAMEC through word of mouth and family support, 1 was referred from a hospital AOD treatment facility and another was referred through a community AOD clinic.

3.4.4 Qualitative data analysis

The method of analysis for the two qualitative data sets was inspired by grounded theory. Data was collected and analysed simultaneously; data was reviewed and re-reviewed several times during the evaluation's two-phase approach. For the first phase of analysis, notes were made immediately following interviews and main topics were identified and condensed into the main topics, common experiences and ideas that interviewees referred to. Clusters of linked themes were established as the process of interviewing continued. A spreadsheet was created to track the appearance of linked themes in the data. The second phase of analysis involved reviewing all informants' responses in reverse order, to ensure that the established thematic categories were accurate. Furthermore, from the basis of similar and dissimilar ideas within each of the main thematic categories the dimensions of the findings were examined.

Although all methods of analysis rely on an element of interpretation, in this evaluation emphasis was placed on presenting informants' views in context, and where possible, in their own words. Confidentiality protocols have been employed regarding the use of direct quotation and paraphrasing. Participants are not identified in this report and quotes have been coded by random letters. Quotes have been chosen to accurately reflect the scope of opinions and experiences reported.

3.5 Methodological considerations

While randomised control trials are often perceived to provide the most robust measures of efficacy and outcomes associated with a particular intervention, the ethical, resource-related, practical and scientific issues that evaluators would face in applying such a protocol at a counselling service of this size rendered such an approach unfeasible. Considering these limitations and the contribution already made by the interim evaluation, it was determined that a process evaluation cross-examining qualitative data with the services' MDS figures was the best basis upon which to document the services' progress. This approach was thought

to enable the collection and presentation of in-depth information which would clarify the utility of particular outcome measures to be implemented across DAMEC Counselling Services in the future.

3.5.1 Internal evaluation

The internal conduct of evaluation, generally speaking, has its advantages and disadvantages. In this case, the disadvantages often cited in regards to internal evaluation were mitigated by particular and specific circumstances. A researcher with no prior relationship with DAMEC was hired to undertake this evaluation, among other research-oriented tasks, from November 2010 until November 2011. The nature of this contract meant that the researcher was able to develop a level of rapport with staff and clients to be expected from an external evaluator on contract for an evaluation period of comparable duration. Furthermore, given that DAMEC operates from two separate sites, consultations with staff in the protocol development process and part of the qualitative fieldwork (e.g. interviews conducted in private counselling rooms) were the only elements of the evaluation undertaken at DAMEC Counselling Services. The perceived benefits of the evaluator being a staff member were shown in the facilitation of more flexible procedures for staff input into the evaluation protocol.

3.5.2 Client sample

Over the period of client recruitment 57 clients were admitted to DAMEC Counselling Services, 56 clients consented to being contacted for the purposes of research and evaluation. Three attempts were made to contact all of these clients, to invite them to participate in this particular evaluation. Given this, that almost half of the total client group came to compose the sample for client interviews, is an achievement to be attributed to the flexible, client centred approach that recruitment protocols were based in. For a client demographic of this size however, the analysis prioritised identifying and describing certain phenomenon, rather than counting the incidence of such phenomenon. Despite this, some associated difficulties remain.

Self-reported measures can present issues regarding the precision of the information given; however they do present significant detail and understanding of the phenomena at hand. One related issue was that a significant portion of the clients contacted had already exited the service when they were interviewed. It was common that clients could not remember the exact number of sessions that they had received or when they first started going to the service. The services' MDS does include the mean number of sessions attended by clients over the evaluation period, but at DAMEC an episode is considered to include up to 6 sessions. Across the client sample that participated in qualitative interviews, the mean number of counselling sessions attended was approximately 5 sessions. However, 4 clients interviewed had received 2 sessions and 1 respondent had only been through assessment. Conversely, 2 clients reported having received more than 10 counselling sessions. It can be summarised then, that since clients were interviewed at various stages of their counselling

experiences at DAMEC, the data set does not speak strongly of particular periods in clients' counselling experiences, but it does reveals detail about the general experiences of clients who attend DAMEC Counselling Services.

Furthermore, when given four options for the conduct of interviews almost all clients preferred to conduct the interview immediately after the consent protocol and over the phone. This was not the case for all clients. Some clients made it clear that they would prefer to meet in person, and that preference was accommodated. Similarly, not all clients felt comfortable being audio-recorded. The predominant use of phone interviews limits the evaluator's ability to reflect on non-verbal forms of communication, which can reflect misunderstandings of questions posed or answers given. The evaluator made every effort to repeat answers back to clients or to request clarification where necessary.

The final issue considered is that this evaluation was conducted across 3 language groups, and in fact, set up infrastructure to include 5 language groups. This raises issues regarding the interpretability of AOD language and counselling procedures, which varies across languages and cultures. Here are two specific examples: the concept of homework does not exist in Vietnamese so the interpreter explained this question with other words, one interpreter suggested using indirect language to refer to drugs because it was rare that the word "drugs" would be used in her language. Subtle changes such as these may have contributed to a minor degree of variation between interviews, but they were approved in the interests of fluid communication and cultural appropriateness in interviews.

4 Literature review

Summary

The literature presented seeks to contextualise the client demographic data, referral pathways, therapeutic approaches and impacts reported in this evaluation, by reviewing literature on levels of CALD service access in Australia, referral pathways, preconceptions of counselling, and evidence-based studies of particular therapeutic approaches. The interim-evaluation of DAMEC Counselling Services in 2010 highlighted the modest body of existing literature that documents the relationship between counselling approaches and cultural and linguistic diversity, with particular emphasis on Brief Solution Focused Therapy. It is unsurprising that, a year later, this evaluation finds itself in familiar territory. It remains clear that religious, cultural, linguistic and spiritual issues are likely to impact upon the way a person participates in counselling, that cultural groups are heterogeneous and that in respect to accessing AOD treatment services, CALD communities in Australia continue to face significant barriers.

The first NSW professional practice guidelines for psychosocial interventions in AOD treatment contexts published (2008), highlights a lack of evidence supporting the application and efficacy of particular psychosocial interventions in AOD treatment settings across culturally and linguistically diverse groups. The guidelines state that "very little research exists that directly tests the application of these approaches to people from culturally and linguistically diverse backgrounds" and furthermore, "it is not immediately clear how the needs and perspectives of people from culturally and linguistically diverse communities fit within these approaches" (Baker et al. 2006 in NSW Health 2008, p63). The guidelines advocate for educational and promotional activities of AOD counsellors where client populations may have varying levels of awareness of harms associated with alcohol and other drugs (2008). They also acknowledge that building rapport within CALD communities, as well as exercising sensitivity and respect when seeking to make inter-agency referrals may be among the keys to appropriate interventions (2008).

Evidence suggests that people from culturally and linguistically diverse backgrounds are likely to face particular difficulties in seeking and obtaining appropriate assistance from AOD services. Accessing services often only occurs once crisis point has been reached within the family, or following a medical or legal intervention (Reid et al. 2001). CALD clients may face stigma, fear of rejection, loss of confidentiality and shame on social, community or family levels (Donato-Hunt et al. 2008). Recent studies show that the help seeking patterns of CALD clients in AOD and mental health services are often different from clients from an Anglo background (Flaherty et al 2010, Hsiao-Wen & Dzokoto 2005).This suggests that culturally relevant approaches to AOD counselling are needed to respond to differing life experiences and stresses to which many ethnic communities have been exposed, including pre- and post-migration experiences. Despite the existence of policies and guidelines that outline inclusive principles by which health services should operate

(NSW Health 1998, 2008), linguistic and cultural issues are widely recognised as barriers to accessing adequate AOD services.

These challenges are often associated with the use of Anglo-centric treatment practices (such as excluding the family) and a lack of culturally appropriate therapeutic practices, translated material, specialist interpreters and bilingual workers (Treloar et al. 2004). Given that western concepts of counselling and self-disclosure do not exist in many CALD communities, scepticism from clients and their families may result from assumptions made by workers in taking an approach focused only on the individual. The interim evaluation of DAMEC Counselling Services referred to Hsiao-Wen and Dzokoto's (2005) study, which questioned the appropriateness of directly importing Western psychological interventions into non-Western contexts, through comparing case studies from Ghana and Taiwan. These authors propose an approach to mental health counselling that considers the dimensions of diversity within a cultural group, including gender, socio-economic, religious and spiritual issues (ibid, 126). Berg and Miller (1992) also argue that the heterogeneity present within cultural groups should form the basis of a therapeutic approach that considers both macro and micro views of ethnic similarities and differences. As the interim-evaluation noted, "therapists need to maintain, suggest Berg et al., both an eco-systemic view of how the ethnic and cultural experiences of the client affect treatment while not losing sight of the micro view of how these cultural traits are experienced at the individual level" (Flaherty & Donato-Hunt 2010, 7). Guterman and Leite (2006) add that spiritual or religious issues might be considered by counsellors in the application of solution focused approaches, taking into consideration that client-centred approaches must recognise that this might not be suitable for all clients. In regards to client-centred approaches, Guterman and Leite (ibid) stress that a thorough understanding of a client's worldview is essential in establishing the basis for conceptualization and intervention along a solution-focused model. The DAMEC's interim evaluation noted that literature concerning Brief Solution Focused Therapy (BSFT) is "largely concerned with the broader theme of individualised service provision" (Flaherty & Donato-Hunt 2010). This was considered to be one of the strengths of this psychosocial intervention. Other literature on culturally appropriate treatment stresses the importance of considering family and community inclusion, acknowledgement of trauma, refugee experiences, assimilation issues and issues associated with initiation into the dominant Australian culture (NSW Health 2008).

5 Results: DAMEC Clients

Summary

Intake at DAMEC Counselling Services rose significantly over the evaluation period, from 59 clients from April to September 2009, to 84 clients over the same months in 2011. Intake of clients referred through a criminal justice setting has doubled over the 30-month period that this evaluation covers, while self-referrals declined sharply over the evaluation period. Over the period that this evaluation studied, just over half of DAMEC Counselling Services clients were born outside Australia. Fifteen per cent were born in Vietnam, corresponding with 15% whose preferred language was Vietnamese. Eight per cent were born in Arabic speaking countries, and 7.7% of clients overall preferred to speak Arabic. Since April 2011, intake of female clients has increased steadily and the number of clients concerned with someone else's drug use sharply increased in 2011. Clients expressed varying attitudes towards AOD counselling upon intake. Negative attitudes and low motivation to attend counselling were observed to relate to juridical coercion and past experiences of service provision.

5.1 Service access patterns and referral

From April 1st 2009 until September 30th 2011, DAMEC Counselling Services provided treatment to 349 clients. Intake trends rose significantly over the evaluation period, although a dip in intake levels from September 2010 until February 2011 was observed. Fifty-eight percent of DAMEC's clients came through the criminal justice system (n=204), while 20% of clients found DAMEC on their own (n=71). Over the evaluation period self referrals steadily declined during the first 6 months of the evaluation (1 in 3 clients, n=20), to plateau over the past year at an average of 11.4% of referrals (n=16). At the same time, the services experienced a dramatic increase in referrals through the criminal justice system. In the initial 6 month period of this evaluation, referrals through criminal justice settings were parallel with self-referrals, composing just over a third of total clients (n=22). From October 2010 to April 2011 referrals from Probation & Parole (P&P), Magistrates Early Referral into Treatment (MERIT), Forum Sentencing, Corrective Services and Justice Health peaked at 75% of clients (n=41). For the 6 months on either side of this period, approximately 2 in 3 clients were referred through a criminal justice setting. These trends are considered in the following charts.

Figure 1 Referral sources over evaluation period

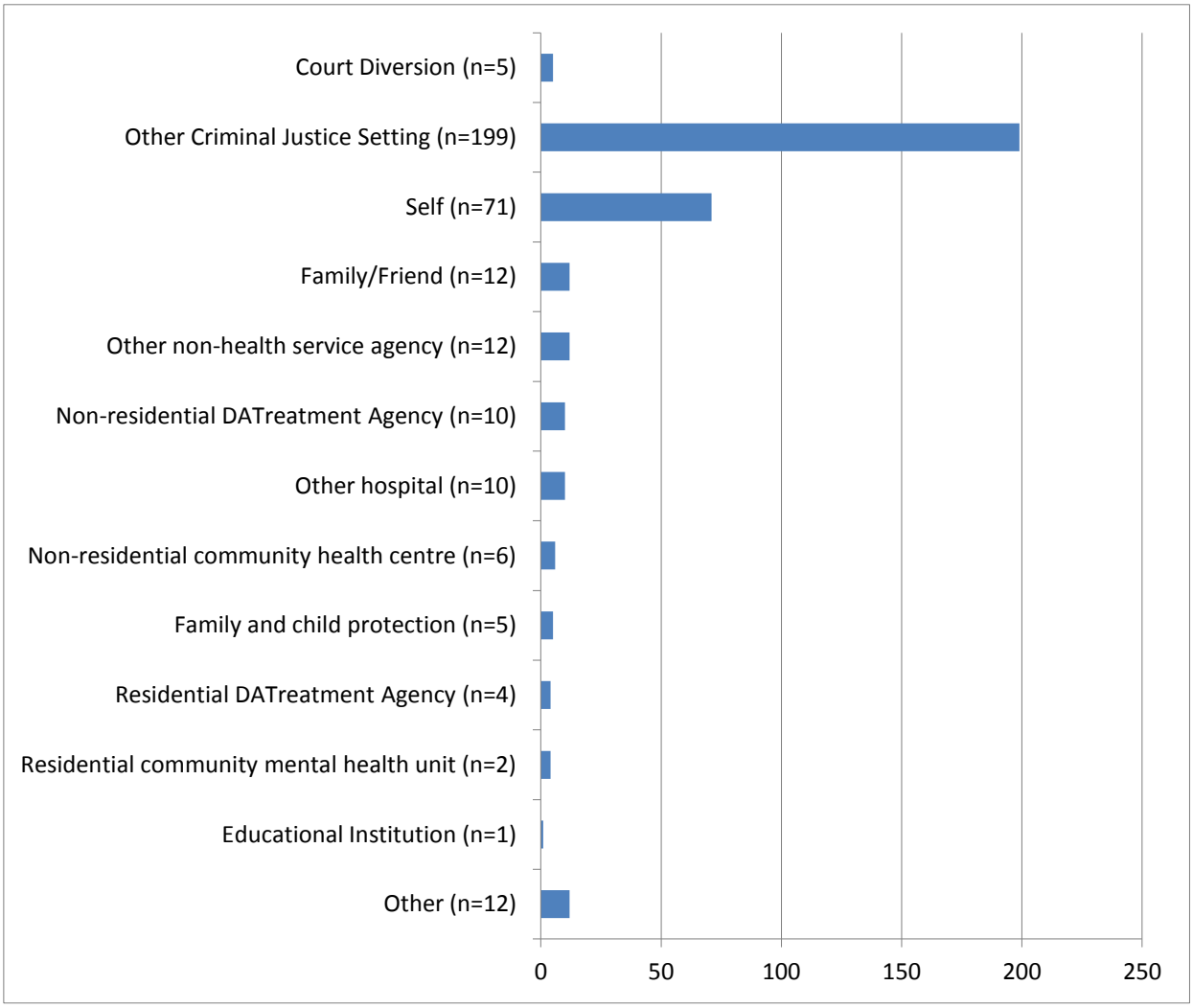
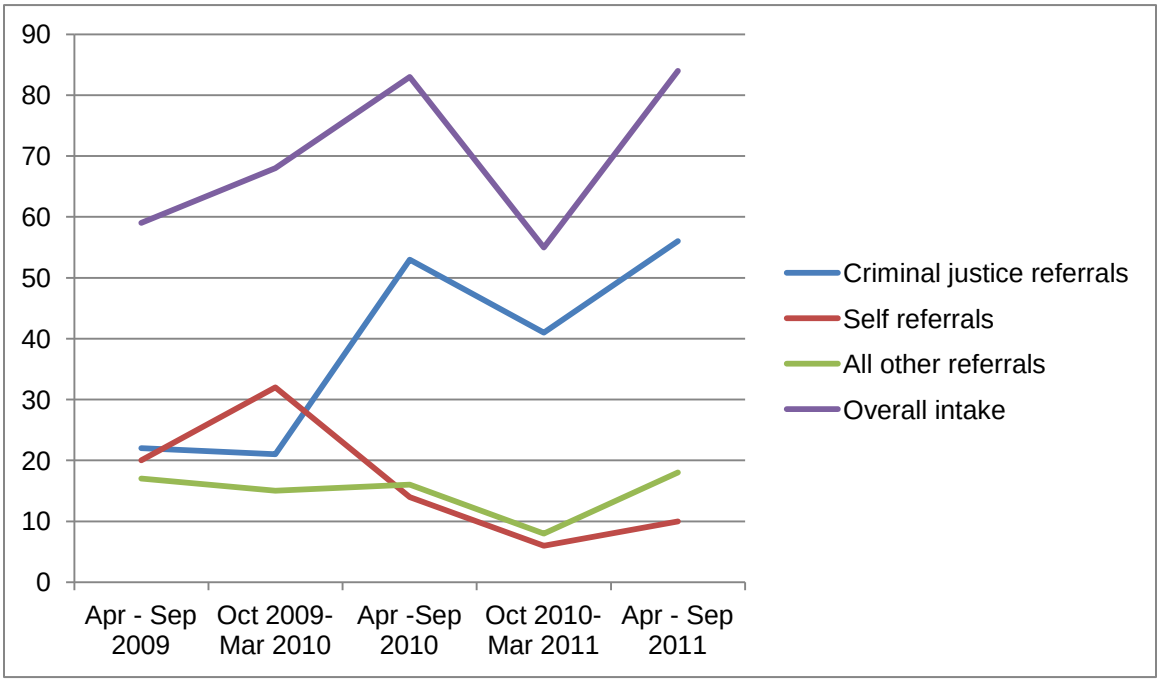


Figure 2 Referral trends



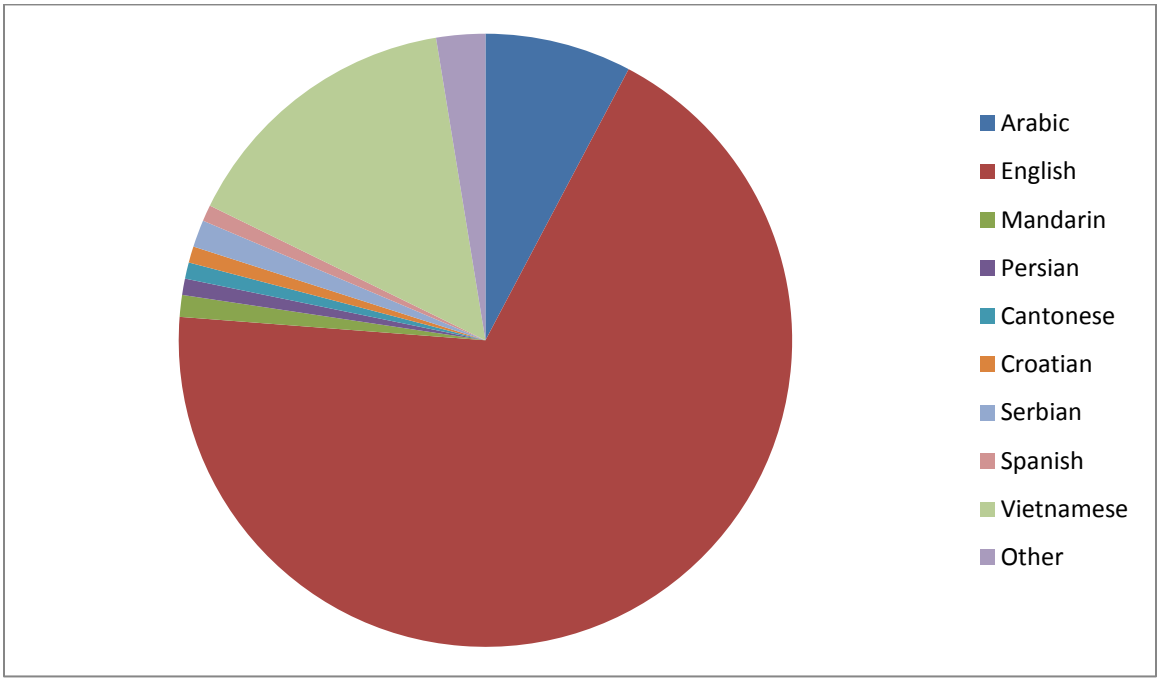
While criminal justice settings and self-referrals were the dominant referrals sources reported in the services' MDS, clients were referred to DAMEC through a number of other channels (as indicated by the green line in the graph above). Over the total evaluation period, other referral sources in order of frequency reported were family and friends (n=12) non-health related community organisations (n=12), non-residential DA agencies (n=10) and hospitals (n=10). Family and child protection services (n=5), residential DA treatment agencies (n=4), residential community mental health units (n=2) and educational institutions (n=1) made relatively few successful referrals to DAMEC over the whole period. Both counsellors and clients noted that the closure of Uniting Care Burnside's family program in Cabramatta early in 2011 had contributed to an increase in clients referred by the Department of Community Services (DoCS) to seek counselling and other family referrals.

Some counsellors emphasised the view that word-of-mouth, inter-family referral or promotion through community groups were increasing sources of referrals for clients from culturally diverse backgrounds. Since in Sydney, AOD counsellors from particular cultural backgrounds are few, some counsellors suggested that advertising and promoting the presence of bicultural and bilingual workers at DAMEC could have had an impact on intake patterns. One counsellor explained, "Usually what happens is that a sister, or wife or father or mother will call and say 'we have issues…' I will explain it [counselling] to them, and sometimes it puts them off, but then another person from the family will call later." Attitudinal challenges with respect to certain referral sources, as well as the relationship between referral pathways and different cultural perceptions of counselling and AOD issues will be discussed further in section 6.3.

5.2 Country of birth and preferred language

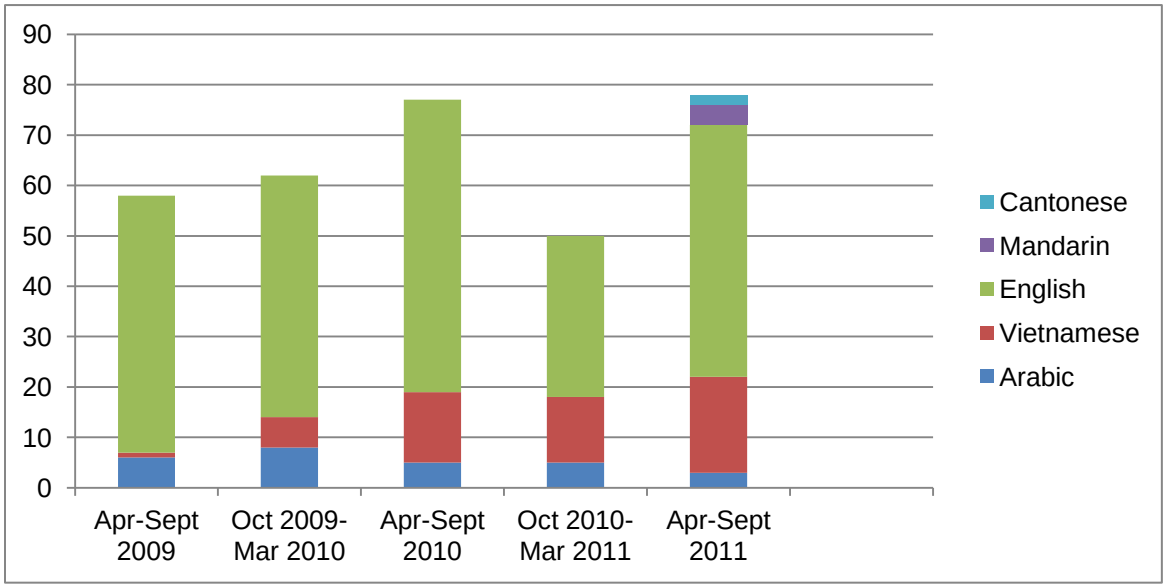
Just over half of DAMEC's clients were born overseas (51.6%), which indicates that a range of cultural influences exist within the client sample captured in the services' MDS. Almost 16% of clients were born in Vietnam, followed by Lebanon (3.4%), Iraq and New Zealand (each 3.1%), Yugoslavia (2.8%), China and Fiji (each 2.4%), Cambodia (2%), East Timor, England and the Philippines (each 1.1%).Overall the most common language preferences at the services since April 2009 were English (68%), Vietnamese (15.2%), Arabic (7.7%). The chart below shows the breakdown of language groups that attended the DAMEC Counselling Services during the whole evaluation period.

Figure 3 Preferred Languages, April 1 2009-September 30 2011



Among the most notable trends across DAMEC Counselling Services over the past 30 months is the dramatic increase in Vietnamese speaking clients attending the services. The portion of active clients who prefer to speak Vietnamese increased from 1.7% in the first period of this evaluation (April-September 2009, n=1) to 22.6% in the final period (April-September 2011, n=19). As also illustrated in the table below, in the last 6 months of the evaluation period, Arabic speaking clients slightly declined in numbers and Mandarin and Cantonese speaking clients began attending DAMEC Counselling Services.

Figure 4 Trends in language needs



Counsellors provided some insight into the particular referral pathways that might have influenced these demographic trends. The recent increase in clients from Chinese backgrounds was observed to have come through Burwood P&P and Blacktown P&P. A counsellor at DAMEC Counselling Services speaks Cantonese, Mandarin and Khmer, and so the service have been able to cater for this emergent need. Furthermore, counsellors identified gaps in the MDS report where phone consultations are not recorded but compose a significant aspect of their service to Arabic and Vietnamese speaking clients in particular.

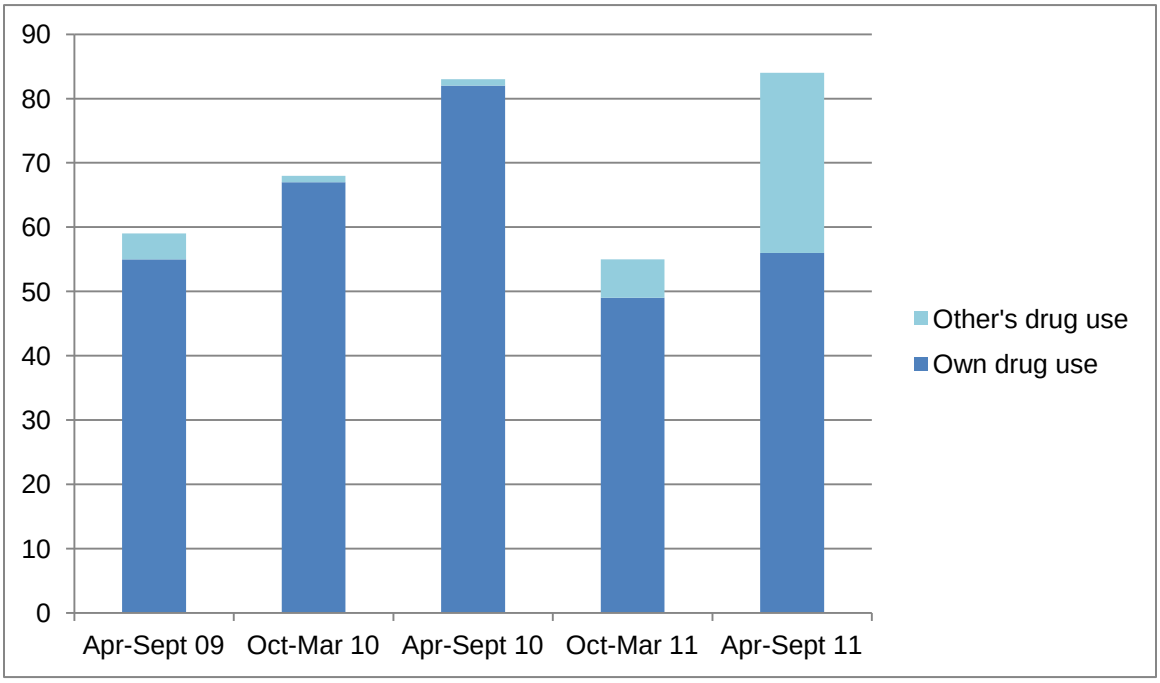
5.3. Gender composition

Over the two and a half year period, 84.3% of intake was composed of men (n=294), while the remainder were identified as women (n=55). The proportion of female clients attending the DAMEC for counselling spiked in 2011, from an average 12.8% of total intake from April 2009 to April 2011 (n=34), to 25% of total intake (n=21) in the final six months of the evaluation period.

5.4 Family counselling

Eighty-nine per cent of clients attending DAMEC Counselling during this evaluation period did so for issues related to their own alcohol and other drug usage. Intake of family members and friends concerned with another person's drug use increased over the period from 4% of the total intake from April to September in 2009 to compose a third of total intake from April to September in 2011. The family counsellor reported undertaking substantial promotional efforts from 2010 until 2011. The qualitative data showed a crossover between individual relapse prevention and the involvement of family members in counselling, many clients referred to the inclusion of their families and partners in the counselling process (or efforts to do so).

Figure 5 Family counselling across the evaluation period



5.5 Preconceptions and attitudes associated with AOD counselling

Thirteen of the 24 clients that comprised the interview sample reported that they did not want to, or did not choose to attend counselling at DAMEC at first. All of these clients were coerced to attend counselling through the criminal justice system or the Department of Community Services (DoCS). Another 2 clients reported some degree of motivation, 9 reported being self-motivated to seek counselling. There was a strong correlation between having been mandated (or coerced) and having low motivation, with 92% of mandated clients not wanting to attend. In the interviews with clients, all respondents referred by P&P, the MERIT Program, Forum Sentencing and DoCS expressed feeling coerced to attend counselling. Clients referred by DoCS similarly expressed that their fear of losing their children motivated them to attend. In interviews, counsellors connected coerced clients to generally low levels of initial motivation to attend counselling. Some counsellors expressed the view that clients' attitudes towards counselling are likely to be influenced by resentment emerging from the view that counselling has been mandated as a punitive measure.

Of the clients interviewed those who referred themselves to DAMEC or had been referred through another AOD agency showed high levels of motivation linked to positive attitudes to counselling. These clients expressed a desire to attend counselling from the beginning. Counsellors substantiated the trend that this data suggests, all agreeing that voluntary or self-referred clients were more motivated to "work on their issues", as one counsellor put it. Furthermore, some counsellors also noted generally high levels of

engagement among clients who had been referred to DAMEC by Job Network Agencies, such as Job Find or socio-economic and community organisations such as Catholic Care.

Attitudes towards counselling were also demonstrated to relate to clients' previous experiences of service provision. The words of one client resonated in the accounts of several others: "I thought the service would be like others I had been to" (P). In response to a P&P officer's suggestion of counselling, one client recalled the following.

> "I was an bit sceptical [at first]... they didn't make me go but I was a bit iffy about it at the beginning, because years ago when I went to detox they used to harass you… ex-alcoholics telling me I can't do this and I can't do that… I was expecting that sort of treatment, but it was nothing like that, they are so friendly and understanding." (B).

Another client also outlined her preconceptions of DAMEC Counselling in this statement,

> "I was actually expecting the same sort of service that I'd gotten from the previous psychologists and counsellors, where at first they seemed interested in what I had to say and then basically it was see you in two weeks, see you in a month, but I was still a mess. I have gotten the opposite to that [at DAMEC], they are fantastic. They are really interested in helping." (H)

These statements suggest that negative previous experiences of service provision in the past corresponded with low motivation to seek counselling from DAMEC.

Of the clients interviewed, 4 reported having expressly low or non-existent expectations of DAMEC when they first attended for counselling. After a few sessions, 3 of these 4 clients said that they changed their views about AOD counselling. While one client's view did not change, stating "I don't need anything, they are only making sure everything is fine" (I) another client stated, "I did one session then we went to court… I am still going there [to DAMEC] of my own free will, not through the courts or anything, I'm just going for anger management" (F). Some counsellors reported that in their experience clients who were initially obliged to attend counselling, if they attend at least a couple of sessions, usually sought to continue counselling beyond the 6-session program. One counsellor explained this, "most of the time we give them 2, 3 or 4 appointments before they front up, but when they do front up, on average, they stay more than other people. Even when the counselling process is finished, they try to keep in contact… but that's ok, because that's empowerment because they are making the decision themselves". One client said, "I didn't think I really needed counselling, so the P&P officer sent me down for the alcohol assessment" (N). Another client said, "My parole officer said I have to go there to do assessment" (E). All but one of the clients who felt coerced to attend counselling said that they had changed their view of counselling after attending.

Other clients interviewed said they did not know what to expect from DAMEC Counselling Services. As one client explained,

> "I'd never done it [counselling] before so I didn't know what to expect. I wasn't too comfortable when I thought it was going to be a whole group of people in the room, but when I found out, and started doing it, it was one on one. I found it a lot more comfortable to talk to and I could open up more, you know what I mean." (F)

One client commented "I didn't know what the service provided" (A). To this end, another client described his experience where the counsellor "let me know what I could expect from counselling" (A). This comment identifies the practice of informing clients about the service when they first attend.

5.6 Support networks

A third of the clients interviewed expressed that they had no support from family and friends to attend counselling (n=8). From this group, one client expressed social isolation in the following statement, "I didn't have much support, I live by myself and don't have many friends" (J). Six clients interviewed felt supported by their families, 3 felt that their partners were the greatest source of support. Of these clients some also spoke about broader support networks involving partners' families and friends. Another 5 clients did not respond to the question, while another cited a P&P officer's supportive role. This client's commented highlighted the significance of personal connection and ongoing relationships between agencies in a client's recovery process (A). Another client expressed that although she received support from other people, she felt that she was "getting more support through DAMEC than anyone else" (H).

5.7 Structural barriers faced by clients

Factors identified by clients as impediments to their progress must be considered when assessing the potential impacts of DAMEC Counselling upon its clients' lives. Clients noted that the need to remain employed affected their ability to attend counselling, "I am working for two or three months every day so I keep ringing the counsellor to say I like to come back but I don't have the chance [sic]" (L). Another client spoke about the stigma associated with counselling as being comparable or worse than the problems he experienced in relation to alcohol consumption. This client said that he feared that his employer would find out that he was attending counselling. "I was worried about my job and losing it, because at this time I came to see counsellor, I had to ask for permission from my employer, my boss always asked me what for and I was worried I'd lose job [sic]... I changed a lot after coming to see the counsellor" (T). Other clients identified socio-economic resources as impediments to undertaking the suggestions offered by their counsellor. This included not being able to do social activities or pursue referrals independently (B).

6 Results: DAMEC's approach to counselling

Summary

"I'd been looking for counselling for a long time. They [counsellors in general] say 'yeah, yeah yeah' but they're not listening to your stories and they're not really asking you questions about it [sic]. But at DAMEC they say 'how about we work with this part, or we work with that part'. *That* is counselling. They really go out of their way to listen to me" (P)

This section describes particular service delivery characteristics at DAMEC through the experiences of the clients interviewed and their counsellors. Most clients interviewed acknowledged the services' flexible client-centred approaches, this was echoed in the evidence presented by counselling staff. The attributes of the counselling staff were the most prominent feature of clients' accounts of their experience of counselling. Patience, listening skills and a friendly demeanour were most commonly referred to by clients as the basis of building rapport, while some clients attributed the assertive, professional and educational approach of their counsellor to their engagement in treatment. Approaches to working with clients from diverse cultural backgrounds, coerced clients, clients with mental health issues, families, and across agencies are detailed in this section. The evidence collected suggests that inter-agency referral patterns and data on cultural background are not adequately reflected in the services' MDS.

6.1 Counsellors

In the data obtained through interviews with DAMEC clients, the characteristics of counsellors themselves featured most significantly in clients' preconceptions of the counselling they had received. Although general approaches to counselling, the supportive behaviours of counsellors and the extra activities that counsellors undertake beyond any specific psychosocial intervention model all made a difference, it was the counselling team themselves who were reported to make the greatest contribution to positive changes in clients' lives. Clients' relationships with their counsellors were also commonly referred to as being a source of motivation or resilience for clients.

Clients most commonly cited listening skills, patience and a friendly demeanour as the most desirable characteristics of counsellors. One client, described feeling "high respect [from DAMEC counsellors], they encourage me to fight more" and good counsellors are "supportive and able to hear my information" (P). He continued to say that "for people like me to trust people it's gotta be both ways, takes a long time, can't be rushed" (P). Other clients also stressed the importance of patience and understanding, stating that counsellors should "be patient enough to explain everything to me" (J), counsellors should "treat people with patience, not lose temper" and "ask the question again if I don't understand the question" (S). One client commented that a "counsellor should be friendly, amusing, should have enthusiasm, [and] knowledge. So if

the counsellor talks that way, treats people that way, they can really help more – I tell more to the counsellor" (U).

Secondly, some clients stressed assertive, professional and educational approaches as having made a positive impact on them. One client remarked that his counsellor "tells me the way it is, the way it should be" "tells me if I'm wrong, where I find in my past, people have been afraid to tell me, they just let me hear what I want to hear" (A). This client added, "If I didn't have the counsellor behind me, I could be doing anything" (A). Several clients spoke about their desire to learn about the effects of alcohol and other drugs, and that the counsellors' ability to educate them was of central importance. One client who attended counselling regarding her son's substance use issues said, "I think that the counsellor has more experience, so I like to have a more professional person to ask for more information and to give me ideas for how to help my son" (L).

Thirdly, while only a few clients mentioned their preference for peer counselling, those that mentioned this felt very passionately about its importance in their treatment. One client emphasised, "it's pointless unless that have stepped in my shoes and been down that track" (A). While other clients valued the experience sharing they would have or did receive through peer counselling, they did not see it as the most important characteristic in a counsellor. One client said, "no one can really know someone else if not going through the same thing, but it doesn't matter, they are more like an ear to unload on" (G). Another client added, "there is a lot of difference between training and experience, but both counselling backgrounds are good" (B). Some counsellors reported sharing their own personal experiences or telling clients a bit about themselves, as part of the process of gaining rapport with clients.

When asked what counsellors did that made them feel understood, clients appreciated counsellors repeating things that clients themselves had said and making reassuring comments. Clients said, "I can tell if they understand me by the way they reassure me, they repeat things back" (C) and "They're not reading it off the thing, they actually remember what I've said, it's personal" (O). Several clients noted that feeling understood depended on the counsellor's ability to speak their preferred language. As one client put it, "we speak [preferred language] so [sic] no problem, I feel very comfortable" (S). The implications of bilingual counselling are further discussed in the following section.

A client centred approach was indicated in references to unique approaches to clients. In fact, the majority of clients identified specific support that their counsellors had provided, this ranged from making inter-agency referrals to accommodating individual needs in the provision of counselling. Clients reported, "they go out of their way to try to do the best for you" (P) and "the Counsellor really goes out of their way" (A). Another client said, "[She/He] tries to understand me and my way [parenting]… she tries to give me ideas about how we could change it to make it better" (L). Some clients noted flexibility with regards to session schedules and the ways that counselling was delivered. One client referred to phone contact, "If I need help she said to ring her"

(O). Another client referred to extra efforts made by the counsellor to work flexible hours to enable the client's attendance, "he stays back to wait for me, because, just my work hours it's so hard to get out, so basically he's revolving around me and my hours" (F). Clients also spoke about the extra effort counsellors had gone to contacting family members, either by phone or by inviting them to join some sessions (D, O).

6.2 Cultural and linguistic appropriateness

Of the clients interviewed, 5 spoke Vietnamese, 2 spoke Mandarin, 1 spoke Arabic and 5 clients who participated spoke more than one language (including English). The following data refers only to those who speak a language other than English. The responses from this half of the interview sample regarding language preferences were mixed. Some bilingual or multilingual clients preferred to speak English "so I can learn" (I) or "a [language] speaking counsellor would be ok too... I've found that translators change what I mean, so I'm not comfortable with a translator..." (L). For clients who didn't speak English proficiently, the notion of language preference is subject to notable limitations. One client said "I can express myself better" [in my language] and "I can have a better understanding [in my language]" (O). When asked if and how clients felt understood by their counsellors, most clients who received counselling in Vietnamese, Arabic or Mandarin (the language groups included in the sample) expressed that sharing a common language was the only way they could tell they were being understood. "The counsellor speaks [my language] so they understand exactly where I'm coming from" (I). Another client said he felt understood because of the common language, but that this did not imply that there could not be room for misunderstandings, where "sometimes there are two meaning for things in Vietnamese" (T). His advice was that "the counsellor should clarify the question by asking it again; to make sure the answer is correct, if he/she isn't sure of the answer." (T)

As well as shared language, cultural commonalities were explored through the qualitative interviews. Most clients did not say very much about culture, although one expressed that he felt commonality with his counsellor because they both had migrated to Australia, albeit from different parts of the world. Another client felt that "it would be harder for me if the counsellor was from there [the place where I was born and spent my childhood]" (G). The counselling team spoke about an approach to each assessment that is free from preconceptions, including preconceptions about a client's culture. Upon meeting a client for the first time, one counsellor explained how she/he might take on a formal demeanour to demonstrate professional boundaries and respect for the client. While all counsellors acknowledged that information is collected in the MDS on country of birth and language preference, all but one of the counsellors mentioned that other information about a client's cultural backgrounds was necessary in order to work with them in a culturally appropriate framework. Counsellors referred to the use of particular psychosocial interventions to learn about a client's cultural background, this evidence is reported in section 6.7.

6.2.1 Identifying ethnicity and collecting data on cultural background

The counselling team reported that the formal process for reporting cultural and linguistic identity during the evaluation period was captured in the MDS elements and on intake forms, but some noted that the information captured in these tools is limited to country of birth and language preference. One counsellor gave the following account in regards to broader structural issues across the sector, “the system doesn’t allow for Australian born [….] culture etc. It doesn’t allow for it, and that makes a lot of different because that is why they don’t engage in other services.” Another counsellor commented that in comparison with other AOD services, that DAMEC has “the advantage in flexible approaches to different clients, compared to other organisations. I’ve worked in other services where culture wasn’t considered, and clients have been disappointed.”

In regard to data recording process employed at DAMEC Counselling Services, some counsellors mentioned recording certain details within case notes. For one counsellor this included taking note of a client’s day to day activities, such as family commitments and social practices; for another counsellor the information recorded in written form focused on deeper issues related to assimilation or migration experiences. Things that counsellors referred to as markers of cultural identity included language, accents, names, information about family gatherings, engagement with family, living with parents in adulthood, cultural celebrations, religious practices. There was a general sense among the counselling team that culture is complex and particular details would be revealed organically over several sessions, however, this view was not unanimous. While one counsellor spoke about asking clients directly for information on their cultural background as part of the intake process, another counsellor spoke about experiences where clients identify their culture as Australian at intake but in later sessions might reveal a more complicated picture of their cultural background. When asked about the way counsellors might respond to information that they attribute to particular cultural influences, one counsellor said, “in demonstrating cultural sensitivity I try to be curious around certain assumptions”. This counsellor explained how she/he might ask questions around certain stereotypes, assumptions and values that a client demonstrates, through a complex understanding of the influence of cultural background in a person’s life. One counsellor referred to employing Narrative Therapy to tease out such issues, while another counsellor offered the complementary view that personally, she/he acknowledged needing to undertake cultural awareness training.

6.2.2 Use of appropriate resources

By and large, the counselling team reflected a creative approach to obtaining appropriate educational and informative materials for clients from particular CALD groups. Counsellors reported that appropriate Vietnamese language resources were quite accessible, with reference to Vietnamese Drug and Alcohol Professionals (VDAP) and the Vietnamese Community in Australia (VCA) as organisations who have contributed to a more substantial body of client-focused literature by comparison to resources available in

other languages. For other languages, counsellors indicated the most common approach was to search for AOD materials on the Internet. An issue that some counsellors identified was the appropriateness of the expression in translated pamphlets. Counsellors found that materials in languages other than English often addressed youth or families, and were unsuitable for single adults. As a final resort, where possible, counsellors translated English language materials for clients during sessions and drew heavily upon Australian Drug Foundation *Drug Info* online English language resources.

6.3 Addressing cross-cultural perceptions of AOD counselling

Counsellors who work primarily with Vietnamese and Arabic clients commented on the common perception that DAMEC offers casework, and a poor awareness of what counselling comprises. One counsellor referred to the common response of clients upon learning about counselling as being "only talking? I can talk to anybody". In response to this, all counsellors spoke about the significance of explaining the concept of counselling to clients. One counsellor detailed an approach that comprised presenting intake and assessment forms alongside a detailed verbal explanation of what the purpose of each form is. Another explained how she/he might talk about the service and what it offers, what the counsellor's role is and what the client's role is, as well as what will happen in each session. Differences between CALD groups were pronounced in the experiences of the counselling team. Arabic clients were reported to express concerns about confidentiality and formal assessment procedures; and feelings of shame and resentment towards services were observed to be quite common among this group. When potential clients found out that counselling exists in their preferred language, attitudes were seen to change but barriers involved with the assessment procedure remained. The provision of information over the phone was a way that recipients of the service avoided formal intake and assessment processes. People who make enquiries over the phone are not included in the services' MDS figures but qualitative evidence suggests that responding to these particular help-seeking methods needs to be understood as part of the current functions of DAMEC Counselling Services.

6.4 Addressing feelings of coercion

As previously discussed in section 4.3.3, negative perceptions towards counselling were found to correlate with coercion and negative past experiences of service provision. Counsellors explained various strategies for addressing negative attitudes and preconceptions of counselling and the low levels of motivation that generally correspond. These included using the assessment process "to reflect back to them how they are talking", using the minimal information that Probation and Parole might have given the service to ask them what the relationship might be with alcohol and/or other drugs and their actions. Additionally, encouraging clients to openly discuss their feelings about attending counselling, validating their concerns and discussing ways to make counselling a worthwhile experience were approaches listed. In some cases where AOD issues were not identified upon assessment, counsellors might ask for clients' consent to contact the referring

agency for more information. Some counsellors commented that coerced clients often come with clearly articulated goals related to their legal proceedings or parole conditions, but that there is scope to work on AOD issues as part of these goals.

6.5 Working with clients with comorbid AOD and mental health issues

"Most of our clients have complex needs" responded one counsellor to a question regarding approaches to working with complex needs clients at the service. The MDS does not capture specific data on previous contact with mental health agencies or diagnosis of mental health issues before attending DAMEC Counselling, the MDS shows that 2 clients were referred to DAMEC through mental health agencies over the evaluation period. For some clients, counsellors identified mental health issues at assessment, for others ongoing sessions revealed and identified symptoms. Counsellors spoke about an approach to comorbid mental health and AOD issues that shows concern for the client, explains symptoms, addresses medication compliance and encourages clients to address such issues. Some counsellors reflected upon the challenges that stigma and prejudice associated with mental health issues, particularly schizophrenia and psychosis, pose to a client's well-being. These counsellors also located particular cultural perceptions that might inhibit a client's ability or will to address their symptoms.

Half of the counselling team referred to the routine use of PsyCheck to identify symptoms and determine if a client needs a more in-depth mental health assessment. This assessment might support the counsellor's referral to the psychologist on staff or a mental health agency. Counsellors were in consensus that the addition of a psychologist on staff has been helpful. While all counsellors were aware of mental health agencies across South West and Western Sydney and were able to refer clients to these organisations, some counsellors reported having experienced difficulties in securing mental health treatment for their clients in their local area. Two counsellors believed that some mental health agencies sometimes disregard possible mental health issues as drug use issues, and have long waiting lists.

The problems identified by counsellors in referring clients for mental health treatment were further compounded by difficulties clients reported in accessing General Practitioners. As one counsellor explained, "clients struggle to identify the issue to their GPs, and GPs don't follow up. We have to provide clients with letters of support, citing symptoms, and then the GP might make a care plan and refer them to psychology." Some counsellors also reported that in their experience, the majority of GPs in Liverpool and Cabramatta were reluctant to see clients with comorbid AOD and mental health issues.

6.6 Working with families

The quantitative data recorded at DAMEC Counselling Services over the evaluation period shows a sharp increase in the percentage of clients admitted to DAMEC to address concerns regarding another person's drug use. These figures are likely to have some connection to the family counsellor position, but also to the significance that the counselling approach at DAMEC gives to family, partner and community support in a client's well-being. Clients themselves identified the uniqueness of DAMEC's approach to family counselling, "I wish there were more specialist services" (L). Family involvement was reported to have been particularly significant in some client's cases, and across the board many clients interviewed reported having been asked about their familial relationships (G, D, C).

6.7 Inter-agency referrals and consultation

For 46 of the 349 clients who received counselling over the 30-month period that this evaluation covers, no data was recorded in the MDS as to what service/s they were referred to. In almost three quarters of cases during the evaluation period, it was reported that the counsellor made no external referrals (n=265). The qualitative data obtained in this evaluation suggests a more complicated image. Of the clients interviewed, more than half said that their counsellor suggested other agencies or services that might be useful. Counsellors spoke about some of the structural issues that inhibit client progress with respect to substance use. Sensitivity to these issues tended to influence what referrals they might make and how they would make them. Counsellors and clients both listed a range of services and activities to which DAMEC Counsellors referred their clients over the evaluation period. One client reflected this in the statement, "they even tried to help me with volunteering work… because they know I like to help people and it makes me feel better" (P).

Of the clients in the qualitative sample who reported not having been referred to additional services or activities, 2 clients said that they were already receiving assistance from other services and didn't need further assistance, 1 said that they didn't need any more support and the rest did not explain why their counsellor had not referred them to other services. One client explain that she was "Already seeing 6 different people, so I didn't want to go anywhere else" (H), another client also reported that his counsellor had suggested "other courses and all that, but" he wanted to "wait and do a few more sessions with [counsellor's name] and see how the court process works out, cause he knows I work really long hours…" (F).

Client testimonies highlighted successful referral techniques as well as unsuccessful ones. Five clients interviewed said that counsellors had made suggestions or given them contact information to pursue on their own, but that they had not pursued those referral suggestions. In explaining why he hadn't followed up other services as suggested by his counsellor, one client said, "the counsellor gave me numbers for some activities, but we have no landline at home so I couldn't call any of them" (B). Another 3 clients said that they had been

successfully referred to other services with the assistance of a letter from their counsellor or a phone call made by their counsellor. Moreover, several clients identified being referred internally to programs run by DAMEC or to family counselling. One client said, “I was offered PPP and anger management, she said I could book into it” (O). “One space was booked out for the anger management course, so our counsellor booked an alternative space… [Counsellor’s name] encourages me to go and do courses, work opportunities” (A).

7 Results: Psychosocial interventions in action

Summary

The counselling team at DAMEC Counselling Services use a triangular model that integrates Brief Solution Focused Therapy (BSFT), Cognitive Behaviour Therapy (CBT) and Narrative Therapy. In determining the application of particular psychosocial interventions, counsellors sought to prioritise individual client needs, taking into consideration cultural background and the interpretability of certain concepts in various languages; levels of distress; attitudes to counselling and willingness to participate. The evidence presented in counsellor interviews corroborated clients' experiences, where an open approach to sessions that affords clients a high degree of control over the agenda set. An integrated mix of psychosocial approaches was justified as a response to individual client needs. While it is impossible to neatly compartmentalise each psychosocial intervention in action, this section seeks to present detailed findings about the everyday application and challenges associated with each apex on DAMEC's triangular model, this informs a sense of what the whole model looks like.

In their own words, counsellors described the model of therapy employed at DAMEC Counselling Services in the following, "the model is very broad", counsellors "use a combination of therapies", the approach "all depends on the individual [client]" and "each client is totally different, you need different approaches". Approaches that were discussed by counsellors were Brief Solution Focused Therapy (BSFT), Cognitive Behaviour Therapy (CBT) and Narrative Therapy; other interventions including Emotion Focused Therapy and Gestalt were also briefly mentioned. Individual counsellors found it difficult to articulate the scope of interventions employed at DAMEC. Most felt that different counsellors have different strengths and different counselling backgrounds, and hence there is "no universal framework or approach". Counsellors said that their awareness of other counsellors' approaches largely owed to informal conversation in the workplace (formal organisational processes are discussed in section 9).

The level of clients' awareness about the particular psychosocial interventions used in their therapy was low, to some extent this may be explained by a having little clinical language with which to name their experiences. Furthermore, clients did not report having been informed about particular psychosocial interventions that compose the counselling model at DAMEC. The majority of clients described the counselling sessions as open and flowing, "it just felt like we were talking, like a conversation" (O). Although some clients mentioned the repetition of exercises over various sessions or the counsellor resuming progress from previous sessions, all clients interviewed reported that their sessions were unstructured.

Counsellors described an open approach that affords clients a high degree of agenda setting of their own accord, and subsequently an integrated mix of psychosocial approaches was necessary for almost all sessions. Counsellors also spoke about reviewing things covered in earlier weeks with clients, undertaking

assessment from week to week, and allowing a few sessions for clients to determine their own goals and aims.

7.1 Brief Solution Focused Therapy (BSFT)

Some counsellors identified BSFT as the focal therapeutic approach employed at DAMEC. One counsellor added “BSFT is important for all clients, because all clients need some solution”. All counsellors agreed, however, that BSFT was not appropriate all the time. BSFT’s strengths were listed, in no particular order, as a way of focusing clients on solutions, as offering a sense of motion and achievement that assists in motivating some clients, and as a structure for achieving goals.

Anecdotal evidence provided by counsellors suggested that, at DAMEC Counselling Services, BSFT works well with clients who have been coerced to attend counselling. One counsellor found it particularly effective when working with male clients who sought firm, pragmatic or tangible results. The clear identification of goals by this client group was attributed to an interest in restoring their personal independence in light of ongoing legal proceedings or parole conditions. One counsellor observed reluctance from P&P-referred clients to discuss their past, and in response to that, BSFT allowed the counsellor to focus on the future. They reported that BSFT offers a sense of “getting something done” by quantifying issues along scales.

It was seen to be not useful or appropriate to apply BSFT in sessions where a client was experiencing current crisis and distress. “It is hard for clients to think about future solutions when the present is too difficult”, one counsellor said. A few counsellors mentioned having difficulties implementing the ‘miracle question’. Another counsellor said, BSFT was “not so great with a lot of emotions coming up”. In such circumstances, another counsellor identified the importance of listening to the client and assisting them to identify what they want.

BSFT was observed in the accounts of several clients also through their references to goal setting and review practices. The majority of clients responded decisively about the identification of goals in counselling sessions. The “counsellor asks us what our goals are and keeps us on track. (A), “[She/he] suggested ways of getting there, bit by bit” (B), “when I attend appointments I discuss and review goals with them”, another client said that goals had helped him to reduce alcohol consumption (I). With regards to the process of developing and identifying goals, some clients felt that they determined their own goals through counselling at DAMEC. One client said, “[counsellor’s name] encourages me to set a small goal first, try to do step by step, when I’m finished, I’m going to improve that goal, and after that I have a bigger goal, and I’m going to get it!” (P). Another client’s comment was that, “my goal is to stop drinking for the children; I set up the target myself” (T). Reciprocity and rapport between counsellors and clients was seen to motivate some clients. One client said, “my goal is to not let the counsellor down. He’s spending a lot of time on me.” (F). Finally, some counsellors explained that goal setting is not necessarily a cross-cultural concept and that they engage clients

by explaining this concept using metaphors for journeying, mapping, and step by step processes. Counsellors were in consensus that it is imperative that clients set their own goals, but that goal review is challenging and should be approached through a series of small goals.

One counsellor explored the combination of Narrative Therapy with BSFT, by identifying threads from stories told and asking questions that build strength from identifying these threads. For example, if a client has mentioned a time when they modified their usage patterns, this counsellor would ask them to identify how they managed to do this, then develop a scale around this and refer to it in future.

7.2 Cognitive Behaviour Therapy (CBT)

The counselling team had different perspectives on the utility of CBT. Counsellors saw this psychosocial intervention's strength in addressing behaviour particularly where family conflict is mentioned or mental health issues influence a client's behaviour, but CBT was not seen to be useful in gaining an understanding of how clients are feeling. One counsellor found that CBT was difficult to implement successfully with clients who are very confident in their knowledge of AOD issues or their own behaviour.

Evidence that CBT was used frequently in sessions featured in the findings from client interviews. One client spoke about discussing the consequences of his actions with his counsellor. The disparity between his intentions and the outcomes of his behaviour were identified in the sessions, "[counsellor's name] would say things like 'don't you realize that… this is what you've done here …' (B). This client, as well as others, also recalled discussing the risks and possible losses, among which damage to relationships and loss of independence were explored (B, F). "We've talked about what happened that night, we've talked about the damage done on both parties, how's it's affected my family, the police and stuff like that" (F). Another client explored the identification of triggering patterns in the sessions. "[Counsellor name] asks me what steps I take through the day to end up doing that" (O). Another client, emphasised how through counselling he worked out how to identify triggers within his previous social circles and places where he had used drugs in the past (G). "My counsellor always advised me not to repeat past mistakes, he always reminded me, so that helped me to change my thinking" (W). "I learned lessons through the counselling service, realised my past mistakes" (U). Many clients spoke about the development of strategies for party and social situations to change behavioural responses (E, G, T, U, W).

Clients' testimonies reflect the common use of homework or take home commitments, which suggest that some elements of CBT are consistently used by the counselling team. Some members of the counselling team were strongly critical of homework tasks that focused people on the drug that they sought to stop or reduce the use of, they preferred to suggest activities that would distract or divert clients from past routines. Such activities might include job seeking, spending time with family, exercise and housework. All counsellors

stressed that any form of homework must be undertaken voluntarily, and that in light of that they "don't push it too much" (S) One counsellor put it this way, "I make it clear that therapy isn't contingent on if they do the homework or not". One client explored the use of homework in her therapy in the following statement. "[The counsellor] gives me things to do in the weeks that I've seen [him/her], and then the following week we go through what I did and what I got out of it" (H). Several clients spoke about the desire to learn about the effects of alcohol or other drugs, this was observed to go hand in hand with information provided in the form of written brochures. "He's given me brochures about alcohol and anger management to take home and read" (F), one client explained. Half of the counsellors referred to the use of drinking diaries, demonstrating the view that they would not be appropriate for all clients. In the client interview sample, 3 clients reported the use of drinking diaries, with mixed views on their efficacy. "One counsellor gave me a drinking diary, another preferred just to ask me in the sessions" (B). While this client said he had not filled out the diary, he said that he liked "to read what the drinking diary says at home, if I read it, I won't forget it". Another client spoke about the drinking diary, "I had a look at it [drinking diary], but I didn't worry about it". Some clients spoke about tasks that are likely to reflect a mix of psychosocial interventions, but take up CBT's emphasis on ongoing tasks outside of the counselling session. For example, one client spoke about systems of recording and modifying moods and emotions. "[The counsellor]'s asked me to write a diary so that we can go through that, how I feel, when I'm feeling good, when I'm feeling bad. [The counsellor] goes, 'it doesn't matter how silly it is, but we can try and work out why you feel the way you feel'" (H). Another described tasks related to family and relationships.

7.3 Narrative Therapy

All counsellors were confident and well-versed in their use of Narrative Therapy, all counsellors referred to using it regularly. Generally counsellors reported the creation of a patient, empathetic and reassuring space for clients to speak as experts on their own situation. The adoption of a curious stance, as in Motivational Interviewing, was also referred to by some counsellors. The strengths of this model of psychosocial intervention were reported to include assisting clients to identify their strengths, which could then be used to talk about the present and the future in conjunction with other intervention models. Counsellors found Narrative Therapy helpful in exploring intentions and purpose behind actions, from which a client's values and hopes could be drawn out. Furthermore, encouraging clients to tell their stories was seen as a good way to learn about clients' support networks and life experiences. By and large, Narrative Therapy was also observed to be a powerful contributor to rapport and trust with between clients and counsellors. Some counsellors also felt it appropriate to reciprocate or initiate stories from clients' pasts by sharing some things about their own personal histories. Counsellors also spoke about the utility of Narrative Therapy in learning about the messages clients got from their parents, and differences between Australian culture and how they grew up.

The use of Narrative Therapy was also pronounced in the evidence that several clients shared. Clients born outside of Australia who participated in interviews presented consistent evidence of Narrative Therapy being used by the counselling team. “We started from childhood and when alcohol came into the picture” (B) one client said. Another spoke about Narrative Therapy role in examining his migration story, “we didn’t really talk about my childhood, we talked more about what happened when we came here [to Australia]” (E). Another client referred to the way Narrative Therapy was used in every session, “we talk about my past, we talk a little bit each session” (O). The practice of envisioning preferred futures was not consistently mentioned in client interviews, but some clients had strong recollections of this technique being used. One client recalled being asked to consider, “If I’d taken a different path than what I did take, if I’d gone with my gut feeling, instead of taking the easy way out… um, actually trying to do things a different way, how would I imagine that things would have turned out” (H).

Counsellors also explained particular situations where Narrative Therapy would generally not be used. One counsellor, in particular, expressed the need to show respect to older people particularly when working with certain cultural groups, age groups and genders. Corroborating this, other counsellors explained that sometimes asking people to tell their personal histories might be regarded as intrusive. This was also noted with use of examples where reluctant or involuntary clients attended sessions. This evidence was echoed in one client’s comment, “I can talk to the counsellor about any problems we discuss together, but the counsellor didn’t go too far into my personal life [positive tone]’ (S). As with all psychosocial interventions, such comments reflect the need for sensitive reflection on their implementation.

8 Impacts of counselling from clients' perspectives

Summary

Clients' initial hopes and expectations when first attending DAMEC Counselling Services, as well as their own perceptions of the impacts of counselling, should influence any impact assessment tool in future service evaluations. This evaluation draws on qualitative evidence, which suggests that, the majority of clients' experience positive impacts from the counselling they receive. These findings highlight particular themes, which should feature in any outcome measures implemented at DAMEC.

The majority of clients interviewed expressed a desire for change and an expectation that DAMEC could offer help to achieve the changes desired. Clients spoke about wanting strategies to resist drugs, manage their anger and emotions, foster healthier relationships, locate and access practical support; and learn about the effects of drugs. "I wanted a different way of looking at life" (A), to "stop blaming other people, learn to understand others perspectives, [have] piece of mind" (B). Other clients described wanting "to be able to get everything off my chest, my feelings, to be able to look at things from a different angle" (H), and to have "a better relationship with my husband, better understanding between us" (M). Understanding the impacts that counselling has on clients' lives must be centred upon the desires and aims that clients express in regards to their experience and expectations of AOD counselling.

Of the 24 clients interviewed, 19 said that they had found counselling helpful to them, 1 person found it somewhat helpful while another person did not find it helpful, and the remaining 3 did not expressly comment on this. Those who found counselling somewhat helpful did not specifically say why, while the client who had not found counselling helpful attributed this to not feeling understood by the counsellor. This client felt that a counsellor who shared the same life experiences would have better suited their needs. Some clients referred to the long-term effects of counselling, saying things like "I am happy, I apply most of it every day… I wanted to learn how to say no to drugs… I can say no now, it's been almost 2 years" (G). Given that most clients were still receiving counselling at DAMEC at the time of interview, some spoke about their current perception of changes resulting from counselling. One client said, "It's making me feel lighter, my troubles don't seem to be weighing my shoulders down as much", "[the counsellor]'s helping me realize that I have a problem, but I'm not the problem" (H). "I try to follow what they told me, what's the problem, what should be to do" (L). For some clients their abstinence was indicative of a clear improvement in their lives, "I don't do anything [substances] anymore". "This service helped me a lot, they explained to me how to refuse/say no with friends. So now I know how to say no to friends, by using a reason/excuse, so this helps me not to drink. Sometimes now I just have half a glass." (T). One client said,

> "I feel positive, I can compare my situation now with the past, I feel better…I always follow the advice/target of the counsellor. I know what I did in the past was wrong, now I give [sic] up and now I take care and look after my husband. Whatever the counsellor said to me, if they are a

good counsellor, I follow them. I gave up and don't get involved in bad things anymore, I achieved my target." (S)

The clients interviewed commonly spoke about perceptions of increased awareness of the harms caused by various substances. "They explained to me the negative effects about alcohol abuse and taught me how to spend my life on something meaningful when I am bored rather than start drinking" (J). One client said, "I needed special information for how to help me to help my son" (L) and felt that she received that through counselling.

Few clients spoke about the use of psychological testing, but one client's comment suggests that psychological testing processes can also be a source of reassurance for clients. "They are doing tests on me so that they can work out what the main problem is, and it's working" (H). In regards to familial support and relationships, clients commented, "it's helped with the problems I have with my wife" (I), "I use my time now to go and do parenting classes" (O) and "this service is good for families and children" (L). In one client's case, seeking counselling and obtaining some desired outcomes meant gaining more independence. This client said "I still have to report to Parole until 2013, but they told me 'you don't need to come and report to us anymore because you are very good now'. [Counsellor name] helped me achieve this" (W).

9 Organisational processes

Summary

While this evaluation did not seek to review organisational structures in detail, it was apparent that the relationship between counselling approaches and the implementation of the counselling model across DAMEC Counselling Services were mediated through existing organisational processes. As these details arose in counsellor interviews, they are reported below.

9.1 Clinical Team Meetings

Weekly clinical team meetings are composed of two parts, administration, and case allocation and review. Counsellor perspectives on the utility of meetings varied, with some concerns raised about the lack of space to discuss challenging cases and approaches, particularly in reference to the implementation of psychosocial interventions.

9.2 Supervision

Counsellors reported fortnightly meetings with external supervisors. Most found that supervision enables them to discuss difficult cases and collegial relationships. Although not all counsellors reported having called upon this function, others found the input of their supervisors with regards to difficult cases, both educational and supportive.

9.3 Case File Review Processes

Counsellors reported no formal case file review processes in place across the services. However various informal case file review processes were noted. These included independent case file review, and reviewing treatment plans with the clients as part of counselling sessions. Also challenging cases are reviewed in an ad hoc manner at clinical team meetings, in conversation with colleagues or as part of supervisory meetings.

9.4 Training and Professional Development

The counselling team were generally of the opinion that DAMEC Counselling Services is supportive of their professional development, but that access to training largely depends on an individual staff member's motivation and initiative. Counsellors felt that funding was a major constraint to their pursuit of training opportunities and conference attendance.

10 Discussion of Findings

Summary

DAMEC Counselling Services are growing. The characteristics of its client demographic and how DAMEC responds to the corresponding challenges posed are the crux of this discussion. Just over half of DAMEC's clients were born overseas, a growing proportion of clients speak languages other than English, with a dramatic increase in Vietnamese speakers attending DAMEC for counselling. Admission of female clients and persons whose concern is another person's alcohol or/and other drug use has also grown proportionately within the services' recent intake. In addition, most DAMEC clients are initially coerced to attend counselling and are likely to experience co-occurring mental health issues. How the services cater for these complex client needs alongside other challenges is shown through this evaluation's findings on counsellors' use of particular psychosocial interventions, application of client-centred approaches, counsellor attributes and organisational processes. This discussion addresses some of the intended outcomes of the evaluation by employing the findings to identify areas for improvement, by discussing the extent to which CALD clients and other complex needs clients are receiving treatment at DAMEC, and by critically examining the level of implementation of the therapeutic approach.

Referral sources and intake trends

The notable shift from self-referred clients to clients referred through the criminal justice sector as the dominant client group is likely to reflect an increased awareness of DAMEC's services across the criminal justice system in South Western Sydney. Referral patterns from Probation and Parole (P&P) particularly stand out, this is not only reflected in the services' MDS figures but also in the evaluation's qualitative data which suggests that P&P agencies outside the Liverpool area also referring increasing numbers of CALD clients to DAMEC. While numbers of referrals from the Department of Community Services (DoCS) appear statistically insignificant at present, the findings show an increase in family counselling at DAMEC that includes clients who were referred by DoCS. It is reasonable to assume that this trend will continue, especially in light of the closure of an AOD family counselling program service in nearby Cabramatta. It is important to reflect upon the coercive nature of these referrals and how this impacts upon the provision of service, and in particular, the efficacy of the counselling model employed. While varying degrees of coercion are likely to factor in most clients' referral pathways, the particular type of coercion referred to in this discussion signals the unique function of the criminal justice system with regards to the privation (or threat of privation) of movement, independence and restricted contact with loved ones.

Outreach, consultation and promotional activities

A degree of cross over between the services' figures on self-referrals and referrals through clients' families, AOD agencies, mental health agencies and hospitals is likely to exist. This is because none of these referral sources have the ability to directly coerce clients through juridical means, and as such referral sources are largely client-reported. The sharp decline in self-referrals and relatively steady intake from all other sources are unlikely to have any relationship to the increase in coerced clients. They may, however, have some bearing upon resource allocation and organisational priorities. It could be assumed that as counsellors' client load has increased overall, resources for community outreach and promotional efforts across AOD services and the community sector have come under increased stress. The qualitative evidence presented in this evaluation suggests, to the contrary, that targeted community outreach and family inclusive practices are a central part of particular staff roles. As the effects that these efforts have on present intake levels are difficult to quantify and are more likely to have some bearing on future intake and referral sources, ongoing consideration about the most appropriate, effective and novel ways to promote DAMEC Counselling Services to CALD communities should occur.

Strategic outreach for CALD communities

Counsellors who work with particular CALD groups reported that they spend large amounts of time liaising with families and providing information over the phone. The experience of working with clients from diverse cultural backgrounds informs client-centred therapeutic approaches. While it was beyond this evaluation's resources to statistically correlate preferred language and country of birth with particular referral sources, the qualitative data provided by counsellors strongly suggests that promotional activities and community outreach must be tailored appropriately to particular CALD groups. Moreover, approaches need to be flexible. With regards to DAMEC's new premises in Auburn, the intake of Arabic clients is likely to increase, especially if culturally sensitive outreach activities and assessment procedures are developed.

Engaging clients: addressing issues related to attrition and coercion

The findings of this evaluation suggest that a client's attitude to counselling is strongly linked to his/her referral pathway. Coercion was seen to generate negative attitudes to counselling, at least initially. Furthermore, since preconceptions of counselling and AOD services vary across cultures, feelings of resentment, negative attitudes towards counselling and low levels of motivation are likely to be compounded in the cases of CALD clients who are mandated (coerced) to attend. The counselling team outlined responses that involve explaining the concept of counselling to clients and the roles

and responsibilities of both clients and counsellors. Counsellors engaged coerced clients to discuss their feeling towards counselling and acknowledge their concerns about attending and how being mandated has made them feel. Counsellors linked AOD counselling to broader objectives that clients may have with regards to court proceedings, parole conditions or access to their children. The qualitative findings present strong evidence that once engaged; counselling is likely to have a positive impact on clients who are referred through the criminal justice system or DoCS. A client's attitudinal change is the crux of this process. For CALD clients, both coerced and voluntary, there are several other issues to also take into account as discussed below.

Speaking the same language: the significance of bilingual counselling

Since April 2009, 80% of clients whose preferred language was not English were able to access AOD counselling at DAMEC in their first language. This group composed 25% of the total service intake over the evaluation period (n=88). Given that DAMEC provides the only services in NSW that have targeted provision for bilingual AOD counselling, it is reasonable to suggest that without the services' bilingual counsellors, these clients would not have accessed counselling. While DAMEC's MDS figures illustrate this point, the other findings of this evaluation highlight a number of other significant points regarding the process of culturally appropriate AOD counselling at DAMEC. Seven of the 8 clients interviewed in Vietnamese, Mandarin and Arabic reported that counselling had impacted positively on their lives. In retrospect, it would have been useful to ask each of these clients how they would have felt if an interpreter had been used, but one client of her own accord expressed strong dissent to the use of interpreters. This client felt that the only way she could tell if her counsellor understood her was by speaking the same language, other clients reiterated the link between understanding and a common language. While the number of Cantonese and Mandarin speaking clients to attend DAMEC for counselling in 2011 appears statistically insignificant, the qualitative findings suggest that more Probation and Parole agencies, as well as other services, are likely to refer to DAMEC if they are aware that counselling in Khmer, Mandarin and Cantonese is also available. The uniqueness of DAMEC's multilingual counselling capabilities implies that service promotion could be especially important.

Culturally informed practice

The counselling team use information shared by clients on their cultural backgrounds to inform their practice. This included taking into consideration family relationships, living arrangements, social, religious and cultural activities, experiences of migration

Use and availability of appropriate AOD resources

and trauma. While good Vietnamese language resources are readily available, counsellors sometimes struggle to find appropriate materials in other languages. When faced with this situation, counsellors translated English language resources verbally. This approach may have the advantage of directness, while it also addresses potential literacy issues faced by clients. However, client independence and empowerment underlies the provision of written information to clients. Counsellors reported that there are no formal processes for cultural information to be recorded in case files or elsewhere. That clients themselves made little reference to cultural background substantiates the claim that cultural data is complex and difficult to quantify, and that in light of this, the lack of formal systems at DAMEC is understandable. It is clear from the accounts of both counsellors and clients, however, that understanding and diverse cultural backgrounds and employing them to strengthen psychosocial interventions, requires listening and enquiring beyond the standard MDS. While not perfect, data collection could be improved through the inclusion of fields such as 'languages spoken at home' and 'ancestry'.

Family inclusive approaches

The findings showed that clients attending counselling regarding another person's AOD use have grown over the evaluation period. All the respondents included in the interview sample who had received family counselling were women. Two female clients had sought counselling to support a family member, while another few women referred to efforts that counsellors had made to include their family members in their AOD treatment or to schedule sessions with DAMEC's family counsellor. The socialised care roles that often apply to women are likely to explain why an increase in female client admissions has occurred over the same period that intake has increased for persons concerned about another person's substance use. The findings of this evaluation did not distinguish the psychosocial interventions used by the family counsellor from the rest of the counselling team. Across the services it was resoundingly clear that counsellors saw family and partner support roles as integral to a client's treatment process, this matches best practice recommendations from the literature on culturally appropriate AOD treatment. Many clients viewed these efforts positively; the findings suggest that clients relate these actions to feeling treated as an individual, with unique needs.

Mental health

The findings indicate that the prevalence of mental health issues among DAMEC clients is high, although the MDS does not capture data on comorbidity. The most

appropriate approaches by counsellors involve sensitivity and awareness of differing cultural perceptions of mental health issues and subsequent treatment options. Addressing stigma associated with mental health issues is of central importance when addressing issues. While there was no formal diagnostic process across the services, staff generally employed a 2-step process beginning with the use of Psycheck and then with internal referral to the psychologist on staff. From there, barriers are often encountered when attempting to refer clients to mental health agencies. Of particular concern are the difficulties that counsellors reported in accessing mental health services, as well as GPs in South-western and Western Sydney who are willing to see clients with co-occurring AOD and mental health issues. Considering that the literature on AOD treatment identifies several barriers faced by CALD clients, for CALD clients with comorbid issues these difficulties are likely to be further exacerbated despite the contribution that Transcultural Mental Health makes to an otherwise thin area of service provision.

Inter-agency referrals

On the practice of inter-agency referrals at DAMEC the evidence identifies a gap in data collection and highlights the efficacy of warm referral techniques. The MDS indicates that few outgoing referrals were made over the evaluation period, while half of the clients interviewed listed various referrals that counsellors had made. It is likely that the low figure reported in the MDS reflects a current gap in practice of logging successful referrals made by counsellors on behalf of clients. Whereas, DAMEC clients tend to view referrals as the provision of contact information, support letters, information on courses available and other suggestions for further treatment, courses or activities clients could undertake. The services may determine it necessary in future to record inter-agency referrals in more detail. The findings of this evaluation suggest that successful referrals are linked to counsellors initiating a phone call to an external service always in the presence of the client. Providing clients with suggestions and information for other services or activities they could access is likely to have a double function, conveying a counsellor's care and interest in the client's life while also highlighting an array of options within the client's reach. These purposes are served, even when a client makes the choice not to pursue a particular referral.

Psychosocial interventions

A client-centred approach underpins counsellors' decisions to employ a combination of psychosocial interventions according to client need. Across the board, the counselling team uses a triangular model that incorporates Brief Solution

Implementing a triangular model: psychosocial interventions at DAMEC Counselling Services

Focused Therapy (BSFT), Cognitive Behaviour Therapy (CBT) and Narrative Therapy. The NSW Health guidelines on psychosocial interventions in AOD treatment settings (2008) suggest that it could be useful to "provide clients with information sheets containing basic information about the type of psychosocial intervention being provided for them" (2008, 25). This does not currently occur at DAMEC, and could enhance the implementation of the therapeutic approach. The findings suggest that most clients do not perceive that counselling has, or follows, a process. Some counsellors suggested that building trust and rapport with clients could be jeopardised by inappropriate over-emphasis of the therapeutic processes being employed.

While the counselling team received training in BSFT in 2010, all counsellors recognise that in certain scenarios this psychosocial intervention has limitations. In practice, particular tools and techniques from BSFT are used widely at the services but promoting BSFT as the central service-wide model would be incorrect. BSFT is seen to work well with coerced clients, but in the experience of counsellors, goal setting and the 'miracle question' are not necessarily cross-cultural concepts. Using these techniques requires some additional explaining of concepts or the use of different language with some clients. Other approaches are prioritised when working with clients experiencing immediate crisis situations. Given the increasing proportion of DAMEC clients who are mandated to attend counselling, it is likely that BSFT will continue to be a core pillar of DAMEC's approach in combination with other interventions.

Enhancing counsellor attributes

Finally, counsellor attributes define the character of client-counsellor interactions above all other factors. Patience, listening skills, understanding and professionalism were cited by DAMEC clients as attributes of the counselling team. In order to support counsellors' work, case review practices should be systematised. Currently, the practice of case review only occurs for challenging cases and even then counsellors feel that there is not enough time to address psychosocial interventions in action or to workshop alternative approaches.

11 Recommendations

1. Discuss the effective practices highlighted in this evaluation in a counselling team meeting in order to enhance consistency across DAMEC Counselling Services.

2. Systematise the reporting of inter-agency referrals in DAMEC's MDS.

3. Collect service-wide data on DAMEC clients' mental health issues, treatment and referral status.

4. Develop and implement an organisational strategy for engaging GPs and mental health services in the treatment of DAMEC Clients.

5. Undertake targeted outreach and promotional activities with CALD community groups in the areas where DAMEC operates.

6. Prepare and distribute an information sheet about the counselling model used at DAMEC.

7. Implement case file review practices, including the documentation of cultural information.

8. Monitor literature on coercive and involuntary AOD treatment to further inform counselling approaches.

9. That DAMEC's Clinical Governance Committee considers implementing the Australian Alcohol Treatment Measure (AATOM-C) and/or the Psychologists and Counsellors Outcome Measure (PACOM) as outcome measures at DAMEC Counselling Services.

11.1 Implementing outcome measures

Implementing an effective outcome measure is a challenge for brief intervention based models, but it is a necessary next step that can be built from the findings of this evaluation and through the use of pre-existing, validated tools. Taking into consideration structural, social and economic factors that may impinge on a client's progress and well-being, the best possible outcome measure would be an intrusive, longitudinal study following the lives of clients for sometime after they are discharged from counselling. This is unlikely to be feasible. However, using an outcome measure tool is within the means, ethics and objectives of DAMEC Counselling Services. This tool would enable future evaluations of the services to measure client satisfaction and attainment of goals.

The findings of this evaluation show that clients attributed a range of changes in their lives to the outcomes of counselling. Clients reported changes in their feelings, relationships, substance use levels, lifestyles, knowledge about alcohol and other drugs, mental health diagnosis, and reporting requirements to criminal justice agencies. An outcome measure should capture information on all of these levels. In implementing an outcome measure, two main issues should be considered. Firstly, clients have different goals and different patterns of service access duration. Secondly, synthesising data concerning feelings, attitudes, perception and desire into a quantitative scale might fail to capture significant details regarding the impacts of counselling.

This evaluation identifies two validated outcome measure tools suitable for use at DAMEC Counselling Services. These are the Australian Alcohol Treatment Measure (AATOM-C) and the Psychologists and Counsellors Outcome Measure (PACOM).

12 Conclusion

As the first service of its kind in Australia, research and evaluation of DAMEC Counselling Services has significant implications for future developments in evidence-based, client and family-centred outpatient alcohol and other drug (AOD) counselling for culturally and linguistically diverse (CALD) communities. The NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines identify a gap in research that studies the range of psychosocial interventions applied in AOD treatment (2008, 25). The authors of the handbook call for further research into other therapeutic approaches, to complement already existing research on Cognitive Behaviour Therapy. “There is clearly a need for more comprehensive research to be conducted across the full range of treatment modalities for psychosocial interventions in problematic drug and alcohol use” (ibid). This evaluation has responded to this call. If a general lack of evidence supporting the efficacy of particular psychosocial interventions in AOD settings is widely recognised and reported, the absence of research into culturally appropriate psychosocial interventions is outstanding. While the few existing studies that look at culturally appropriate counselling approaches have been highlighted in this evaluation’s literature review, this evaluation is a contribution to understanding the implementation of an integrated model of counselling, involving three core psychosocial interventions, with culturally and linguistically diverse clients.

Through describing the services’ function, client needs and level of implementation of the counselling model; this report concludes that DAMEC Counselling Services continues to meet the enhanced standards set up at its inception. In satisfying the aims of this final evaluation, the evaluation also reflected upon the enhanced standards set for the service in 2008 and can claim through the evidence collected that they continued to be met.

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Simpson, M., Lawrinson, P., Copeland, J., & Gates, P. (2009). The Alcohol Treatment Outcome Measure (ATOM): A new clinical tool for standardising outcome measurement for alcohol treatment. *Addictive Behaviors, 34(1),* 121-124.

Treloar, C et al. (2004) *Barriers and incentives to treatment for illicit drug users, Department of Health and Ageing*, Australian Government, p77.

14 Appendices

Appendix I: General consent form

D.A.M.E.C. Counselling Service, Level 2, 219 George Street, Liverpool NSW 2170

Telephone: (02) 8706 0150

D.A.M.E.C
Drug and Alcohol Multicultural Education Centre

CONSENT TO PARTICIPATE IN RESEARCH

1. I understand that in order to undertake research and evaluation, DAMEC may need to use client data or request to contact clients to ask for their opinions and experiences.

2. I give my consent for DAMEC to include my client records in research and evaluation. I understand that my name and personal details will always be kept confidential.

3. I consent to being invited to participate in future research that DAMEC may conduct. I do so, also understanding that I may choose to decline any such invitation.

4. I acknowledge that all DAMEC Research and Evaluation involving this Counselling Service will be conducted in a manner conforming to ethical and scientific standards.

5. I acknowledge that authorities whose role is to ensure that research is conducted ethically may request access to the same data that the researcher uses in order to monitor this research.

6. I understand my identity will not be disclosed to anyone else, and it will not be used in publications or presentations.

7. I know that no person involved in my usual care at DAMEC will know if I have participated in research or not.

8. I acknowledge that refusal to agree to any/all of the above will not affect my usual counselling at DAMEC.

9. I acknowledge that I have been given time to consider the information, ask questions and to seek other advice.

Before signing, please read 'IMPORTANT NOTE' following.

IMPORTANT NOTE:

This consent should only be signed by a person over the age of 18years.

If you are under the age of 18 years, you are not required to sign this form.

I have read (or had read to me in a language that I understand) and I understand the contents of this consent form.

Name of participant _____ Date of Birth _____

Contact number _____

Email of participant _____

Signature of participant _____ Date: _____

Name of witness _____

Signature of witness _____ Date: _____

Appendix II: HREC approval letter

The NSW Government agency dedicated to the control and cure of cancer through prevention, detection, innovation, research and information.

cancer institute NSW

Ms Rachel Rowe
PO Box 2315
Strawberry Hills
NSW 2315
2/08/2011

Dear Ms Rachel Rowe,

Cancer Institute NSW Population & Health Services Research Ethics Committee
AU RED Reference: HREC/11/CIPHS/36
Cancer Institute NSW reference number: 2011/06/331
Project Title: What is working? A process evaluation of DAMEC'S counselling service.

Thank you for your correspondence dated 04/07/2011 responding to a request for further information/clarification of the above referenced study, submitted to the Cancer Institute NSW Population & Health Services Research Ethics Committee for single ethical and scientific review. The Committee reviewed your response at its meeting held on 21/07/2011 and I am pleased to inform you that full ethical approval has been granted.
The following documents were reviewed during the Committee's deliberation of the study:

- Researcher response letter, dated 4 July 2011
- Evaluation Protocol, Version 4, dated 4 July 2011
- Consent Form – DAMEC Clients, Version 2, dated 4 July 2011
- Consent Form – DAMEC Counsellors, Version 2, dated 4 July 2011

ACTION: The Committee approved the study, complimenting the researcher on the quality of their response which was very comprehensive and resolved all issues.
The NSW Population & Health Services Research Ethics Committee has been accredited by the NSW Department of Health to provide single ethical and scientific review of research proposals conducted within the NSW public health system.

The Committee is a joint initiative of the Cancer Institute NSW and NSW Department of Health. The Committee has been constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* and relevant legislation and guidelines.

Please note that ethical approval is valid for **5 years**, conditional on the following:

- Principal investigators will immediately report anything which might warrant a review of ethical approval of the research, including unforeseen events that might affect continued ethical acceptability.

- Proposed amendments to the research proposal or conduct of the research which may affect the ethical acceptability of the research are to be provided to the NSW Population & Health Services Research Ethics Committee for review.
- The NSW Population & Health Services Research Ethics Committee will be notified giving reasons, if the research is discontinued before the expected date of completion.
- The Principal Investigator will provide an annual progress report to the NSW Population & Health Services Research Ethics Committee and at the completion of the study.

For further information about the NSW Population & Health Services Research Ethics Committee, please refer to our website www.cancerinstitute.org.au/research.

Should you have any queries about the ethical review of your research proposal, please contact Kate Lowrie, Admin Support Officer – Ethics on 02 9374 5616 or email ethics@cancerinstitute.org.au.

The NSW Population & Health Services Research Ethics Committee wishes you well in your research endeavours.

Yours sincerely,

Kimberly Strong, PhD

Ethics Coordinator

Cancer Institute NSW

NSW Population & Health Services Research Ethics Committee

We plan to publish a report about the Counselling Service because we think that sharing information will help to improve our own service and others like it.

Results of the study will be provided to you, upon your request, either by email or post.

Reports, based on the information we collect, will be made available to health and community sector workers via e-groups, journals and conferences in 2012.

Who do I talk to if I have a problem, complaint or concern?

This interview process has been approved by the NSW Population and Health Services Research Ethics Committee.

If you have any concerns about the conduct of interviews, or your rights as a participant please contact:

Mr Kelvin Chambers, DAMEC CEO on (02) 96993552 or

Prof Jan Copeland, DAMEC Board Chairperson on (02) 93850231.

What happens next?

This information is yours to keep and think about.

In the next few days DAMEC Research Officer, Rachel Rowe will telephone you to ask if you would like to participate in an interview. Alternatively, if you wish to participate, or ask any questions please call:

Rachel Rowe on (02) 81131304.

Thank you for taking the time to consider participating in this study.

Approved by NSW Population & Health Services Research Ethics Committee

V5, July 2, 2011.

D.A.M.E.C. Counselling Service,
Level 2, 219 George Street,
Liverpool NSW 2170

Telephone: (02) 8706 0150

Invitation

You are being invited to participate in an interview as part of an evaluation of DAMEC's Counselling Service. This evaluation is being conducted by DAMEC's Research Officer, Rachel Rowe and has been approved by the NSW Population & Health Services Research Ethics Committee.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the interview?

Your experiences will help us to understand what is working and what might not be working at the counselling service. It will help us to make the counselling service better for the people who use it.

Who will be interviewed?

People who come to DAMEC counselling will be invited to participate in interviews.

What will happen in the interview?

You will be asked a series of open questions about when you first came to counselling, what happened in counselling sessions and what you felt about the counselling you received.

The interview will take about 15 minutes to complete.

Interpreters will be available in Vietnamese and Arabic.

We will ask you to choose where you want to be interviewed. There are 4 different places to choose from at the Counselling Service, at a public place or at your home; or we can call you on the telephone.

DAMEC's Research Officer will call you to ask if you are interested. If you are interested, you will make a time and place to talk with her (and an interpreter if you wish).

Do I have a choice?

Yes. Participation in this interview is voluntary.

If you decide not to participate, it will not affect the relationship between you & your counsellor.

Your counsellor will not know if you have participated in the evaluation.

Are there any risks?

Every person is different, the information shared in the questionnaire or interview may be of a sensitive nature and speaking about it may be difficult or cause distress.

You don't have to answer any question you do not want to.

You can stop the interview at any time.

Responses will be kept confidential and anonymous, except as required by law.

Will anyone find out it's me?

Your counsellor will not be present at the interview and they will never find out what you say in your interview.

The only people who will see your responses will be the person who transcribes the interview, the researcher and the interpreter (if you use one).

Your name and personal details will be removed from all file names and notes. Files will be stored securely at the DAMEC Research Office in Redfern.

Will taking part in this interview cost me anything?

Participation will not cost you anything.

All arrangements will focus on what is most convenient for you.

What happens with the information I give?

Since we will be speaking with many people, we aim to write a report about the general things that people tell us, particularly where the same thing appears as a common experience or an unusual experience. Your contribution to the report will be anonymous.

Appendix IV: Interview schedule for DAMEC Counsellors

1. What is the admission procedure when a client first comes to the service?
1a. What documents are used in this procedure?

2. Are there trends you notice between clients who are referred through Probation and Parole and those who are not? [if 'yes' proceed to 2a. if 'no' proceed to 3]
2a. Could you describe these?

3. How do you normally determine a clients' cultural background when they come to the service?

4. How is cultural background recorded at a service level?

5. Does a clients' cultural background influence how you approach the session and the client? In what ways?

6. Could you describe a few instances where a client's cultural background influenced how you worked with them?

7. What are some of multiple complex needs you come across working at this service?
7a. Could you give me some examples of how you worked with clients who have coexisting mental health and alcohol or other drug related issues?

8. When a client first comes to the service, how do you get a sense of what they want out of counselling and more broadly, what they want at that particular point in their lives?
8a. Do you introduce the concept of goal-setting in sessions or do clients generally to articulate their own goals?

9. Do you have counselling team meetings?
9a. What is the structure of these meetings?

10. What tools are used to review client files?
10a. How effective are these for helping you to deal with difficult cases?

11. I'd like to learn about the ways you approach counselling. Are there any particular approaches that you draw upon in your work?
11a. What are the benefits or challenges of these when applied in this Counselling Service?
11b. Do you explain your counselling approach to clients?

12. Speaking about the service as a whole, how would you describe the scope of approaches to counselling used?

13. Do you use BSFT in your sessions?
[if 'yes' continue to question 13a. if 'no' continue to 13b.]
13a. Can you describe how you use it?
13b. What are the advantages and disadvantages of a BSFT approach according to your experience?

14. How often do you undertake goal review with clients?

14a. What factors determine when you undertake goal review with clients?

15. Do you use self-help materials, information brochures etc with clients? Do you encounter any difficulties when doing so/accessing appropriate resources?

16. Do you consult with external service providers on case management plans?

16a. Do you refer clients to other services? Could you give me some common examples of services you refer to and how you make the referrals?

17. Can you tell me about the supervision you receive? How is it structured? Is there anything about it that you would improve?

18. Can you tell me about the training and professional development opportunities that the counselling team has?

19. Are there areas that you think the service needs improving in?
[If 'yes' continue to question 19a]

19a. In what areas does the service need improving, and have you got any ideas for how this improvement could occur?

20. In what kinds of services have you been employed as a counsellor in the past? In what ways is DAMEC different or the same as other services where you have provided counselling previously?

Appendix V: Interview schedule for DAMEC Clients

[Suggested script, appropriate paraphrasing to allow fluidity is advisable]

I'm interested in your story about how you first came to this counselling service and what you expected. I'm going to ask you some questions about that to begin with, please feel free to add anything that you feel is important.

1. When did you first come to the counselling service?

2. How did you find out about the service? [prompt] Did somebody refer you here? [if 'yes' proceed to 2a; if 'no' continue to 3]

2a. [prompt] Who referred you?

3. Did you want to come to counselling at the beginning?

4. Were there other people who wanted you to come to counselling? [if 'yes' proceed to 4a; if 'no' continue to 5]

4a. What role did these people play?

5. What did you want to get out of counselling when you first came to DAMEC Counselling?

5a. Do you think that coming to counselling has helped you achieve this/these things?
5b. What kinds of things make you think that it has/hasn't helped?

6. What kinds of things do you need in a counsellor?

6a. How can you tell if your counsellor understands where you are coming from?
7. What is your preferred language?
8. Does it matter to you if your counsellor speaks your preferred language?

8a. [prompt] In what ways has speaking [Vietnamese, Arabic or English] helped or made counselling more difficult for you?

I'd like to hear about the counselling sessions you have been to at DAMEC Counselling Service.

9. Did you feel you were following a process? [if 'yes' proceed to 9a; if 'no' continue to 10]

9a. Could you tell me about it?

10. Did you feel that you were in control in the sessions or was it driven by the counsellor?

[The following questions are prompts, which may or may not be needed depending on the information that the client divulges].

11. Did the counsellor encourage you to tell your story?

11a. Did the counsellor talk to you about your story and how your life has developed?

12. Were you asked how thoughts and thinking triggered your use of alcohol or drugs?

12a. Were you encouraged to identify your thoughts about using and reshape them?

13. Were you asked by the counsellor to imagine “if things were different”?

14. Do you talk about setting goals and working towards them with your counsellor? [if ‘yes’ proceed to 14a & 14b; if ‘no’ continue to 15]

14a. Who sets these goals?
14b. Do you review them? [if ‘yes’ proceed to 14c & 14d; if ‘no’ continue to 15]
14c. How do you review them?
14d. How often do you review these goals?

15. Do you ever have homework to do outside of the session? [if ‘yes’ proceed to 15a & 15b; if ‘no’ continue to 16]

15a. What kinds of things?
15b. Do you think they are useful?

16. Did you feel that your counsellor understood you?

17. Did your counsellor suggest other services or activities you could try out to get other help? [if ‘yes’ proceed to 17a & 17b. if ‘no’ conclude the interview]

17a. What services and/or activities did they refer you to?
17b. Did they contact these services/places for you, or give you the contact so you could call?

Thank you for participating in this interview, it’s been very good to hear about your experiences. I don’t have any more questions to ask but is there anything else that you would like to add?

D.A.M.E.C
Drug and Alcohol Multicultural Education Centre

Evaluation of DAMEC Counselling Services

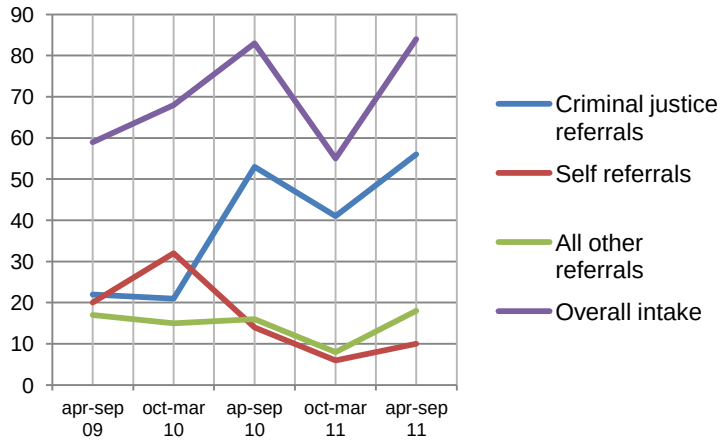
Summary Sheet

Background

Drug and Alcohol Multicultural Education Centre (DAMEC) Counselling Services aim to address the need for alcohol and other drug (AOD) service provision to CALD communities in South-western Sydney. DAMEC provides culturally appropriate outpatient counselling that addresses AOD use and co-occurring mental health issues. In 2008, the Liverpool based service received funding to establish and maintain a counselling service in which two assigned workers would undertake counselling in Vietnamese and Arabic. In 2010, the service expanded to include family counselling. In 2011, DAMEC's *Vietnamese Transitions Project* recommenced its casework program to support participants upon release from prison. In this same year, DAMEC Counselling also opened an Arabic and English language service at the Auburn Centre for Community.

Aims & methods

This process evaluation aimed to gain understanding about the client demographic attending the service, to identify the referral sources and intake patterns at the service, and to explore the characteristics and developments within DAMEC's model of counselling. This evaluation employed a mixed method approach which involved analysis of the Minimum Data Set (MDS) collected by the service from April 1st 2009 until September 30th 2011, and qualitative interviews with 24 active or recent DAMEC clients and all members of DAMEC's counselling team (n=6).



Intake & referral trends

Intake at DAMEC Counselling Services rose significantly over the evaluation period, from 59 clients from April to September 2009, to 84 clients over the same months in 2011. Total number of clients during the evaluation period was 349. There were notable increases in Vietnamese speaking clients, from 1.7% in 2009 to 22.6 in 2011. Intake of clients referred through a criminal justice setting has doubled over the 30-month period that this evaluation covers, while self-referrals declined sharply over the evaluation period (see chart above). Corresponding with the introduction of family counselling in 2010, intake of family members, particularly women, sharply increased.

> ""We speak [my language] so no problem, I feel very comfortable."
>
> – DAMEC client

Culturally & linguistically appropriate counselling

Over the evaluation period, just over half of DAMEC Counselling Services' clients were born outside Australia. Twenty-five per cent of DAMEC's clients preferred to speak languages other than English (n=88). Of these clients, 80% were able to access AOD counselling at DAMEC in their preferred language. Cultural background was reported to influence perceptions and understanding of counselling. Counsellors demonstrated the use of flexible,

D.A.M.E.C
Drug and Alcohol Multicultural Education Centre

Evaluation of DAMEC Counselling Services

Summary Sheet

Recommendations

1. Discuss the effective practices highlighted in this evaluation in a counselling team meeting in order to enhance consistency across DAMEC Counselling Services.
2. Systematise the reporting of inter-agency referrals in DAMEC's MDS.
3. Collect service-wide data on DAMEC clients' mental health issues, treatment and referral status.
4. Develop and implement an organisational strategy for engaging GPs and Mental Health services in the treatment of DAMEC Clients.
5. Undertake targeted outreach and promotional activities with CALD community groups in the areas where DAMEC operates.
6. Prepare and distribute an information sheet about the counselling model used at DAMEC.
7. Implement case file review practices, including the documentation of cultural information.
8. Monitor literature on coercive and involuntary AOD treatment to further inform counselling approaches.
9. That DAMEC's Clinical Governance Committee considers implementing the Australian Alcohol Treatment Measure (AATOM-C) and/or the Psychologists and Counsellors Outcome Measure (PACOM) as outcome measures across DAMEC Counselling Services.

client centred approaches (involving, for example, phone contact or family involvement) which inform clients about counselling and tailor psychosocial interventions to client need.

> "I'd been looking for counselling for a long time... at DAMEC they say 'how about we work with this part, or we work with that part'. *That* is counselling. They really go out of thei way to listen to me."
>
> – DAMEC client

Other complex needs

Counsellors reported that the majority of DAMEC clients present with comorbid AOD and mental health issues, but that barriers exist to successfully referring clients to GPs and mental health organisations. Another issue faced related to negative attitudes and low motivation to attend counselling that were observed to relate to juridical coercion and/or negative past experiences of service provision. Counsellors address these issues by directly addressing clients' concerns and encouraging clients to set their own treatment goals.

> "I am happy. I apply most of it every day… I wanted to learn how to say no to drugs… I can say no now, it's been almost 2 years."
>
> – DAMEC client

Psychosocial interventions in action

The counselling team at DAMEC employs a triangular model that integrates Brief Solution Focused Therapy (BSFT), Cognitive Behaviour Therapy (CBT) and Narrative Therapy. In determining which approaches to use, counsellors sought to prioritise individual client needs, taking into consideration cultural background and the interpretability of concepts in various languages, levels of distress and levels of motivation to participate in counselling. This evaluation found that levels of client awareness about the interventions employed at the service were low.

Conclusion

Through describing the services' function, client needs and level of implementation of the counselling model; this report concludes that DAMEC Counselling Services continues to meet the enhanced standards set up at its inception. In satisfying the aims of this final evaluation, the evaluation also reflected upon the enhanced standards set for the service in 2008 and can claim through the evidence collected that they continued to be met.

Office Use Only
Ref. No:

Australian Government
Department of Health and Ageing

NON GOVERNMENT ORGANISATION TREATMENT GRANTS PROGRAM (NGOTGP)

INVITATION TO APPLY FOR FUNDING

Instructions for Submitting Applications for the NGOTGP funding

Applications close at **2:00PM** (Eastern Daylight Saving Time) on Friday, 23 December, 2011. You must submit your Application as follows:

You must provide 4 unbound (i.e. unstapled) copies, plus an electronic copy in Microsoft Word 2003 format of your Application delivered to:

The Non Government Organisation Treatment Grants Program
Department of Health and Ageing
Tender Box
Ref DoHA/106/1112
Sirius Building,
Foyer, Ground Floor,
23 Furzer Street
WODEN ACT 2606

Late Applications

The Department will accept your Application if it is late as a direct result of mishandling by the Department. In all other circumstances, in the interests of fairness, the Department reserves the right not to accept late Applications. In considering whether it would be fair to accept a late Application, the Department will take into account the degree of lateness, whether the cause of the lateness was beyond the Applicant's control and such other facts as it considers relevant. The Department may also ask the Applicant to provide evidence to support its claims regarding the reasons for late submittal. If the Applicant considers that their Application will be late they should notify the Contact officer prior to the Closing Time advising of the circumstances for the lateness. The chair of the Department's Application Assessment Panel will take the reasons into consideration when deciding whether or not to accept the late Application.

Enquiries

All enquiries relating to this Invitation to Apply (ITA) for funding under the NGOTGP should be directed via email to NGOTGP@health.gov.au.

Please do not alter the sequence of the information or delete any part of the ITA.

SECTION 1 - APPLICANT DETAILS

Details of Applicant

Applicant Organisational Type

[Tick box against organisational type]

- ☑ a) Incorporated Associations (incorporated under State/Territory legislation, commonly have 'Association' or 'Incorporated' or 'Inc' in their legal name);
- ☐ b) Incorporated Cooperatives (also incorporated under State/Territory legislation, commonly have "Cooperative' in their legal name);
- ☐ c) Companies (incorporated under the Corporations Act 2001 – may be not-for-profit or for-profit proprietary company (limited by shares or by guarantee or public companies);
- ☐ d) Aboriginal Corporations (incorporated under the Aboriginal and Torres Strait Islander Act 2006 and administered by the Office of the Registrar of Aboriginal and Torres Strait Islander Corporations);
- ☐ e) Organisations established through a specific piece of Commonwealth or State/Territory legislation (many public benevolent institutions, churches, universities, unions etc);
- ☐ f) Partnerships;
- ☐ g) Trustees on behalf of a Trust;
- ☐ h) State/Territory or Local Governments;
- ☐ i) where there is no suitable alternative, an individual or - jointly and separately – individuals.
- ☐ (j) other (please specify) .....

Applicant Organisational Details

DETAIL REQUIRED	APPLICANT'S RESPONSE:
Applicant Name [This must be the name of the legal entity submitting the Application. This will also be the name of the contracting party if the Application for funding is successful.]	The Drug and Alcohol Multicultural Education Centre (DAMEC) Inc.
Australian Business Number (ABN) [If the Applicant is an entity registered on the Australian Business Register, then the ABN used by the Applicant must be given]	44 792 123 447
Australian Company Number (ACN) [If the Applicant is an Australian company then the ACN must be given unless the number also appears in the ABN given above]	
Registered Business Name [If the Applicant uses a name registered under the business names register kept under the law of a State or Territory of Australia, then that name should be given]	The Drug and Alcohol Multicultural Education Centre (DAMEC) Inc.
Registered Business Address [This needs to be the official address in respect of the legal entity submitting the Application. If the Applicant is using a business name, it may be the address registered in respect of the business]	Level 2 619 Elizabeth Street Redfern NSW 2016
Address for Notices [This needs to be the address the Applicant primarily wishes to be used for notices given under any Deed for Multi Project Funding (if different to the Registered Business Address)]	PO Box 2315 Strawberry Hills NSW 2012
Insurance Confirm current insurance levels are consistent with the Non Government Organisation Treatment Grants Program Guidelines (2.4 – Conditions of Funding) OR Confirm willingness to obtain required levels of insurance if successful.	Insurance levels are currently met.
Has the applicant or consortia organisation submitted an application for funding for the activities that are the subject of this application from another funding source? [Please provide details, or note 'NA' if no other applications have been lodged.]	N/A

Authorised Contacts

	Preferred Contact	Alternative Contact
Name:	Kelvin Chambers	Sarina Afa
Position/Title:	CEO	Office Manager
Postal Address:	PO Box 2315 Strawberry Hills NSW 2012	PO Box 2315 Strawberry Hills NSW 2012
Street Address:	Level 2 619 Elizabeth Street Redfern NSW 2016	Level 2 619 Elizabeth Street Redfern NSW 2016
Phone Number:	(02) 9699 3552	(02) 9699 3552
Fax Number:	(02) 9699 3131	(02) 9699 3131
Email:	ceo@damec.org.au	sarina@damec.org.au

Referees

	Referee 1	Referee 2
Name:	Ralph Moore	Larry Pierce
Company:	NSW Ministry of Health	NADA
Position/Title:	Manager, Population Health & Community Engagement	CEO
Phone Number:	02 9424 5938	02 9698 8669
Email:	rmoor@doh.health.nsw.gov.au	larry@nada.org.au

Is the Organisation or any person nominated in this application under or pending financial or legal investigation? If YES, please provide details:	YES / NO
	No

Briefly outline current alcohol and other drug treatment programs being delivered by your organisation (eg. residential treatment, detoxification services, counselling and referral information services). (Word limit 500)

DAMEC's goals are to reduce the harms caused through the misuse of Alcohol and other Drugs for CALD communities across NSW. It delivers this objective through the provision of counselling services, research and short term community development projects. DAMEC provides a therapeutic framework that encourages change and addressing issues that predispose drug and alcohol use.

DAMEC currently provides an outpatient counselling service targeting culturally and linguistically diverse clients with substance use issues. These services are provided currently at two sites Liverpool (Sydney South West) and Auburn (Sydney West). These clients are provided with a triangular intervention comprising of the DAMEC brief solution focused therapy, cognitive behaviour therapy and narrative therapy. DAMEC clients tend to be complex with over 90% having a co-existing condition including mental health and other socio disadvantaged issues.

DAMEC currently employs three specific bilingual counsellors (Vietnamese, Arabic & Khmer). The service also provides therapeutic family intervention with its Family Therapist and specific psychological intervention through its Psychologist if assessed and required. (These services are provided outside NGOTGP funding)

DAMEC provides enhanced client access through extended family outreach. DAMEC has developed a model that works with carers and family members requiring support. This provides a culturally appropriate response to CALD families stigmatised by drug use.

DAMEC also provides consultation and liaison with mainstream Drug and Alcohol services including We Help Ourselves (WHOs) Odyssey House and St Vincent's Hospital. DAMEC also attends local community information sessions and outreach sessions providing information on Alcohol and other Drugs using culturally appropriate techniques that may include language specific resources.

SECTION 2 – PROJECT DETAILS

Please Note: Your response to each assessment criterion must not exceed 500 words. Failure to respond to the minimum requirements for each criterion will result in your application not being further considered.

Assessment Criterion 1 – Need

Project Name				
DAMEC Day Clinic				
Commonwealth Electorate of principal place of service delivery				
Reid				
State Electorate of principal place of service delivery				
Auburn				
Amount of funding requested (GST exclusive)				**$1,234,754**
Is the proposed project an extension of an existing project? If YES, please provide details.				No
What is the aim of Project?				
DAMEC working within a multi sectoral framework will provide services that reduce the harms caused by the use of alcohol and other drugs for people from a culturally diverse background across NSW.				
Please indicate the type of treatment you will provide**:** Mark as many as appropriate				
Residential treatment program		Outreach program		Abstinence Only
Non-residential treatment program	X	Aftercare program	X	
Counselling		Referral services		
Estimate the number of clients you plan on treating over the project period.				288
Please indicate the target population group of clients: Mark as many as appropriate				
Youth		Aboriginal and Torres Strait Islander People		Whole of community
Women only		Families with children	X	Comorbidity
Men only		Culturally diverse	X	Other

How will the treatment service meet the needs of your target group?

DAMEC is one of the few multicultural services across NSW if not nationally that provide service intervention for CALD clients with a substance use issue and co morbid presentation. There are a few ethno specific drug and alcohol counsellors within some ethno specific services but not an agency with an overall service priority.

DAMEC has found that CALD communities are often unable to attend traditional inpatient rehabilitation centres. DAMEC has surveyed many of its current clients to assess the reasons why.

In general most CALD communities (DAMEC surveyed predominately Vietnamese, Arabic and Khmer speaking groups) still have some form of family structures intact. When there is a substance use issue within the family, often immediate and extended family members are involved in the treatment process.

Rehabilitation services including most Therapeutic Communities have a service delivery response that expects some inpatient admission anywhere from 4 weeks to 12 months. Many clients have reported to DAMEC that this is an access barrier preventing them from the opportunity to undertake this treatment option.

Further many of the current inpatient treatment options are very English language specific and Western model based. DAMEC proposes to adopt the same model development as with the counselling service to develop a culturally appropriate and sensitive framework.

Organisations will be asked to evaluate the overall outcomes of the project. The following points should be considered in developing the evaluation:

Project Objectives:
What are the key objectives of the project (ie what do you hope to achieve)?
Project Activities:
What are the key activities you intend to undertake to meet your project objectives?
Performance Indicators:
What measurements will you use to determine whether you have met your objectives?
(Add more dot points and rows as required)

Objective:
DAMEC will deliver culturally sensitive specialist AOD interventions for individuals and families from a culturally and linguistically diverse background

Activity 1:
Provide Day Clinic services for people from CALD background , their families and carers seeking intervention for AOD use and/or co occurring mental health issues.

Performance Indicators:
- MDS data (including demographic data)
- Psychologists and Counsellors Outcome Measure (PACOM)

Activity 2:
Implement a 12 week Solution Focussed Strength Based Program Inpatient Therapy Framework for CALD clients.

- Adapt the Brief Solution Focussed Day Model to be cross culturally appropriate.
- Develop assessment & referral protocols

Activity 3:
Promote health by utilising strength based and solution focussed approaches to therapeutic intervention

Performance Indicators:
- Development of DAMEC BFST model
- Clinical case review meetings

Activity 4:
Continue to evaluate and modify its model of therapeutic intervention to improve cultural sensitivity and application;

Performance Indicators:
- DAMEC's Evaluation of Day Clinic Service
- PACOM measures
- Clinical case review meetings

Activity 5:
Provide therapeutic interventions which are congruent with other organisational objectives

Performance Indicators:
- Clinical Governance Sub Committee Review
- Clinical case review meetings
- 2 Internal training sessions by external consultant

Activity 6:
Formally evaluate all interventions, either externally by suitably qualified and experienced consultants, or internally through DAMEC research staff.

Performance Indicators:
- DAMEC's Annual Evaluation of Day Clinic Service

What is the catchment area for your service? Comment on the availability of the AOD treatment services in your area.
DAMEC Day Clinic will take referrals across NSW. DAMEC Counselling service is one the only CALD dedicated drug and alcohol treatment service available in NSW. There are no specific inpatient day clinics or therapeutic communities across Australia for persons from CALD backgrounds.
Provide information to demonstrate that the project is consistent with the National Drug Strategy.
DAMEC's primary role sits within the first pillar of the National Illicit Drug Strategy namely demand reduction. DAMEC's counselling service predominately works within Objective 3 supporting people to recover from dependence and reconnect with the community. DAMEC also provides some community education that operates at a tertiary level preventing the early uptake of alcohol and other drugs.
Provide information to demonstrate that the project is consistent with your state or territory drug treatment guidelines.
DAMEC's Strategic Plan (20010-2013) and DAMEC's yearly Business Plan contributes directly to S3 of the NSW State Plan in reducing illicit drug use, smoking and drinking. *NSW Health Drug and Alcohol Plan 20011-2015 (Draft)* Further DAMEC also meets objectives: *S2.10 need for better access to treatment for CALD groups and* *S 2.13 highlights need to build better relationships with agencies representing particular population groups, including CALD groups.* DAMEC is also identified in the NSW Health Drug and Alcohol Plan 2010 -2013 as a key provider of drug and alcohol services for CALD communities in NSW.

List other organistions and stakeholders providing support to your project, and indicate their role and your relationship with the organisation.
DAMEC has developed strong networks over many years. These include: Networks for support, consultation, and referral regarding alcohol and other drug issues in South Western Sydney: • Drug Health South Western Local Health Network • Open Family • Uniting Care Burnside • Cabramatta Youth Team • Probation Parole • Forum Sentencing • Mental Health Services South West Sydney Local Health Network • Transcultural Mental health Service • STARRTS • NSW Refugee Health Service Networks for support, consultation and referral regarding the Vietnamese and Arabic-speaking communities in NSW: • Fairfield Migrant Resource Centre • Liverpool Migrant Resource Centre • The Vietnamese Community in Australia • Vietnamese Women's Association Other local agencies with whom DAMEC has effective working relationships: • Fairfield Council • Centrelink • Local police and Ethnic Community Liaison Officers • Department of Housing • Anglicare • Breakthrough Employment Cabramatta

Governance, Accreditation and Quality Assurance
Assessment Criterion 2 – Organisational capacity

Describe the governance structure of your organisation. (Flow charts accepted)	
DAMEC is a non-government registered charity. DAMEC's Board of Directors is elected annually. There are four ex-officio members appointed to the Board on an annual basis representing four key services including STARRTS, NSW Refugee Health Service & Transcultural Mental Health Service. DAMEC uses a subcommittee structure to assist the Board. The current subcommittees include; Executive Committee; Quality Improvement; Research; Projects & Clinical Governance. DAMEC delegates daily management of the service to its Chief Executive Officer. DAMEC employs two sub managers; Project & Research and a Clinical Team Leader. Staff are answerable through their line manager to the CEO to the Board of DAMEC. DAMEC has a governance structure in place according to the requirement of ACHS accreditation which details timetables for structural review, governance review and policy review. DAMEC is independently audited each year. DAMEC currently employs three external supervisors to provide clinical support and management of the counselling team.	
Is your service formally accredited? If YES provide type of accreditation and associated standards, the provider and date of award.	YES
Australia Council of Health Standards Equip 5 Day Procedures	
Provide evidence that staff employed by your organisation are appropriately qualified to deliver the proposed services in line with any required state/territory standards.	
DAMEC credentials currently registered staff and supervisors (eg psychologists through AHPRA). All staff have to demonstrate achieving or the equivalent of CERT IV Drug and Alcohol. Several staff are members of the Counsellors and Psychotherapists Association (CAPA). DAMEC continues to be a member of APSAD.	
List the staffing requirements needed to meet the agreed work commitments. List the proposed staff recruitment needed to meet these commitments. What contingency plans does the organisation have to ensure staffing will be maintained during the term of the grant?	
DAMEC will require three full time drug and alcohol counsellors and an assertive case management Officer. DAMEC will need to recruit staff as it is a new service for the organisation. If staff leave during the grant DAMEC will adopt its recruitment and employment policies.	
Provide information on the outcomes of any previous service delivery grants including: Treatment completion rates, number of clients assisted (including from target groups), utilisation/occupancy rates, findings of evaluation reports, outcomes achieved etc.	
DAMEC' Counselling has seen 585 clients from 2008 to 2011. This is an average of 195 clients per year. 45% are from a NESB. DAMEC has estimated in the past three months of the 75 clients seen 25 would be appropriate for a day clinic DAMEC's Annual Evaluation report is attached)	

Successful projects must complete regular progress reports and a project evaluation on completion. Does you organisation have the administrative capacity to provide this information?	
	YES
Can your organisation collect and contribute statistical data to the Alcohol and Other Drug Treatment Services National Minimum Data Set? Refer Australian Institute of Health and Welfare website for further information: http://www.aihw.gov.au/publications/index.cfm/title/10427	YES

Assessment Criterion 3 – Sustainability

Is this project dependent on other funding submissions you have made? please provide details.
No.
If this funding is not forthcoming, will this project still be undertaken?
No.
Explain how the proposed project outcomes are sustainable and can be continued after the NGOTGP funding is expended?
DAMEC' Day Clinic model may be funded from other sources but will need ongoing Government funding to continue.

SECTION 3 – BUDGET DETAILS

Finance:
Project Budget (GST Exclusive)

	2012 – 13 $	2013 – 14 $	2014 – 15 $
Salaries 3 FTE Counsellors **1 FTE Case Manager Officer** Please indicate no. of staff	**191,000**	**196,730**	**202,630**
Salary On-costs	**26,720**	**27521**	**28346**
TOTAL SALARY COSTS	**217,720**	**224,251**	**230976**
Set Up Costs – new services	**50,000**	**0**	**0**
Project Administration (including costs of reporting) Admin support (1.5FTE) Bank fees Payline fees All amounts >$10,000 must be listed separately	 **5,000** **800** **2,000**	 **5,150** **824** **2060**	 **5303** **849** **2122**
Insurance **Public Liability Insurance** **Professional indemnity Insurance** **Workers Compensation Insurance**	**11,000**	**11,330**	**11670**
Project travel	**12,000**	**12360**	**12730**
Resources (Literature etc)	**8,000**	**8240**	**8487**
Accounting / Audit fees	**3,000**	**3090**	**3183**
Other: **Computer maintenance** **Project costs** **Rent** **Utilities** **Training** **Telephone** **Staff Amenities** **Supervision (clinical)** Please list each item separately. All amounts >$10,000 must be listed separately	**2,000** **3,000** **65,000** **12360** **8,000** **10,000** **1,000** **22,400**	**2060** **3090** **67000** **12730** **8240** **10300** **1030** **23072**	**2122** **3183** **69000** **13110** **8487** **10600** **1061** **23764**
	433,280	**394,827**	**406647**
10% GST	**43328**	**39482**	**40664**
TOTAL PROJECT COST:	476608	434309	447291

Project funding from all sources

If you will receive any other funding to support this project (State/local government, donations etc) please complete the table below.

	2012 – 2013 $	**2013 – 2014 $**	**2014 – 2015 $**
Your Organisation's contribution	**40,000**	**42,000**	**44,000**
State & Territory Government funding	**0**	**0**	**0**
Donations	**0**	**0**	**0**
Income from other sources: eg: client contributions	**0**	**0**	**0**
TOTAL GST inclusive	**40,000**	**42,000**	**44,000**

SECTION 4 - ACKNOWLEDGEMENTS

If this Application for funding is successful, the Applicant acknowledges and agrees:

that a description of the project, the amount of the funding and name of the Applicant's organisation may be:

- included in the Department's reporting on the internet in line with the Commonwealth Grant Guidelines and Senate Orders;
- used by the Commonwealth in media releases and other publications (such as Annual Reports); and/or
- used to compile a consolidated report.

that it will be required to provide proof that it has sufficient insurance cover to conduct the proposed activities specified in this Application Form; and

that the funding will be provided in accordance with the terms of the Department of Health and Ageing's Deed for Multi Project Funding and the Applicant agrees to abide by the terms of that Agreement.

[Indicate whether the Applicant makes the above acknowledgements] YES

If NO, please explain why the Applicant has not made the above acknowledgements.

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SECTION 5 - DECLARATION

Guidance for completing this Declaration
This Declaration must be signed by an authorised representative of the Applicant (or, if this is a consortia organisations Application, an authorised representative of the Lead Organisation). The authorised representative should be a person who is legally empowered to enter into Deed for Multi Project Funding on behalf of the Applicant / lead organisation. An Application which does not provide all required information or which contains false or misleading information will be excluded from consideration.

I hereby apply for funding under the **Non Government Organisation Treatment Grants Program** of

$**1,234,754**

for

DAMEC Counselling

I certify that the information given in this Application is complete and accurate.

I declare that the Applicant is not listed as a terrorist under section 15 of the *Charter of the United Nations Act 1945*.[1]

Signature: _____

Name (BLOCK LETTERS): KELVIN CHAMBERS

Position in Applicant: Chief Executive Officer

Date: 19th December 2011

[1] A consolidated list of such persons, entities and associated assets is maintained by the Department of Foreign Affairs and Trade under the *Charter of the United Nations (Dealing with Assets) Regulations 2008*.

SECTION 6 – APPLICATION CHECKLIST

Before you submit your Application, complete the following checklist to ensure that your Application is complete.

Before You Begin

[ ] Read this Invitation to Apply (ITA)

[ ] Ensure that you understand the assessment criteria as detailed in the ITA.

[ ] Where an entity does not have a Funding Agreement in place with the Commonwealth represented by the Department of Health and Ageing - Read the Department of Health and Ageing's Deed for Multi project funding provided with this Invitation to Apply. When you submit your Application, you must confirm that, if your Application is successful, you will accept the terms of the Deed for Multi Project Funding. If you are not able to accept the terms in the Deed for Multi Project Funding, please specify in your application any areas where compliance is not possible and the reasons why.

[ ] Where an existing entity has a Funding Agreement in place with the Commonwealth represented by the Department of Health and Ageing, details must be included in your Application under Section 3 - Project funding from all sources.

Completing Your Application

[ ] Complete the Application Form in English.

[ ] Complete and sign the Declaration of the ITA, Form (Note: The Declaration must be signed by an authorised officer of the Applicant).

Submitting Your Application

[ ] Check that you have completed each Section of the Application Form that is required.

Please note: If you are applying for funding under both the Fund and the Non Government Organisation Treatment Grants Program you will be required to provide the following documentation once.

For non-government Applicants:

[ ] Attach to the Application one (1) copy of the Applicant's Certificate of Incorporation.

[ ] Attach to the Application one (1) copy of the Applicant's previous financial year's audited financial statements.

For Applicants submitting a consortia Application:

[ ] Ensure that the nominated lead organisation (the Applicant) is a legal entity (incorporated body) capable of entering into a Deed for Multi Project Funding with the Commonwealth.

[ ] Attach to the Application a letter of support from each consortia organisation.

For Applicants applying for both funding streams please indicate to which Funding Application you have attached the required documentation.

[ ] Attached to this Application.

[ ] Attached to the Substance Misuse Service Delivery Grants Application.