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EARLY INTERVENTION IN THE REAL WORLD

Providing culturally informed mental health services to Aboriginal youth: The YouthLink model in Western Australia

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Aim: Aboriginal young people are more likely to experience mental health issues and to access mental health services than other young Australians, yet there are few culturally informed mental health programs and services available. This study describes and documents the effectiveness of the culturally sensitive model within YouthLink, a state-wide mental health service program in Western Australia for young people aged 13 to 24 years of age.

Methods: A mixed-method design including a descriptive approach reporting on the YouthLink framework and an empirical research design where 40 Aboriginal clients completed client feedback monitoring measures between 2014 and 2016.

Results: The YouthLink culturally informed conceptual framework adheres to best practice principles relevant to work with Indigenous people, family and communities. Aboriginal young people indicated improvement across the treatment period as shown by within-group differences between the first and last session scores on feedback measures. Therapeutic alliance (together with lower baseline acuity and female gender) also contributed significantly to positive treatment outcomes.

Conclusions: Through a strong role of Aboriginal practitioners, relationships with Aboriginal communities, and greater service flexibility that embraces cultural meaning and knowledge, YouthLink has sought to enhance its response to the needs of Aboriginal youth.

KEYWORDS

Aboriginal, cultural competency, healthcare measurement, outcomes, rating scales, youth mental health

1 | INTRODUCTION

In this paper, we present a description of a youth mental health service providing culturally sensitive practice to Aboriginal young people. Aboriginal Australians form a small percentage of the overall Australian population (3%), yet they are 2.5 times more likely to access mental health services than other Australians (Australian Institute of Health and Welfare [AIHW], 2009a, Vos, Barker, Begg, Stanley, & Lopez, 2009, Westerman, 2004). High levels of adverse life events, systemic discrimination and psychosocial risk factors impact significantly on Aboriginal young people's social and emotional well-being (Belfer, 2008; King, Smith, & Gracey, 2009; Zubrick et al.,

2010), and it has been estimated that 27% to 40% have mental health problems and behavioural issues (AIHW, 2009a, Chalmers et al., 2014, Westerman, 2010, Zubrick et al., 2010).

Given these alarming figures, national policies and strategies have advocated for an urgent need to strengthen the mental health and well-being of Indigenous people and improve service access (Dudgeon, Milroy, & Walker, 2014, Framework 2014, Zubrick et al., 2010). Mainstream services, however, have at times been described as unsuitable, due to the lack of culturally informed care and a sense of distrust on the part of Aboriginal people (Hunter, 2014; Isaacs, Pyett, Oakley-Browne, Gruis, & Waples-Crowe, 2010; Parker & Milroy, 2014; Vicary & Bishop, 2005). Alternative models are being

sought, which promote an enhanced role for Aboriginal practitioners (APs), stronger relationships with Aboriginal communities and greater service flexibility. While the elements of culturally informed care have been well articulated, there is a paucity of studies describing service models with a strong evidence base (Champion, Franks, & Taylor, 2008; Dudgeon et al., 2014; Walker & Sonn, 2010; Westerman, 2004).

The first aim of this paper is to present a successful framework provided by a state-wide mental health service program in Western Australia. YouthLink provides specialist mental health treatment to young people aged 13 to 24 years of age who have serious mental health disorders, and are homeless or experience significant barriers to accessing mainstream mental health services. Such barriers include cultural barriers such as Aboriginal and Torres Strait Islander identity, or sexual and gender diversity. Approximately 50% of its referrals are for young Aboriginal people. Within its small multidisciplinary team, YouthLink prioritizes the employment of 2 Aboriginal practitioners. These practitioners provide direct clinical services, maintain an active presence in the Aboriginal community and within family networks and support non-Indigenous workers in providing strong culturally informed practice. The first aim of this paper is to describe the care process and implementation of YouthLink. As a way of organizing a description of the cultural appropriateness of Youth Link's services for Aboriginal youth, its process of care is described against best practice principles for mental health work with Aboriginal people, family and communities (Dudgeon et al., 2014).

The second aim of this paper is to demonstrate the effectiveness of this service in improving the mental health outcomes of Aboriginal young people. Recommended quality improvement approaches involve the documentation of both processes and outcomes of care (AIHW, 2009a; Puszka et al., 2015) yet an evaluation of Aboriginal mental health services presents with some challenges. An evidence-based approach to service evaluation is the preferred method of the dominant Western culture yet it may be perceived as conceptually dissonant with Indigenous health servicing perspectives. Indicative of this issue are concerns raised about the cultural and social appropriateness of standardized outcome measures, and an absence of performance standards (AIHW, 2009b; Bishop, Vicary, Andrews, & Pearson, 2006; Puszka et al., 2015; Swan & Raphael, 1995). Considerable efforts are required to address these issues, especially in public mental health services where standardized National Outcomes and Casemix Collection (NOCC) measures are routine and mandatory. In an attempt to accommodate the requirements of both service provision and Indigenous appropriate servicing, Youthlink has been utilizing the Outcome and Session Rating Scales, (ORS and SRS; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Miller, Duncan, Brown, Sorrell, & Chalk, 2006) as feedback monitoring tools.

The ORS consists of 4 brief questions about the client's well-being, and the SRS asks about the person's therapeutic bond with their mental health worker. The ORS and SRS are completed at every session or as needed (Miller, 2014; Miller, Duncan, Brown, Sparks, & Claud, 2003). Studies with non-Indigenous youth report strong clinical utility for the ORS and SRS in assessing clinical change over time and treatment effectiveness (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Hall et al., 2013; Kwan & Rickwood, 2015; Miller et al.,

2003; Shimokawa, Lambert, & Smart, 2010). To our knowledge, there are no reports on the use of ORS and SRS measures in Aboriginal youths, yet they show considerable advantages over other standardized measurement approaches. They do not involve formal evaluation or diagnosis and the client's self-evaluation is used as the norm against which subsequent ratings are compared. Client responses are discussed during the session and serve as a conversation tool to guide the contents of therapy within the person's personal, cultural and psychosocial context. This practice serves to emphasize respect, shared meaning and learning, which are essential components for a safe and respectful cultural practice (Williams, 1999). It also encourages clinicians to familiarize themselves with a holistic understanding of multi-factorial issues impacting on the young person, their family, and their community, and assists in developing strong therapeutic relationship (Duncan, Sparks, & Miller, 2006). Given the paucity of standardized culturally sensitive measures or approaches to measuring well-being, we utilized the ORS and SRS as an active compromise in an attempt to demonstrate the program's effectiveness.

Another advantage of these measures is that the SRS provides a quantitative measure of the relational bond which exists between client and practitioner (Bickman et al., 2011; Hall et al., 2013; Hansen, Howe, Sutton, & Ronan, 2015; Kwan & Rickwood, 2015; Shimokawa et al., 2010). Given that the collaborative alliance between client and practitioner is a central aspect of treatment effectiveness (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012) its role in promoting a positive treatment outcome in Aboriginal youth may provide an indirect measure of practitioner cultural competency. In the current report, we therefore examined the extent to which therapeutic alliance (measured with the SRS) contributed to patient outcomes (measured with the ORS) using regression analyses methods.

In summary, this study aimed to describe Youth Link's processes and outcomes of care. In the first section, its care framework is organized against best practice models. In the second section, ORS and SRS measures completed by 40 Aboriginal young people are reported as a way of evaluating the effectiveness of the program and therapeutic alliance (ORS and SRS measures).

2 | YOUTHLINK DESCRIPTION AND GUIDING PRINCIPLES

2.1 | Service description

YouthLink, Youth Mental Health Program, North Metropolitan Health Service Mental Health (NMHS MH), Perth, Western Australia, provides recovery-oriented and evidence-based treatment for young people with complex mental health and psycho-social-cultural needs. It provides psychosocial and psychotherapeutic interventions, which are responsive to both the individual young person and to the systems within which they live. YouthLink provides a flexible approach to engagement with young people, with outreach capacity and assertive follow-up. Collaborative partnerships are developed between case managers, teams and health and community services, to provide person-centred care and a range of interventions including psychoeducation, supportive counselling and evidence-based psychological

therapies. The team is multidisciplinary (clinical psychology, social work, psychiatry and clinical nursing), including 2 full-time Aboriginal mental health practitioners. These Aboriginal mental health practitioners provide direct clinical services to young people, provide cultural consultation to non-Indigenous clinicians and a community triage function to support community-based referrals.

2.2 | Process of care

The principles of best practice have been articulated slightly differently since the landmark National Aboriginal Health Strategy (Party, 1989), but its aspirations and goals have been retained in recent frameworks (Framework, 2014). Table 1 shows a set of 9 guiding principles that describe "best practice" relevant to work in mental health, social and emotional well-being with Indigenous people, family and communities (Framework, 2014) together with their application to Youth Link's conceptual framework.

Table 1 shows that YouthLink has developed a large pool of knowledge and expertise about the mental health of Aboriginal young people. Through a strong role of APs in supporting non-Indigenous workers and in providing direct clinical services, YouthLink services can offer an understanding of the cultural, personal and psychosocial issues affecting young people (*Principle 3*) and can assist in bringing awareness of the struggles of Aboriginal people, and the impact of adverse events on the young person, family functioning, kinship, attachment styles and cultural identity (*Principle 4*). Awareness about Aboriginal history and the effects of colonization has allowed YouthLink to consider the effects on social disadvantage and marginalization, and put systems in place to overcome a mistrust of services (eg, through "vouching") and reducing barriers (*Principle 6*).

Another central component to Youth Link's success is its service flexibility which embraces cultural meaning and knowledge. Its multidisciplinary team members focus on holistic health (*Principle 1*), and respect of the young people's choices about their care and traditional rules fosters the right to self-determination (*Principle 2*) and respect of human rights (*Principle 5*). Its flexible triage entry pathways ensures a "no wrong door" approach (*Principle 7*), and a strength and recovery-based framework ensures that clients focus on personal growth and development in a manner that is personally meaningful (*Principle 9*). Relationships with Aboriginal communities provide a critical recognition of the role of family and kinship. They bring a source of knowledge and "vouching" for YouthLink services, and also a model of identity, strength and well-being for young people (*Principles 7*). Connections with kinship, ritual and spiritual relationships are needed for strong cultural identity, and to promote good mental health and well-being (*Principles 8*).

3 | EVALUATION OF PROGRAM EFFECTIVENESS

3.1 | Participants

Participants included 40 clients who identified themselves as Aboriginal and who completed the ORS and SRS at YouthLink between April

TABLE 1 Nine guiding principles for a culturally informed practice with Indigenous people, family and communities (Dudgeon et al., 2014), and how these are addressed at YouthLink with its multidisciplinary team including Aboriginal Practitioners (AP)

1. Health as holistic, encompassing mental, physical, cultural and spiritual health

- YouthLink includes a multidisciplinary team and has forged strong partnership with community-based organizations
- Clinicians use a therapeutic approach which specifically addresses Aboriginal concepts of health and well-being
- Assessment and care planning comprise the development of a cultural formulation
- Storytelling, narratives and connections to people and places form a centre-piece and make meaning about experiences and in the process of healing and therapy
- The therapeutic framework varies between clients depending on their needs and may be exploratory or supportive
- Therapy focuses on social and emotional well-being and the development of life skills in a cultural context

2. Right to self-determination

- In YouthLink, young persons are partners in decisions about their care, and they are provided with sufficient information so that they can make informed decisions in an autonomous way
- The AP work with the young persons and their families to explain the service process and requirements and support engagement
- At triage, an appropriate clinician is allocated for young persons based on gender, cultural and other issues
- Where services are provided by a non-Indigenous clinician, the first meeting may involve AP to optimize culturally appropriate engagement strategies, including vouching. Also, the young person they may request access to AP at any point during the episode of care.
- It is acknowledged that young persons may have ambivalence with the modern and cultural world, impacting on their sense of self and personal schema, and that it is important to discuss their experiences in their preferred context through a process of shared meaning
- YouthLink respects the significance of traditional rules, which govern relationships between kinship and regulate position in landscape reference

3. Need for cultural understanding

- YouthLink's AP are available to young persons to assist with family history, cultural identity, family and cultural issues
- AP are co-signatories to the care plans developed by non-Indigenous clinicians
- Therapeutic contents are shaped by an understanding about culture, identity and spiritual beliefs
- Therapy is delivered at the young person's preference at a place of significance because connectedness to land is imperative, and locations have great spiritual, physical, social and cultural connections
- Flexibility is provided to accommodate different conceptions of time
- Awareness of cultural bound syndromes; cases are discussed in regular clinical review meetings, and where appropriate, with the AP together with community members

4. Recognition that the experiences of trauma and loss have intergenerational effects

- YouthLink's AP assist and consult with non-Indigenous clinicians and other agencies/organizations to bring awareness about the role of racism, impact of segregation, incarceration, lack of access to quality education and health services and low socio-economic status on individuals, family, community and well-being
- Understanding that complex trauma stems from historical and present government policies including transgenerational trauma of colonization and the forced removal of children
- Young persons are assessed for abuse and trauma history and integrative treatments are offered for young people with complex trauma
- AP do outreach visits to discuss community members concerns as each complex case can present with extended family suffering from same grief and trauma

5. Recognition and respect of human rights

- YouthLink's care provision is consistent with legislations regarding Australian Human Rights Commission Act 1986; Australian Racial Discrimination Act 1975; and Equal Opportunity Act 1984

(Continues)

TABLE 1 (Continued)

- Informed consent is discussed with the client and it ensures the client is not re-traumatized and that decisions are shared
- Clinical work with Aboriginal young people is allocated to clinicians according to the individual young person's preference to work with either an aboriginal or non-aboriginal clinical and with respect to the client's preference for gender of clinician

6. Racism, stigma, environmental adversity, social disadvantage have negative impacts

- Acknowledgement of Aboriginal history where racist beliefs contributed to legislation decisions, and where cultural racism had detrimental effects on self-esteem, mistrust of the dominant culture, and social disadvantage
- As Aboriginal people come from a diverse nation, some clients are also subject to lateral violation within their own community
- Awareness that Aboriginal identity has been constructed, imposed and used in the creation of assimilation and other destructive practices; different language groups may act to cause questions about identity, creating a state of hyper-vigilance
- Decolonising projects challenge ingrained assumptions about identity and YouthLink provides this supportive therapy with the client

7. Recognition of the centrality of family and kinship and the bonds of reciprocal affection, responsibility and sharing

- Family and community play a critical role in the lives and identity of Aboriginal people and can be a source of strength and well-being; they have a role and responsibility and provide a sense of belonging and ensuring ongoing connection to the dreaming
- A cooperative therapeutic approach acknowledges the young persons' context of their family and community
- Flexible pathways to care enable communities (family and community members) to make referrals; the AP can do outreach visits to discuss community members concerns and assessment
- Where the referral is not appropriate, the AP works actively with the family and community to obtain support from other agencies/ services

8. Recognition of individual and community cultural diversity

- The unique status of every individual is defined by their connections with other people through their kinship, ritual and spiritual relationship.
- Individuals have unique backgrounds, and have the rights to choices, flexibility and control
- When required, Aboriginal elders and Nangkarees (traditional healers) are consulted about the cultural context of initial presentations and cultural issues
- Emphasis on "vouching" where community members act as cultural referees, where YouthLink and clinicians are deemed as culturally safe, creating a positive contagion effect

9. Recognition of Indigenous strengths

- Working from a strength and recovery-based framework that is culturally appropriate and flexible, and which provides support according to the needs and strengths of the young person, their families and/or carers
- Strong focus on enhancing social and community inclusion, recovery and the capacity for young people to achieve their desired goals and live successfully in the community
- Therapeutic approach to focus on self-development and growth, which builds on the client's own individual strengths (ego-strengthening). The focus on self-efficacy and advocacy in turn improving self-esteem and confidence, and sense of identity that is personally meaningful.

2014 and December 2016. Inclusion criterion included a minimum of 2 sessions rated with the ORS and SRS. Half of all clients (22/40, 55%) were seen by the APs, and the other half by non-Indigenous practitioners. Average duration of care was 10.4 months.

This project was conducted as a part of North Metropolitan Mental Health Service Quality Assurance and Evaluation activity and approved for publication by NMHS Human Research Ethics Committee. The Aboriginal Health Council of Western Australia (AHCWA) also raised no objections to the study or its publication.

TABLE 2 Demographic and clinical characteristics

Variable	Whole sample, M(SD), range; or count (percentages)
Age	17.0 (2.8), 13-23
Gender (M/F)	22 / 17
Diagnosis with ICD-10 CM label (frequency count and percentages)	Schizophrenia and other psychoses = 1 (2.5%)
	Mood disorders, n = 12 (30%)
	Anxiety disorders, n = 18 (45%)
	Disorders of personality, n = 2 (5%)
	Mixed conduct and emotional disorder in childhood = 4 (10%)
	Co-occuring psychiatric disorders = 24 (60%)
Co-occurring clinical characteristics	Self-harm or suicidal ideations = 14 (35%)
	Substance dependence/use disorder = 20 (50%)
	Childhood adverse events = 28 (70%)
	Homelessness = 3 (7%)
Previous inpatient admissions	2.5 (5.5), 0-31
HoNOS: Mean total baseline score	17.3 (6.4), 4-29 (n = 20)
HoNOS: Mean total final score	14.4 (6.7), 0-25 (n = 17)
ORS: Mean total baseline score	19.7 (9.1), 3.6-40.0
ORS: Mean total final score	27.0 (10.5), 1.1-40.0
SRS: Mean total baseline score	31.9 (7.3), 12.5-40.0
SRS: Mean total final score	33.3 (7.4), 16.2-40.0

Abbreviations: HoNOS, Health of the Nation Outcome Scores; ORS, Outcome Rating Scale; SRS, Session Rating Scale.

3.2 | Measures

The ORS (Miller et al., 2003) assesses well-being with 4 questions asking about personal well-being, relational well-being (family, close relationships), social well-being (school, work, church), global well-being (life overall). The SRS asks about therapeutic alliance with 4 questions on different elements of the treatment session (relationship, goals, topics, global rating). The SRS and ORS are both completed by the client themselves. Instructions ask the young person to place a mark on 10-cm line with low estimates (low well-being/disagreement) to the left and high estimates (high well-being/agreement) to the right. The score is the summation of the marks to the nearest millimetre. YouthLink practitioners received formal training with an accredited trainer, and its usage by the practitioner and client was entirely voluntary.

Results of the ORS were also compared against scores on the Health of the Nation Outcome Scales (HoNOS) (Wing et al., 1998). This clinician-rated scale is a standardized tool which assesses mental health with 12 items on a 5-point scale (ranging from 0 to 4).

3.3 | Statistical analyses

Data were analysed using SPSS version 23. The distributions and normality plots suggested that assumptions of normality were not violated. The ORS clinical cutoff was set as 25 (Miller et al., 2003).
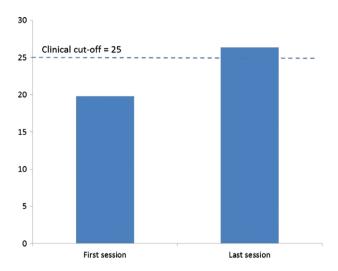
FIGURE 1 Total Outcome Rating Scale scores at the first and last sessions

Change across therapy was assessed with repeated measures General Linear Model (GLM), and by calculating the number of clients who met the following criteria: (1) recovery (% of clients achieving clinically significant change by the end of therapy, defined as a baseline score in the clinical range; 5 point improvements; and a termination score > = 25); (2) improved (% of clients achieving clinical cut-off by the end of the therapy); (3) no change (<5 score change); and (4) deterioration. Other data of interest included ORS and SRS mean scores; treatment gain scores (Mean T2-T1, divided by SD of T1) and number of sessions required for minimum expected treatment response (ETR).

Hierarchical multiple regression analyses were used to examine the contribution of therapeutic alliance (mean SRS score across treatment) to treatment gains (on the ORS). Given that possible covariates might include clinical acuity at the start of treatment, number of sessions, age and gender, these were added all at once in a first model, after which non-significant predictors were removed. Number of sessions and age did not add to the relationship and were removed in the final model. Final model comprised ORS treatment gains (dependent variable); baseline ORS and gender as Steps 1 and 2; and SRS mean scores as Step 3.

4 | RESULTS

There were 40 clients (55% male, average age 17 years old). Table 2 shows that anxiety disorders such as adjustment disorder or post-

traumatic stress disorder accounted for 45% of all clients. Clients demonstrated an acute clinical profile demonstrated by multiple comorbidities, self-harm or suicidal ideation, substance dependence, childhood adverse events, homelessness and multiple previous inpatient admissions. A baseline score of 16.7 on the HoNOS suggests severe clinical symptoms.

Clients completed an average of 11.4 sessions (median = 7.5, range 2-55). There were significant improvements across the treatment period (see Figure 1), as shown by within-group difference between the first and last ORS session scores (paired t test t [39] = 4.0, $P < .001$) and a treatment effect size of 0.69. Overall, 65% of clients improved: 35% achieved clinical recovery and 30% achieved clinical cut-off by the final session. A further 25% showed no change and 10% deteriorated. Treatment gain scores (overall change) correlated significantly with HoNOS measured change, $\rho = 0.49$, $P < .05$, but not with any demographic or clinical characteristics (age, gender, number of inpatient admissions) or number of sessions (all $P > .10$). Inspection of the 4 ORS domains showed overall within-subjects effects ($F[4,35] = 4.05$, $P = .008$, $\eta^2 = 0.31$) in all 4 domains (all $P < .001$). There were no significant between-subject effects of gender, age, number of sessions or previous admissions (all $P > .29$). Progresses were observed by the fifth session (Figure 2) which is in line with expected rates of progress. The average number of sessions required to reach the minimum ETR was 3.7.

Therapeutic alliance (SRS scores) increased between the first and last session (see Table 2), although the difference did not reach statistical significance ($F[4,29] = 0.70$, $P = .59$). There were no significant between-subject effects of covariates (all $P > .30$). Nonetheless, the final SRS correlated significantly with final ORS, $\rho = 0.55$, $P < .001$, and baseline ORS and SRS analyses were just outside of statistical significance, $\rho = 0.28$, $P = .07$, suggesting an association between therapeutic alliance and treatment outcome.

Hierarchical multiple regression analyses examined the contribution of therapeutic alliance to treatment gains. Results showed that SRS mean scores, baseline ORS and gender were all significant predictors of ORS gains, $F[3,32] = 8.1$ $P < .01$. Baseline ORS performance explained 19% of the total variance, gender explained 14% of the variance on top of baseline ORS, and therapeutic relationship (SRS average) explained 19% on top of baseline performance and gender (Table 3). Therefore, lower acuity at baseline, female gender and a higher therapeutic bond all contributed significantly but independently towards a better outcome. The above hierarchical multiple regression analyses were repeated adding the practitioner's heritage
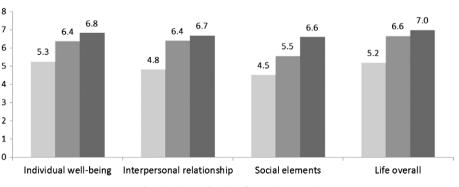

FIGURE 2 Outcome Rating Scale client progress at baseline, fifth and last sessions

TABLE 3 Regression analyses for Outcome Rating Scale (ORS) gain score

Dependent variable	Predictors	β (95% CI) for predictor	R^2 (Step 1)	R^2 change after predictors added (Steps 2 and 3)
ORS gains	ORS (baseline)	−.81 (−1.2 to −.5)	.19**	
	Gender	−.46 (−.15.8 to −3.)		.14*
	SRS (average)	.48 (.30 to 1.1)		.19**

Note: *$P < .05$; **$P < .01$.

(Aboriginal or non-Aboriginal) in the model, but this variable was not a significant contributor to the model ($P = .85$), with an R^2 change of less than .01 ($\beta = -0.03$, 95% CI = −9.1-7.6).

5 | SUMMARY AND DISCUSSION

This study sought to describe the YouthLink care framework in relation to best practice models, and to demonstrate the program's effectiveness with an analysis of the SRS and ORS measures completed by 40 young Aboriginal people.

This process demonstrates that YouthLink practice is well aligned onto best practice elements as detailed in the National Aboriginal health strategies. YouthLink has sought to implement effective strategies to work with Aboriginal youths and their communities, though recognition of the person's right for self-determination and a need for cultural understanding which includes both negative effects from intergenerational trauma, grief and loss, and positive beneficial effects of communities and kinship, diversity and Aboriginal strengths. A critical role is played by Youth Link's APs who provide direct case management and clinical treatment, and a responsive presence within family and community networks. These practitioners are fully embedded in all clinical processes and provide consultation at all levels of clinical and organization practice. These Practitioners also act to integrate cultural and clinical competencies within the system and individual practitioners, and in supporting non-Indigenous clinicians in delivering culturally sensitive practice. This model is a very powerful resource for supporting other clinicians and assisting to create culturally aware services.

The results also show that young people who present to Youth-Link have severe clinical presentations involving multiple psychiatric diagnoses, previous inpatient admissions, high rates of childhood adverse events, self-harm, substance dependence and homelessness. This is consistent with studies showing that Aboriginal young people are caught in multiple layers of strain which include major life stressors, separation from family and culture, emotional and behavioural problems as well conduct difficulties and increased risk of suicide (Belfer, 2008; Zubrick et al., 2010). Improved access to specialist services, which seek to provide cultural sensitive practice is therefore important to support the needs of these young people.

Capturing outcome data in a culturally appropriate way often presents a challenge as an evidence-based approach that is imposed by the dominant culture may be perceived as being in conflict with

Indigenous servicing of mental health. Youth Link's attempt to reconcile appropriate servicing of Aboriginal mental health within the broader health service requirements was achieved with the utilization of ORS and SRS self-report measures. While the measures have not yet been cross-cultural validated, the principles of feedback monitoring can be considered more culturally appropriate and more aligned with an Aboriginal perspectives than standardized measurement approaches. ORS items are self-rated and the results are discussed collaboratively during the session in real time. Issues can be framed within a context that is respectful of the person's cultural, spiritual, social and emotional identity, which is in line with the principles of collaborative involvement (Sundet, 2009), shared learning and mutual respect (Walker & Sonn, 2010). The experience of YouthLink Aboriginal and non-APs' is that the ORS and SRS scales serve as an important clinical tool in promoting strong communication with Aboriginal young people. The measures are well tolerated, have strong face validity, and are valued for their brevity and versatility which allows them to be used in street outreach settings. Importantly, ORS data are entirely in line with normative data collated in non-Indigenous clients (Miller, 2014; Miller, Duncan, Sorrell, & Brown, 2005) suggesting that the measure does not discriminate against Aboriginal people.

The ORS measures provide evidence of self-reported clinical improvements by Aboriginal young people, as shown by significant improvements in well-being in total and domain scores and in treatment gains, across the treatment period. A total of 65% of clients improved (35% meeting criteria for clinical recovery and 30% for clinical off-off). ORS treatment gains also correlated with improved HoNOS score. While acknowledging the limitations of these measures, ORS data were able to document improvements across the treatment period and quantify the degree of clinical change.

On the SRS, results showed that therapeutic alliance contributed significantly to improved clinical outcomes, and specifically 19% of the variance. This represents stronger effects than in non-Indigenous populations where it is estimated to account for 8% of variability in patient outcomes (Del Re et al., 2012). The current results therefore suggest that strong bonds with the therapist contributed to improved outcomes in Aboriginal youth, together with other factors such as lower baseline clinical presentation (lower acuity) and being female. The practitioner's Indigenous heritage did not contribute significantly to the model, suggesting that a strong therapeutic relationship is a stronger predictor of clinical outcomes than the practitioner's Aboriginal heritage. The current findings act to reinforce findings that non-Indigenous workers can work successfully with Aboriginal clients with adequate skills, training, support and supervision (O'Brien, Boddy, & Hardy, 2007; O'connor, Chur-Hansen, & Turnbull, 2015; Ranzijn, McConnochie, & Nolan, 2009; Reibel & Walker, 2010; Westerman, 2010).

In addition to the limitations addressed above, the results cannot be compared against other services given the paucity of reports on culturally sensitive service models. Similarly, there was no comparison group against which to assess the efficacy of this treatment model. Nonetheless, the high percentage of referrals and activations of Aboriginal youths suggests that YouthLink is well accepted by the community and that it fills an important need. Finally, this study was not designed to measure the impact of ORS and SRS feedback

measure for improving client outcomes, although there is evidence showing that such measures can increase treatment efficacy (Duncan & Murray, 2012).

Altogether, this study provides details of a service, which assists young Aboriginal people with complex mental health and psychosocial and cultural issues. Through a strong role of APs, relationships with Aboriginal communities, and service flexibility that embraces cultural meaning and knowledge, YouthLink has sought to enhance its response to the needs of Aboriginal young people. The results show that the ORS and SRS represent a valuable alternative approach to standardized measures, and show strong face validity and clinical utility. The measures are simple, brief and appropriate, and are successful in capturing clients perspectives about their treatment progress and therapeutic bond.

ACKNOWLEDGEMENTS

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