Service models for young people with alcohol and other drugs and/or co-occurring issues

LITERATURE REVIEW

Mental Health Commission (WA)

19 February 2020

nous | 20 YEARS OF INFLUENCE

Contents

1 Introduction

1.1 Purpose

Nous Group (Nous) has developed this review paper to inform the co-design of an alcohol and other drug (AOD) service in the Kimberley for young people with complex needs. The purpose of this review paper is to give insight into what effective service models for young people (aged 12-25) – particularly Aboriginal young people – with AOD and/or co-occurring issues look like. These co-occurring issues could include mental health issues, and behavioural issues linked to disability and Fetal Alcohol Spectrum Disorder (FASD). There was a focus on identifying effective service models in regional and remote contexts.

The key questions that this review paper seeks to investigate are:

- **What are common features or practices of effective service models for young people with AOD and/or co-occurring issues?**
- **How are effective service models for young people with AOD and/or co-occurring issues structured, to improve equity of access?**

1.2 Methodology

To inform this paper, Nous conducted a comprehensive search for and review of peer-reviewed literature and grey literature from local, national and international sources. Nous also conducted six interviews with service providers from Western Australia and other national jurisdictions, including the Northern Territory, New South Wales and Victoria. These interviews provided Nous with the opportunity to learn from their experiences of organisations that provide services to young people, particularly Aboriginal young people, with AOD and/or co-occurring issues. We would like to thank and acknowledge the contributions of the organisations listed in Table 1, who shared their time and knowledge with the Nous team.

Table 1 | Organisation interview schedule

Organisation	Location
headspace Pilbara	Western Australia
BushMob	Northern Territory
Volatile Substance Use Program	Northern Territory
Junaa Buwa! Centre for Youth Wellbeing	New South Wales
Bunjilwarra	Victoria
Youth Support and Advocacy Service	Victoria

1.3 Limitations

A preliminary review of the literature revealed that there is limited information available in the public domain on service models for Aboriginal young people with AOD and/or co-occurring issues that operate within regional and remote contexts. This is reflected in the findings of similar reviews already undertaken. For example, the Sax Institute were commissioned by the New South Wales Ministry of Health to identify the most effective interventions to reduce the risk of AOD related harm among at-risk Aboriginal young people. However, it was found that they needed to widen the scope of their initial search.[1] Similarly, Lee et al. conducted a detailed search for peer-reviewed journal articles that evaluated interventions targeting young Indigenous Australians aged 8-25 with the primary aim of reducing substance use, and concluded that there is a **"pressing need for more evidence to guide efforts to address substance use among young Indigenous Australians."**[2]

Consequently, the scope of this literature review was widened to also include:

- **service models for non-Aboriginal young people with AOD and/or co-occurring issues**
- **service models for Aboriginal young people with other health issues (e.g. mental or sexual health)**
- **service models for Aboriginal people with AOD and/or co-occurring issues**
- **service models for young people with AOD and/or co-occurring issues from Indigenous nationalities in other relevant countries (e.g. New Zealand or Canada).**

While literature on service models that operated in regional and remote contexts was preferred, literature on service models that operated in metropolitan areas was not excluded.

1.4 Overview of key findings

The literature review and interviews with interjurisdictional service providers revealed a **range of features, principles and practices** common to effective service models for young people with AOD and/or co-occurring issues. These features have been organised under **four pillars of best practice,** described in Table 2 overleaf.

[1] C M Doran, I Kinchin, R Bainbridge, J McCalman & A Shakeshaft, Effectiveness of alcohol and other drug interventions in at-risk Aboriginal youth, Sax Institute, 2017.
[2] K S Lee, M Jagtenberg, C M Ellis & K M Conigrave, Pressing need for more evidence to guide efforts to address substance use among young Indigenous Australians, Health Promotion Journal of Australia, 2013.

Table 2 | Overview of key findings

Pillar	Description of the pillar	Features
ACCESSIBLE	Effective service models are **accessible** to all young people within their jurisdiction without discrimination.	**Effective service models:** • Provide flexibility in how services can be accessed by and delivered to young people • Create spaces that are safe and welcoming to young people • Respond to young people looking to access the service in a timely manner • Adopt various approaches to ensure they are accessible to young people who do not live nearby
ACCEPTABLE	Effective service models provide Aboriginal young people, and their families and carers with a culturally safe environment and experience, and are **acceptable** to the Aboriginal communities they intend to serve.	**Effective service models:** • Are designed in partnership with local communities to ensure they reflect local norms and are locally owned and led • Adopt a warm referral approach to build trust within the community • Embed culture in all aspects of the service model • Are delivered by culturally competent organisations
CAPABLE	Effective service models have enough staff, with the right **capability** and capacity to meet the needs of young people effectively and efficiently.	**Effective service models:** • Employ capable staff who understand the needs of young people and how to meet them • Collaborate with other services to leverage existing capability and capacity
QUALITY	Effective service models adopt practices that are based on the best available evidence in order to deliver high **quality** outcomes for young people.	**Effective service models:** • Are comprehensive and integrated to meet the needs of the young person as a whole • Engage families and carers in young people's care, where possible and appropriate • Provide appropriate aftercare to help young people exiting the service to sustain positive outcomes

The following sections expand on features that are considered 'best practice' for each of the pillars. These features are supplemented by case studies that provide examples of organisations that have implemented features of 'best practice', and the outcomes these features achieved.

2 Pillars of best practice

2.1 Accessible

ACCESSIBLE

Effective service models are accessible to all young people within their jurisdiction without discrimination.

Effective service models:

- Provide flexibility in how services can be accessed by and delivered to young people
- Create spaces that are safe and welcoming to young people
- Respond to young people looking to access the service in a timely manner
- Adopt various approaches to ensure they are accessible to young people who do not live nearby

2.1.1 Provide flexibility in how services can be accessed by and delivered to young people

The literature reveals that flexibility in service delivery is critical for young people with AOD issues. This is because young people who access services for AOD issues differ significantly in a range of ways, including:

- **Comorbid diagnoses:** Comorbidity is highly prevalent among young people with AOD issues. Armstrong and Costello identified that around 60 per cent of children and young people with an AOD issue had a comorbid diagnosis.[3] Comorbid diagnoses range significantly, and often require different approaches.
- **Developmental stage:** The term '*young people*' encompasses a broad age cohort (often from 12 to 25 years) and therefore different (and complex) developmental stages and needs. As identified by Birelson and Vance, 12-17-year-olds have different needs to 18-25-year-olds, and services that target the entire cohort without providing flexibility can risk treating younger adolescents as more independent and autonomous than they really are.[4]
- **Risk factors:** Young people with AOD and/or co-occurring issues commonly face a range of other risk factors such as family conflict and violence, homelessness, education and learning difficulties, and other indicators of socio-economic disadvantage, that can impact their ability to access and participate in services.[5] Research shows that if service models do not address these other risk factors *as well as* a young person's AOD and/or co-occurring issues, they are more likely to fail.[6] This is discussed further in Section 2.4.1.

To address young people's unique and varying needs, **effective service models provide flexibility in how young people can access the service, and how and what services are delivered**.[7] Flexibility and providing

[3] T D Armstrong & E J Costello, Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity, Journal of Consulting and Clinical Psychology, 2002.
[4] P Birelson & A Vance, Developing the 'youth model' in mental health services, Australasian Psychiatry, 2008.
[5] P Crane, J Buckley & C Francis, A framework for youth alcohol and other drug practice, Dovetail, 2012; A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[6] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[7] C Marel, K L Mills, R Kingston, K Gournay, M Deady, F Kay-Lambkin, A Baker & M Teesson, Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings, UNSW Australia, 2016.

choice are also central components of a trauma-informed approach – which is vital to supporting young people with AOD and/or co-occurring issues.[8]

Effective service models adopt a flexible approach to how young people can access the service, providing multiple entry points, including options for drop-ins and self-referral.[9] A study by headspace revealed that for many young people, "the standard appointment-based 9 to 5 approach was [...] not appropriate."[10] To overcome this, effective service models provide extended opening hours, after 5pm and on the weekend.[11] In addition to this, they maintain an 'open door policy', giving young people the option to re-enter after graduating or voluntarily leaving the service, if required.[12]

"We build into the culture that this is a resource for young Aboriginal people. You can return, you are welcome. We have a lot of success with second and third admissions."

- Interjurisdictional service provider

Research also identifies that flexibility in how and what services are delivered is important, with Doran et al. reporting that "an intervention needs to be flexible enough to meet the needs of individual clients and use various delivery modes (... mentoring approaches, motivational interviewing or [cognitive behavioural therapy] techniques)."[13] For example, young people with FASD may have language difficulties or trouble thinking in abstract terms;[14] consequently, McLean, McDougall and Russell asserted that for these young people, "highly abstract and verbal counselling approaches should be replaced by concrete goals set with the assistance of visual cues and explicit skills coaching."[15] An interjurisdictional service provider identified that the diversity in their cohorts can be extremely challenging, and that they manage it by assessing the needs of each young person and dividing cohorts into smaller groups that share similar characteristics. While the entire cohort would all participate in general activities such as life skills training, they would be split up into individuals and small groups for more specific activities such as psychoeducation sessions. Another interjurisdictional service provider identified that at the beginning of each day at the residential rehabilitation centre, all the young people and staff have a group conversation to set up what they want to do and achieve that day.

BushMob – a Northern Territory-based service for young people aged 12-25 with AOD issues, described in Case Study 7 – is an example of a service that provides young people with flexibility. The BushMob service model is based on the core principle of providing young people with choice and flexibility – while still meeting their developmental need for boundaries. **BushMob does this by developing individual case plans for each young person, and enabling young people to move through the program individually**. While some elements of the program are not negotiable, there is significant flexibility in others. BushMob "[works] with young people where they are at. We will nurture them through, within the range of their tolerance."

[8] Western Sydney Primary Health Network, Investigating Alcohol and Other Drug Service Needs of Young People in Western Sydney.
[9] B Cole, Key principles underpinning youth mental health models, Orygen, 2018; S E Hetrick, A P Bailey, K E Smith, A Malla, S Mathias, S P Singh, A O'Reilly, S K Verma, L Benoit, T M Fleming, M R Moro, D J Rickwood, J Duffy, T Eriksen, R Illback, C A Fisher & P D McGorry, Integrated (one-stop shop) youth health care: best available evidence and future directions, Medical Journal of Australia, 2017.
[10] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Heath Foundation, 2015.
[11] S E Hetrick, A P Bailey, K E Smith, A Malla, S Mathias, S P Singh, A O'Reilly, S K Verma, L Benoit, T M Fleming, M R Moro, D J Rickwood, J Duffy, T Eriksen, R Illback, C A Fisher & P D McGorry, Integrated (one-stop shop) youth health care: best available evidence and future directions, Medical Journal of Australia, 2017.
[12] B Cole, Key principles underpinning youth mental health models, Orygen, 2018.
[13] C M Doran, I Kinchin, R Bainbridge, J McCalman & A Shakeshaft, Effectiveness of alcohol and other drug interventions in at-risk Aboriginal youth, Sax Institute, 2017.
[14] National Organisation for Fetal Alcohol Spectrum Disorder, FASD Characteristics across the Lifespan [fact sheet].
[15] S McLean, S McDougall & V Russell, Supporting children living with fetal alcohol spectrum disorders: Practice principles, Australian Institute of Family Studies, 2014.

"Autonomy and flexibility in young people's days is very important."

- Interjurisdictional service provider

There is also research that posits that the duration of a young person's care should be flexible, and vary depending on the severity of their AOD and/or co-occurring issues, and the risks they face.[16] This is an approach adopted by Bunjilwarra, a residential rehabilitation and healing service for Aboriginal young people aged 16-25 in Victoria. Young people are able to stay at Bunjilwarra between eight and 13 weeks, depending on their goals and needs.[17] While some providers recommend tailoring the duration of care to the young person's needs, some studies have found that the length of treatment is directly linked to the reduction of AOD use over time, and that effective treatment **requires a minimum of three months**.[18] This was echoed by BushMob, who identified that they "want to invite young people to establish a narrative that will enable them to make sustained choice. To do that, you often **need longer than three months in therapy.**" For young people who have more complex needs, a much longer duration could be required.[19] For residential bed-based services, the young person does not necessarily need to stay at the facility for the entire duration of their treatment. The literature consistently reinforces the importance of aftercare as a critical mechanism in making sure young people receive the duration of treatment they need.

Despite the importance of treatment duration on the outcomes of treatment, there should be a place for brief interventions as part of a service model for young people. Young people with complex needs are more likely to attend services intermittently and in brief bursts.[20] Thus, Bruun and Mitchell argued that service models that only provide long-term interventions may waste opportunities to reach the young people who require the most help.[21]

2.1.2 Create spaces that are safe and welcoming to young people

It is widely recognised that how a space is designed and set up can have a significant impact on how it is experienced.[22] In various studies, young people consistently said that services need to create spaces that are "youth-friendly,"[23] "safe and comfortable,"[24] "relaxed and welcoming,"[25] and "not visibly clinical,"[26] to encourage them to access the service, and to keep them engaged.[27]

[16] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[17] Bunjilwarra Koori Youth Alcohol & Drug Healing Service, http://bunjilwarra.org.au/.
[18] S Schuetz & M Berry, Review of best practice around behaviour change in young offenders with alcohol and other drug issues, Caraniche for Australian Community Support Organisation, 2009.
[19] S Schuetz & M Berry, Review of best practice around behaviour change in young offenders with alcohol and other drug issues, Caraniche for Australian Community Support Organisation, 2009.
[20] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[21] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[22] P Crane, C Francis & J Buckley, Practice strategies and interventions youth alcohol and drug good practice guide, Dovetail, 2013.
[23] S E Hetrick, A P Bailey, K E Smith, A Malla, S Mathias, S P Singh, A O'Reilly, S K Verma, L Benoit, T M Fleming, M R Moro, D J Rickwood, J Duffy, T Eriksen, R Illback, C A Fisher & P D McGorry, Integrated (one-stop shop) youth health care: best available evidence and future directions, Medical Journal of Australia, 2017.
[24] T Szirom, D King & K Desmond, Barriers to service provision for young people with presenting substance misuse and mental health problems, SuccessWorks, 2004.
[25] T Szirom, D King & K Desmond, Barriers to service provision for young people with presenting substance misuse and mental health problems, SuccessWorks, 2004.
[26] S E Hetrick, A P Bailey, K E Smith, A Malla, S Mathias, S P Singh, A O'Reilly, S K Verma, L Benoit, T M Fleming, M R Moro, D J Rickwood, J Duffy, T Eriksen, R Illback, C A Fisher & P D McGorry, Integrated (one-stop shop) youth health care: best available evidence and future directions, Medical Journal of Australia, 2017.
[27] K Muir, A Powell & S McDermott, 'They don't treat you like a virus': youth-friendly lessons from the Australian National Youth Mental Health Foundation, Health and Social Care in the Community, 2012.

> *The first time I [came to headspace] I was like really nervous and paranoid, but it looked like a real kid friendly place and that put me at ease [...] It's not like other places. It's got young people here, there are things on the walls [...] You won't get that at another doctors surgery or where other counsellors are.*

Source: K Muir, A Powell & S McDermott, 'They don't treat you like a virus': youth-friendly lessons from the Australian National Youth Mental Health Foundation, Health and Social Care in the Community, 2012.

A study of enablers and barriers to young people accessing services reported that "the waiting room needed to be welcoming, safe and comfortable. To be welcoming of all young people, having art and poster work that acknowledged the diverse backgrounds of young people [...] was needed."[28] Aboriginal young people interviewed for this study welcomed displays of Aboriginal and Torres Strait Islander culture – such as art work and the Aboriginal and Torres Strait Islander flags – throughout the centre. This study also identified that "therapy rooms that did not look like a typical clinical environment, and options for services to take place outside the usual clinical rooms, including outside, [...] could help."[29] The literature provides some guidance on how to design safe and welcoming spaces; however, young people often have different ideas about what a youth-friendly interior design should look like.[30] For example, although some young people prefer private waiting areas, others prefer ones that are more open.[31] **To ensure that the space is safe and welcoming to the young people who will be using it, those young people need to be involved in the design process**, as shown in Case Study 1 below.[32]

> *When you listen to children and young people, innovative ideas can be generated. It was up to us to listen and work out how to respond to those ideas to put them in action.*

Source: Commissioner for Children and Young People Western Australia, Kids on Country program – Coolgardie, Engaging with Aboriginal Children and Young People Toolkit https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kids-on-country-program-coolgardie/.

[28] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Heath Foundation, 2015.
[29] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Heath Foundation, 2015.
[30] K Muir, A Powell & S McDermott, 'They don't treat you like a virus': youth-friendly lessons from the Australian National Youth Mental Health Foundation, Health and Social Care in the Community, 2012.
[31] D Rickwood, G Anile, N Telford, K Thomas, A Brown & A Parker, Service Innovation Project Component 1: Best Practice Framework, headspace National Youth Mental Health Foundation, 2014.
[32] T Szirom, D King & K Desmond, Barriers to service provision for young people with presenting substance misuse and mental health problems, SuccessWorks, 2004.

Case Study 1 | The Youthie

THE YOUTHIE

Tamworth Regional Council, New South Wales

Approach

The Youthie is a drop-in youth centre for young people aged 12-18 offering a variety of healthy, social, recreational, arts and cultural activities. The Youthie provides these activities in a safe, AOD-free environment.[33]

It is located in a regional, low socioeconomic community which houses the majority of the region's Aboriginal and Torres Strait Islander population, has the highest concentration of social housing, and has a considerably high incidence of crime. Additionally, 25 per cent of the community is aged between ten-24 years old.[34]

The need for a purpose-built youth centre emerged as a recurring priority through extensive research and analysis conducted in the community over a four-year period. The planning and designing of the centre was conducted in partnership with young people and the community. For example, design workshops were conducted with young people and community members in which participants generated concept designs and identified preferred design elements. Further to this, young people were invited to be part of creating a personalised physical environment for the centre. An Indigenous artist was employed to work with the community to create a unique setting that respected local young people and their contributions, and that reflected the local Indigenous culture.[35]

Outcomes

The design process of The Youthie is highlighted in the literature as "a noteworthy example of comprehensive youth engagement in practice."[36] Involving young people in the design of The Youthie was critical to generating a supportive youth centre that meets the needs of young people and the community.[37]

The Youthie continues to provide an attractive and accessible environment for young people with activities of interest to them today.

The attitudes and behaviours of staff are also important in creating safe and welcoming spaces. Research by Muir, Powell and McDermott identified that for many young people, it was more important to have capable staff who made them feel comfortable, than the 'look' of the service.[38] One of the key barriers to young people accessing services is a fear of being judged or misunderstood. Therefore, it is important that staff are friendly, non-judgemental and respectful.[39] The presence of open and accepting staff is particularly critical for Aboriginal young people, and young people from other vulnerable groups (e.g. LGBTQ+ young people) who might have additional concerns of being judged or not accepted.[40]

[33] Tamworth Regional Council, The Youthie, https://www.tamworth.nsw.gov.au/Community/Tamworth-Regional-Youth-Centre/The-Youthie.
[34] K Dimoulias, At the 'center': Young people's involvement in youth centers from design to usage, Designing Cities with Children and Young People: Beyond Playgrounds and Skate Parks, K Bishop & L Corkery (eds.), 2017.
[35] K Dimoulias, At the 'center': Young people's involvement in youth centers from design to usage, Designing Cities with Children and Young People: Beyond Playgrounds and Skate Parks, K Bishop & L Corkery (eds.), 2017.
[36] K Dimoulias, At the 'center': Young people's involvement in youth centers from design to usage, Designing Cities with Children and Young People: Beyond Playgrounds and Skate Parks, K Bishop & L Corkery (eds.), 2017.
[37] K Dimoulias, At the 'center': Young people's involvement in youth centers from design to usage, Designing Cities with Children and Young People: Beyond Playgrounds and Skate Parks, K Bishop & L Corkery (eds.), 2017.
[38] K Muir, A Powell & S McDermott, 'They don't treat you like a virus': youth-friendly lessons from the Australian National Youth Mental Health Foundation, Health and Social Care in the Community, 2012.
[39] S E Hetrick, A P Bailey, K E Smith, A Malla, S Mathias, S P Singh, A O'Reilly, S K Verma, L Benoit, T M Fleming, M R Moro, D J Rickwood, J Duffy, T Eriksen, R Illback, C A Fisher & P D McGorry, Integrated (one-stop shop) youth health care: best available evidence and future directions, Medical Journal of Australia, 2017.
[40] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.

2.1.3 Respond to young people looking to access the service in a timely manner

Research identifies that young people's motivation to seek help "can often be [...] fluctuating or fragile,"[41] and needs to be capitalised on in a timely manner. Long wait-times were consistently identified by young people in various studies as a barrier to service access.[42] As noted by participants involved in the co-design of headspace Pilbara, described in Case Study 3, for young people, **"service responses have to be immediate, or they may not happen at all."**[43]

Effective service models adopt a highly responsive approach to young people looking to access the service by minimising wait times, where possible. Being able to access a service when it is needed, and when the young person was ready to do so, is clearly a facilitator of engagement with services.[44] This was echoed by Hetrick et al. who reported that, "satisfaction [with youth mental health services] would be improved if a more timely service (shorter wait time) could be provided."[45] Table 3 below identifies several strategies to reduce wait times.

Importantly, there are a range of factors that impact wait times, including workforce capacity and the size and layout of physical settings, that cannot always be addressed. A survey by headspace found that 90 per cent of headspace centres reported that "workforce limitations affect their ability to meet demand," while about 60 per cent reported that "the physical setting of their centre (size, layout) limited capacity to meet demand."[46] Where these factors cannot be addressed to reduce wait times, it is important for services to keep young people engaged and motivated while they are waiting to access the service. Long wait lists and "a lack of support offered whilst on the waitlist" was identified by the Commissioner for Children and Young People of Western Australia as an important issue in the service system for children and young people in Western Australia.[47] Table 3 also identifies several strategies employed by effective service models to ensure young people are supported while waiting for services.

[41] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.
[42] N Van Dyke, C Maddern, R Walker & T Reibel, Young People's Experiences with Health Services: Final Report, Commissioner for Children and Young People Western Australia, 2014; Orygen, the National Centre of Excellence in Youth Mental Health, Youth Mental Health Policy Briefing: A better fit: Improving the access and acceptability of youth mental health services; T Szirom, D King & K Desmond, Barriers to service provision for young people with presenting substance misuse and mental health problems, SuccessWorks, 2004.
[43] S Garwood, J Sercombe, & P Boldy, Environmental scan and insights report for the preparation of a headspace service model for the Pilbara region of Western Australia, AnglicareWA, 2017.
[44] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.
[45] S E Hetrick, A P Bailey, K E Smith, A Malla, S Mathias, S P Singh, A O'Reilly, S K Verma, L Benoit, T M Fleming, M R Moro, D J Rickwood, J Duffy, T Eriksen, R Illback, C A Fisher & P D McGorry, Integrated (one-stop shop) youth health care: best available evidence and future directions, Medical Journal of Australia, 2017.
[46] Headspace National Youth Mental Health Foundation, Increasing demand in youth mental health: A rising tide of need, 2019.
[47] C Pettit, Review of the Clinical Governance of Public Mental Health Services in Western Australia, Commissioner for Children and Young People Western Australia, 2019.

Table 3 | Strategies to reduce wait times and support young people waiting for services [48]

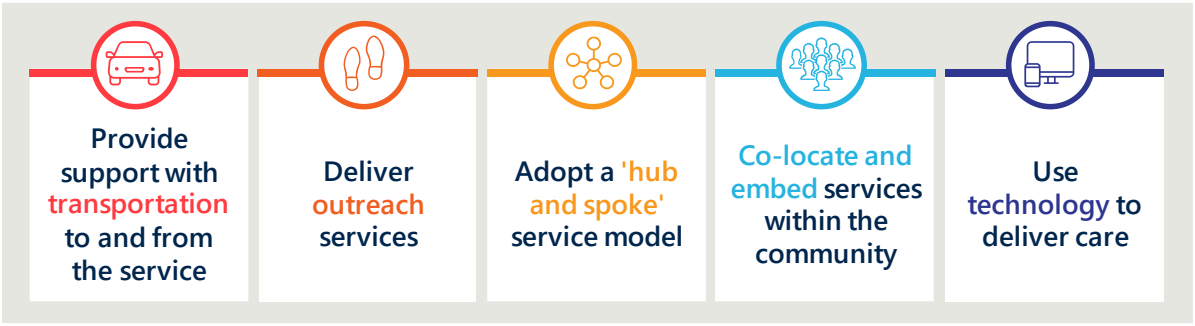
STRATEGIES TO REDUCE WAIT TIMES	STRATEGIES TO SUPPORT YOUNG PEOPLE WAITING
Monitoring cancellations to maximise attendance from wait lists	Providing support to young people by phone or an online service between sessions
Referring young people to alternative services	Facilitating group or peer support activities
Arranging student placements to increase staffing capacity	Delivering brief intervention therapy modules to engage young people between sessions
Quickly filling workforce vacancies	Giving young people self-help information and resources

2.1.4 Adopt various approaches to ensure they are accessible to young people who do not live nearby

The literature identifies that young people residing in regional and remote communities are more likely to engage in risky alcohol consumption and illicit drug use, and have lower access to treatment and support services than their metropolitan counterparts.[49] This is due to factors such as distance, financial and time costs, and transport availability.[50] A review of headspace centres found that as few as 1 per cent of those in remote Australia live within 30 kilometres of a centre.[51]

Research reveals that there are five approaches which are adopted by effective service models in regional and remote locations to ensure they are accessible for young people with AOD and/or co-occurring issues who do not live near to the service. These approaches are set out in Figure 1 below, and detailed in the sections that follow.

Figure 1 | Best practice service delivery models for youth services in regional and remote locations



Provide support with transportation to and from the service

It is well-recognised that transport is a major barrier for young people living in regional and remote areas in accessing health services. Various studies have found that a lack of access to affordable transport is an

[48] Headspace National Youth Mental Health Foundation, Increasing demand in youth mental health: A rising tide of need, 2019.
[49] Australian Institute of Health and Welfare, Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment, 2016-17; E Humphery, C McDonald, R Clough, O Griffiths, L Peake & I Zappe, Highway to health: better access for rural, regional and remote patients, Parliament of Australia, Canberra, 2007.
[50] Australian Institute of Health and Welfare, Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment, 2016-17; E Humphery, C McDonald, R Clough, O Griffiths, L Peake & I Zappe, Highway to health: better access for rural, regional and remote patients, Parliament of Australia, Canberra, 2007.
[51] Orygen, Inquiry into the accessibility and quality of mental health services in rural and remote Australia, The University of Melbourne, 2018.

issue for most young people.[52] Young people who are particularly vulnerable are those without a strong family support system, their own transport or income to pay for transport. The result of this barrier is that young people are rarely able to access services that are not near where they live. For example, most young people attending a headspace centre live within ten kilometres of the centre that they attend.[53]

For young people who do not live near to services, transport support is a commonly used component of service models that aim to lower barriers to access.[54] Research shows that transport support is particularly relevant for young people who are Aboriginal, have AOD problems, or are homeless.[55] A 2018 report by the Australian Government's Community Affairs References Committee found that in recognition of this need, "some service providers are working to offer transport as part of their service."[56] For example, the Kununurra Waringarri Aboriginal Corporation, which offers a range of services including AOD services, informed the Committee that "a lot of the people we work with don't have vehicles, so we need to go out, pick them up and bring them into town so that they can go to… appointments."[57] Similarly, a headspace service provider shared that "transport is a big [barrier] across the board so to assist with that I spoke to the Department of Transport and got $20,000 worth of funding to pay for taxis for our young people around this area to come in, so that's lot better."[58]

Deliver outreach services

Delivering services via outreach has been found to be an effective method of reaching 'hard to reach' young people who are unlikely to access a service without an introduction in a space where they feel safe and comfortable.[59] Research identifies that outreach services are particularly "valued by young people from Aboriginal and Torres Strait Islander communities, where [they] could help with transport problems and other inhibitors to attending at the centre."[60]

Outreach models of service are used extensively by headspace services to provide care to young people living in regional and remote areas. For example, the headspace centre in Warwick, a regional town in Queensland which is 130 kilometres outside of Brisbane, provides outreach services to Stanthorpe, another regional town in Queensland nearby.[61] An independent evaluation of headspace by the University of New

[52] J Anderson, E Howarth, M Vainre, P B Jones & A Humphrey, A scoping literature review of service-level barriers for access and engagement with mental health services for children and young people, Children and Youth Services Review, 2017; G Currie, F Gammie, C Waingold, D Paterson & D Vandersar, Rural and Regional Young People and Transport: Improving access to transport for young people in rural and regional Australia, National Youth Affairs Research Scheme, 2005; D Aisbett, C P Boyd, K J Francis, K Newnham & K Newnham, Understanding barriers to mental health service utilization for adolescents in rural Australia, Rural Remore Health, 2007.
[53] D Rickwood, M Webb, V Kennedy & N Telford, Who are the Young People Choosing Web-based Mental Health Support? Findings From the Implementation of Australia's National Web-based Youth Mental Health Service, eheadspace, JMIR Mental Health, 2016.
[54] N R Velaga, J D Nelson, S D Wright & J H Farrington, The Potential Role of Flexible Transport Services in Enhancing Rural Public Transport Provision, Journal of Public Transportation, 2012; A Dew, K Bulkeley, C Veitch, A Bundy, G Gallego, M Lincoln, J Brentnall & S Griffiths, Addressing the barriers to accessing therapy services in rural and remote areas, Disability and Rehabilitation, 2012.
[55] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.
[56] J Radcliffe, P Holder, M Morrison, A Kohen, K Gauthier, H Dibley, M Kirby, K McGarry, M Finch & C Stewart, Accessibility and quality of mental health services in rural and remote Australia, Parliament of Australia, 2018.
[57] J Radcliffe, P Holder, M Morrison, A Kohen, K Gauthier, H Dibley, M Kirby, K McGarry, M Finch & C Stewart, Accessibility and quality of mental health services in rural and remote Australia, Parliament of Australia, 2018.
[58] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.
[59] F Hilferty, R Cassells, K Muir, A Duncan, D Christensen, F Mitrou, G Gao, A Mavisakalyan, K Hafeskost, Y Tarverdi, H Nguyen, C Wingrove & I Katz, Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program, UNSW Australia, 2015.
[60] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.
[61] F Hilferty, R Cassells, K Muir, A Duncan, D Christensen, F Mitrou, G Gao, A Mavisakalyan, K Hafeskost, Y Tarverdi, H Nguyen, C Wingrove & I Katz, Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program, UNSW Australia, 2015.

South Wales prepared for the Australian Department of Health, suggested that an 'outreach' model of service delivery should be adopted across all headspace centres.[62]

> *The increased provision of outreach services was the second most clearly identified strategy for enhancing headspace services [in regional and remote communities].*

Source: F Hilferty, R Cassells, K Muir, A Duncan, D Christensen, F Mitrou, G Gao, A Mavisakalyan, K Hafeskost, Y Tarverdi, H Nguyen, C Wingrove & I Katz, Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program, UNSW Australia, 2015.

There is also research which suggests that delivering outreach services can be cheaper than supporting individuals to travel to services. Gruen, Weeramanthri and Bailie found that on average, it cost less to deliver consultations through the Specialist Outreach Service (AU$277), than to bring the same individuals to the outpatient clinic in Darwin (AU$450).[63]

However, while delivering outreach services can be an effective way of overcoming transportation issues, there are a range of challenges associated with this mode of service delivery, particularly where it involves flying-in-and-flying-out (FIFO) or driving-in-and-driving-out (DIDO). Delivering outreach services can involve travelling long distances and working long hours, and staff can feel isolated. This can lead to staff burnout and ultimately, issues with recruiting and retaining staff.[64] Additionally, research suggests that "outreach workers are not usually considered with the same regard as community insiders,"[65] and that as 'outsiders', they "often have little local knowledge and lack community trust."[66] As a consequence, Hanley concluded that: **"[FIFO and DIDO outreach services] should be seen not as a replacement for local health care, but as part of the necessary compromise between the tyranny of distance and equity of access to health services."**[67]

Adopt a 'hub and spoke' service model

A commonly used service model for overcoming the 'tyranny of distance' is the 'hub and spoke' service model. A 'hub and spoke' model arranges service delivery units into a network consisting of a 'hub' that provides a full range of services in a densely populated area (e.g. major towns or cities), and secondary units called 'spokes' that may provide a more limited range of services in more remote areas.[68] People attending spokes who are found to require more intensive services are routed to the hub for treatment.[69] This approach has been adopted by the Remote Alcohol and Drug Interventions and Outcomes (RADIO)

[62] F Hilferty, R Cassells, K Muir, A Duncan, D Christensen, F Mitrou, G Gao, A Mavisakalyan, K Hafeskost, Y Tarverdi, H Nguyen, C Wingrove & I Katz, Is headspace making a difference to young people's lives? Final report of the independent evaluation of the headspace program, UNSW Australia, 2015.
[63] R L Gruen, T S Weeramanthri & R S Bailie, Outreach and improved access to specialist services for indigenous people in remote Australia: the requirements for sustainability, Journal of Epidemiology & Community Health, 2002.
[64] N Arefadib & T Moore, Reporting the Health and Development of Children in Rural and Remote Australia, The Centre for Community Child Health at the Royal Children's Hospital and the Murdoch Children's Research Institute, 2017.
[65] R Wilson & K Ushner, Rural nurses: a convenient co-location strategy for the rural mental health care of young people, Journal of Clinical Nursing, 2015.
[66] L Roufeil & K Battye, Effective regional, rural and remote family relationships service delivery, Australian Institute of Family Studies, 2008, https://aifs.gov.au/cfca/publications/effective-regional-rural-and-remote-family-and-relationship.
[67] P Hanley, The FIFO conundrum, The Australian Journal of Rural Health, 2012.
[68] J Elrod & J Fortenberry Jr., The hub-and-spoke organization design: an avenue for serving patients well, BMC Health Services Research, 2017.
[69] J Elrod & J Fortenberry Jr., The hub-and-spoke organization design: an avenue for serving patients well, BMC Health Services Research, 2017.

service in Queensland, which delivers a range of AOD services to young people, primarily Aboriginal and Torres Strait Islander young people. It is described below in Case Study 2.

Case Study 2 | Remote Alcohol and Drug Interventions and Outcomes

REMOTE ALCOHOL AND DRUG INTERVENTIONS AND OUTCOMES (RADIO)

Youth Empowered Towards Independence (YETI), Queensland

Approach

RADIO is a 'hub and spoke' style program conceived from the need to provide a holistic service to young people living in remote communities that gives them access to information, referrals, AOD counselling, and coordinated therapeutic case management.

In the first year, RADIO was delivered in three sites. Key local remote services signed sub-contract agreements with YETI to deliver the program within each community (the spokes), namely the Cooktown District Community Centre, Weipa Community Care and NPA Family and Community Services ATSI Corporation. Each sub-contract organisation advertised, interviewed and successfully recruited local people to staff the roles of the RADIO AOD clinicians. Workers attended orientation, which involved participating in a range of activities on-site at YETI (the hub).

All of the communities where RADIO is located are demographically and culturally unique – with 78 per cent of RADIO participants coming from Aboriginal and Torres Strait Islander backgrounds – and require individualised approaches to staff development and service delivery.[70]

Outcomes

YETI's most recent annual report identifies that since commencement, "RADIO [has] continued to gather momentum with a steady growth of client numbers, continued capacity training, increasing levels of worker confidence building and the development of many unique activities created as diversionary measures for clients."[71] One client described the program as "very supportive, helpful and good to give advice."[72] As of 2017-2018, 102 individual young people had contact with the program, and there had been 1,233 individual contacts in total.[73]

The literature identifies that 'hub and spoke' service models generally enable those living in remote areas to access care of the same quality as people living in more densely populated areas. Research by Weber et al. found that for children with cystic fibrosis, there was no difference in lung function outcomes achieved by children who were treated at the central academic facility (the hub), and those who were treated at the outreach clinics that are supported by the central academic facility (the spokes).[74] Another benefit of these models is increased efficiency, achieved by reducing costly duplication of services across several sites.[75]

However, there are also limitations to the 'hub and spoke' service model. One limitation is 'spoke overextension', which is at risk of occurring when the service model is working across a highly dispersed region. If spokes are positioned too far from the hub, the hub will be unable to provide adequate support and service failures may occur.[76] Another limitation is the impact of a dispersed workforce. Staff may feel isolated or resent the lack of autonomy to operate as they see fit at the spokes, leading to dissatisfaction and ultimately, reduced staff retention.[77] Finally, these service models depend on transportation systems

[70] Youth Empowered Towards Independence, Annual Report 2017-2018.
[71] Youth Empowered Towards Independence, Annual Report 2017-2018.
[72] Youth Empowered Towards Independence, Annual Report 2017-2018.
[73] Youth Empowered Towards Independence, Annual Report 2017-2018.
[74] H Weber, P Robinson & R Ehrlich, Do children with cystic fibrosis receiving outreach care have poorer clinical outcomes than those treated at a specialist cystic fibrosis centre?, Australian Journal of Rural Health, 2017.
[75] J Elrod & J Fortenberry Jr., The hub-and-spoke organization design: an avenue for serving patients well, BMC Health Services Research, 2017.
[76] J Elrod & J Fortenberry Jr., The hub-and-spoke organization design: an avenue for serving patients well, BMC Health Services Research, 2017.
[77] J Elrod & J Fortenberry Jr., The hub-and-spoke organization design: an avenue for serving patients well, BMC Health Services Research, 2017.

being in place between the hubs and spokes to enable people to realise the entire continuum of care offered by the service model.[78]

Co-locate or embed services within the community

Research reveals that co-locating or embedding services with other services can reduce distances required to travel to access services, and in turn encourage people to access them.[79] For example, Wilson conducted a study looking at how young people with mental health problems from rural areas could be assisted to access help at an early point in their mental health decline. Her primary recommendation was that co-locating nurses in rural communities in places that are convenient to access for young people, like police stations, schools and community organisations, would make it more likely for young people to access those services.[80]

Co-locating services can also help overcome other barriers to service entry, including the stigma associated with accessing mental health and AOD services.[81] A study by headspace found that young people from Aboriginal and some culturally and linguistically diverse backgrounds have "a heightened sense of shame attached to not being able to deal with your personal problems yourself and an expectation of keeping problems within your family."[82] Participants involved in co-design workshops to design headspace Pilbara – which is described in Case Study 3 – **identified "the value of young people being able to engage with headspace workers in a less direct-manner, through embedding service provision […] within services that experience a strong positive reputation with young people."** [83] Schools, youth centres, and social and emotional wellbeing services were identified as important opportunities for embedding headspace personnel.

While there are clear advantages to co-locating or embedding services within remote communities, there are also some risks. Where one of the organisations involved in the arrangement has signed the lease for the premises, that organisation carries substantial risk and there is the potential for power imbalances to arise. Additionally, if one of the agencies or organisations involved in the arrangement leaves, it could be challenging to find a replacement, potentially leaving a community without two previously critical services.[84]

[78] J Elrod & J Fortenberry Jr., The hub-and-spoke organization design: an avenue for serving patients well, BMC Health Services Research, 2017.
[79] D Moran, C Hall & A McVittie, Benefits and Costs of Co-locating Services in Rural Scotland, Scottish Executive Environment and Rural Affairs Department, 2007.
[80] R Wilson & K Ushner, Rural nurses: a convenient co-location strategy for the rural mental health care of young people, Journal of Clinical Nursing, 2015.
[81] R Wilson & K Ushner, Rural nurses: a convenient co-location strategy for the rural mental health care of young people, Journal of Clinical Nursing, 2015.
[82] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.
[83] S Garwood, J Sercombe, & P Boldy, Environmental scan and insights report for the preparation of a headspace service model for the Pilbara region of Western Australia, AnglicareWA, 2017.
[84] Community Door, Co-location, https://communitydoor.org.au/collaboration/co-location.

Case Study 3 | headspace Pilbara

HEADSPACE PILBARA

Anglicare, Western Australia

Approach

headspace Pilbara is Australia's first innovative headspace service, providing outreach services to young people aged 12-25 through co-location with Pilbara community, education and health services. headspace Pilbara support young people to enhance their wellbeing by providing mental health and AOD services, vocational and education services, and primary and sexual health services.[85]

headspace Pilbara youth workers are based in Newman, Port Hedland and Karratha, but the service model has been designed to be flexible to reach young people seeking help and support across the entire Pilbara region. In each site, headspace Pilbara have a home base, are co-located in youth centres, and have youth workers embedded in schools.[86]

Outcomes

As of 2019, headspace Pilbara had delivered more than 450 individual sessions to young people, hosted 19 types of group sessions for young people, operated from over 20 co-located and embedded venues, and travelled more than 100,000 kilometres to deliver on the service model. Overall, headspace Pilbara engaged with over 6,500 young people and community members via workshops, trainings, events, activities and programs between May 2018 and September 2019.

While the headspace Pilbara service model is still very new, there is early anecdotal evidence that embedded workers are "without doubt, unrivalled in being able to build strong and trusting relationships."[87]

Use technology to deliver care

The increasing use of telehealth is described by researchers, St Clair, Murtagh, Kelly and Cook as a "game changer" for the provision of health services to Aboriginal communities in remote locations.[88] Telehealth involves the use of technology to deliver health care and information either directly to a person requiring assistance or to a health worker seeking professional support.[89]

While there has been limited research into the efficacy of telehealth in the context of treating Aboriginal young people with AOD issues, there is evidence that supports its efficacy with young people, Aboriginal young people and for the treatment of AOD issues separately. For example, a study into young people's satisfaction with 'eheadspace' – an online mental health support and counselling service – concluded that overall, young people were very satisfied with the service.[90] Similarly, a study evaluating iBobbly – a self-help app targeting suicidal ideation, depression, psychological distress and impulsivity among Aboriginal young people that is described in further detail in Case Study 4 – found there were substantial reductions in participants' Patient Health Questionnaire (PHQ-9) and Kessler Psychological Distress Scale (K10) scores.[91] To support the use of telehealth to treat AOD issues, two reviews of literature on telehealth for addictive behaviours and AOD use were conducted. They both concluded there is evidence of its efficacy.[92]

[85] headspace National Youth Mental Foundation, headspace Pilbara, https://headspace.org.au/headspace-centres/pilbara/.
[86] A Kazim, S Clark & D Juskov, headspace Pilbara: the journey of co-design [presentation], AnglicareWA.
[87] A Kazim, S Clark & D Juskov, headspace Pilbara: the journey of co-design [presentation], AnglicareWA.
[88] M St Clair, D P Murtagh, J Kelly & J Cook, Telehealth a game changer: closing the gap in remote Aboriginal communities, Medical Journal of Australia, 2019.
[89] O J Mechanic & A B Kimball, Telehealth systems, StatPearls Publishing, 2019.
[90] D Rickwood, A Wallace, V Kennedy, S O'Sullivan, N Telford & S Leicester, Young People's Satisfaction With the Online Mental Health Service eheadspace: Development and Implementation of a Service Satisfaction Measure, JMIR Mental Health, 2019.
[91] J Tighe, F Shand, R Ridani, A Mackinnon, N De La Mata & H Christensen, Ibobbly mobile health intervention for suicide prevention in Australian Indigenous youth: a pilot randomised controlled trial, BMJ Open, 2017,
[92] J Chebli, A Blaszczynski & S M Gainsbury, Internet-Based Interventions for Addictive Behaviours: A Systematic Review, Journal of Gambling Studies, 2016; A Ohinmaa, P Chatterley, T Nguyen & P Jacobs, Telehealth in substance abuse and addiction: Review of the literature on smoking, alcohol, drug abuse and gambling (Report), Institute of Health Economics, 2010.

Case Study 4 | iBobbly

IBOBBLY

Black Dog Institute, Western Australia

Approach

iBobbly is a self-help app targeting suicidal ideation, depression, psychological distress and impulsivity among Aboriginal young people that was developed by the Black Dog Institute in partnership with Aboriginal community members from the Kimberley. The imagery within iBobbly was created by Aboriginal artists and graphic designers. The language used was chosen in consultation with young people in Broome, and full gender-matched audio was developed to overcome low literacy and to follow cultural protocol.[93]

iBobbly has four main features:

1. **How do I feel:** Guides young people through a self-assessment and gives them feedback on how they are going.
2. **Stuff I can use**: Teaches young people how to manage their thoughts and feelings including any suicidal thoughts.
3. **How I'm going to beat this:** Assists young people to develop personalised action plans and provides them with tools to monitor their progress.
4. **Help:** Provides young people with help and support options.[94]

Outcomes

In 2017, Tighe et al. conducted a pilot randomised controlled trial which aimed to evaluate the effectiveness of the iBobbly app. The trial involved 61 Aboriginal people aged 18-35 years old from the Kimberley receiving six weeks of acceptance-based therapy delivered through the iBobbly app. Trial participants reported significantly lower PHQ-9 and K10 scores, which suggested that acceptance-based therapy offered through the app had reduced depressive symptoms and psychological distress.[95]

A second, large-scale trial was concluded in August 2019, involving six locations around Australia and more than 400 participants. The results of this trial are expected for release in early 2020.[96]

While telehealth has been praised for allowing access to services for people to whom such services would not otherwise be available,[97] treating AOD issues can require complex in-person procedures and regular follow-up which limit what can be achieved using telehealth alone.[98] Case Study 5 and Case Study 6 are examples of how telehealth can be used to complement traditional treatments.

[93] J Tighe, F Shand, R Ridani, A Mackinnon, N De La Mata & H Christensen, Ibobbly mobile health intervention for suicide prevention in Australian Indigenous youth: a pilot randomised controlled trial, BMJ Open, 2017
[94] Black Dog Institute, iBobbly, https://www.blackdoginstitute.org.au/getting-help/self-help-tools-apps/ibobbly-app.
[95] J Tighe, F Shand, R Ridani, A Mackinnon, N De La Mata & H Christensen, Ibobbly mobile health intervention for suicide prevention in Australian Indigenous youth: a pilot randomised controlled trial, BMJ Open, 2017
[96] Black Dog Institute, iBobbly, https://www.blackdoginstitute.org.au/getting-help/self-help-tools-apps/ibobbly-app.
[97] D Savin, M T Garry, P Zuccaro & D Novins, Telepsychiatry for Treating Rural American Indian Youth, Clinical Perspectives, 2005.
[98] S Luthra, Opiod crisis in rural areas may be tackled through telemedicine, The Washington Post, 28 September 2016, https://www.washingtonpost.com/news/to-your-health/wp/2016/09/27/opioid-crisis-in-rural-areas-may-be-tackled-through-telemedicine/.

Case Study 5 | SPARX-R

SPARX-R

University of Auckland, New Zealand

Approach

SPARX-R is a seven-module computer-administered self-directed Computerised Cognitive Behavioural Therapy (cCBT) intervention. It is an adjunct to usual AOD counselling designed as a means to address co-existing mental health and substance use problems in a group of young people attending a community AOD service in Auckland, New Zealand. SPARX-R was designed to support young people with mild to moderate symptoms of depression.

Participants complete SPARX-R during their appointments with Altered High Youth Services and under the supervision of their AOD clinician at a rate of approximately one module per week – or fortnightly, depending on the regularity of their appointments.[99]

Outcomes

Barbiellini conducted an evaluation of the utility and acceptability of SPARX-R in the context of an AOD treatment service for young people. It concluded that SPARX-R can be successfully incorporated into AOD treatment services for young people, and has promise as a way of providing evidence-based mental health interventions in this population to address co-existing mental health and AOD issues. Moreover, the implementation of cCBT through computer-administered interventions such as SPARX-R can be used to address the shortage of trained professionals to deliver effective treatment for young people with co-existing mental health and AOD issues.[100]

Case Study 6 | eGetGoing

EGETGOING

CRC Health Group, United States of America

Approach

eGetgoing uses an Internet-based video conferencing platform to deliver confidential verbal and visual-based therapy to patients with opioid dependence. The aim of eGetgoing is not to displace traditional treatment, but to complement it or provide an alternative to people who otherwise do not have access.

After installing the eGetgoing platform on a computer, people can register for specific therapy sessions, then sign in and access real-time group or individual counselling sessions.[101]

Outcomes

King et al. conducted an evaluation of the eGetgoing platform in 2009. 37 participants were involved in the evaluation. One group received eGetgoing enhanced counselling, while the other group received on-site enhanced counselling to enhance their routine care. Both groups were provided with the same manual-guided relapse control therapy that was delivered by the same group leaders. The evaluation found that all participants had significant decreases in drug use, and that treatment satisfaction was good and comparable across delivery conditions (eGetgoing v. on-site).[102]

A second randomised controlled trial of the eGetgoing platform conducted by King et al. in 2014 had similar results.[103]

[99] R A Barbiellini, E-therapy in Youth Addition Services [thesis], University of Auckland, 2016.
[100] R A Barbiellini, E-therapy in Youth Addition Services [thesis], University of Auckland, 2016.
[101] CRC Health, Online Treatment, https://www.crchealth.com/find-a-treatment-center/online-treatment/.
[102] V L King, K B Stoller, M Kidorf, K Kindbom, S Hursh, T Brady & R K Brooner, Assessing the effectiveness of an Internet-based videoconferencing platform for delivering intensified substance abuse counselling, Journal of Substance Abuse Treatment, 2009.
[103] V L King, R K Brooner, J M Peirce, K Kolodner & M S Kidorf, A randomized trial of web-based videoconferencing for substance abuse counselling, Journal of Substance Abuse Treatment, 2014.

2.2 Acceptable

ACCEPTABLE

Effective service models provide Aboriginal young people, and their families and carers with a culturally safe environment and experience, and are **acceptable** to the Aboriginal communities they intend to serve.

Effective service models:

- Are designed in partnership with local communities to ensure they reflect local norms and are locally owned and led
- Adopt a warm referral approach to build trust within the community
- Embed culture in all aspects of the service model
- Are delivered by culturally competent organisations

2.2.1 Are designed in partnership with local communities to ensure they reflect local norms and are locally owned and led

"You need to have Aboriginal people from the right language groups involved in the design process."

- Interjurisdictional service provider

The literature identifies that authentic engagement with local communities is key to developing culturally safe services that are acceptable to those communities for two key reasons.

1. **Local community engagement ensures that services reflect local cultural beliefs, norms and values:** Each Aboriginal community is unique and has its own cultural beliefs, norms and values which can be impossible for those outside of the community to comprehend completely.[104] Additionally, many communities in the Kimberley are home to several family and language groups. It follows that to develop a service that reflects the cultural beliefs, norms and values of a specific community, it is essential that it is designed in partnership with members or representatives of all (or as many) communities that will access the service and understand them best.
2. **Local community engagement ensures that services are locally-driven and owned:** Engaging local community members in the design of a service ensures that they are involved in the problem-solving process, "rather than passively on the receiving end of directive policy,"[105] which can help to foster a sense of local empowerment and ownership over the final result. It is critical to note that to achieve this outcome, engagement with local communities cannot be a 'once-off' – it must involve genuine partnership to co-design the service, from conception through to delivery.

[104] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.
[105] C M Doran, I Kinchin, R Bainbridge, J McCalman & A Shakeshaft, Effectiveness of alcohol and other drug interventions in at-risk Aboriginal youth, Sax Institute, 2017.

Case Study 7 | BushMob

BUSHMOB

BushMob Aboriginal Corporation, Northern Territory

Approach

BushMob is a community-based therapeutic service for high-risk young people aged 12-25 with AOD issues. Many young people involved in BushMob have co-occurring issues, including mental health problems and FASD. In 2014, BushMob estimated that 30 per cent of young people involved in BushMob were affected by FASD.[106] While BushMob does not cater exclusively to Aboriginal and Torres Strait Islander young people, most young people involved in the service (over 95 per cent) identify as such.[107]

BushMob comprises of residential and non-residential components. It operates medium-stay residential programs at Alice Springs and Loves Creek Station. BushMob also offers intensive outreach, advocacy and case management, and adventure therapy bush trips.[108]

BushMob was developed over 21 years ago by Will MacGregor, through engagement with young people, grannies and granddads in the community. As MacGregor identifies, "what we tried to do in the beginning was listen to what local people wanted for their young people."[109] BushMob has therefore "developed from the priorities expressed by Aboriginal and Torres Strait Islander peoples in the Northern Territory about strengthening youth against high-risk behaviours."[110]

Community input and oversight over BushMob is key to its functioning. MacGregor shares that, "there's always been community oversight around our stuff. We're not some tucked away clinical service attached to a hospital. We've actually got really strong boards of management, or directors, who are a good match for our local region. They keep an eye on things. There's other people in the community that come back and forward. And if they think we're doing the wrong thing, they tell us. And we encourage that… There's some sort of community ownership."[111]

Outcomes

Each year, around 700 young people access BushMob, of whom 110 attend the residential program.[112] BushMob has been described by experts as "[encapsulating] what we consider to be a key best-practice principle in the diversion of Indigenous young people – that all youth diversionary programs for Indigenous young people are **community owned, developed and driven.**"[113]

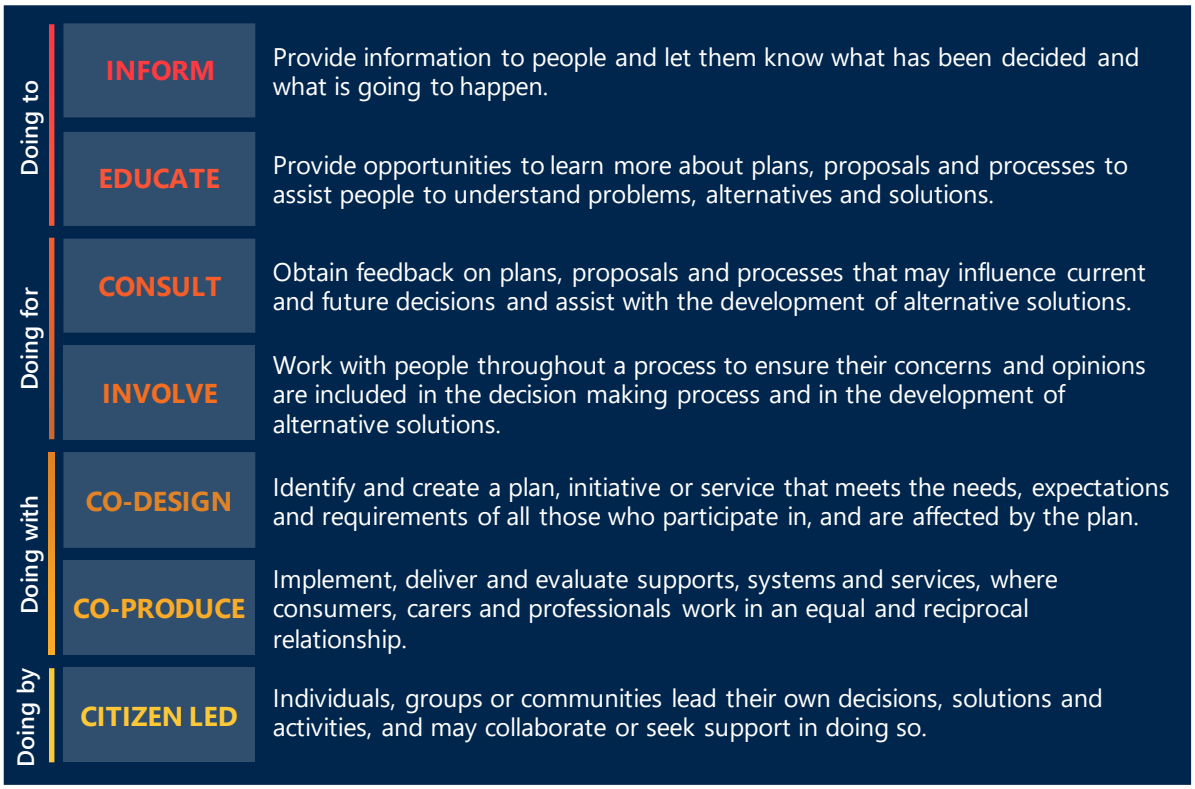
Similarly, an evaluation of BushMob conducted by Pryor in 2009 highlighted that "BushMob practices emerged from the requests of families and communities, and… years on are still being valued by families and communities."[114]

There are a range of ways that local communities can be involved in service design which vary in terms of how much involvement is required from local community members, and to what extent they can influence decision-making, as shown in Figure 2. Ideally, service models should be co-designed or co-produced, as local communities should be as involved in decisions that affect them as possible.[115] It is important to note that the co-design process must be tailored to participants and their unique cultural, geographical, social

[106] J Hands, Inquiry into the Adequacy of Youth Diversionary Programs in NSW: Submission 24, NSW Coalition of Aboriginal Regional Alliances, 2018.
[107] Krone Consulting, The Bushmob model of treatment for high risk children and Young People in the Northern Territory who use alcohol and other drugs, and engage in criminal and other anti-social behaviours, BushMob Aboriginal Corporation, 2016.
[108] Krone Consulting, The Bushmob model of treatment for high risk children and Young People in the Northern Territory who use alcohol and other drugs, and engage in criminal and other anti-social behaviours, BushMob Aboriginal Corporation, 2016.
[109] P Gregoire, Providing a Future for NT Youth: An Interview with Bush Mob CEO Will MacGregory, Sydney Criminal Lawyers, 2017, https://www.sydneycriminallawyers.com.au/blog/providing-a-future-for-nt-youth-an-interview-with-bush-mob-ceo-will-macgregor/.
[110] Krone Consulting, The Bushmob model of treatment for high risk children and Young People in the Northern Territory who use alcohol and other drugs, and engage in criminal and other anti-social behaviours, BushMob Aboriginal Corporation, 2016.
[111] P Gregoire, Providing a Future for NT Youth: An Interview with Bush Mob CEO Will MacGregory, Sydney Criminal Lawyers, 2017, https://www.sydneycriminallawyers.com.au/blog/providing-a-future-for-nt-youth-an-interview-with-bush-mob-ceo-will-macgregor/.
[112] Krone Consulting, The Bushmob model of treatment for high risk children and Young People in the Northern Territory who use alcohol and other drugs, and engage in criminal and other anti-social behaviours, BushMob Aboriginal Corporation, 2016.
[113] J Hands, Inquiry into the Adequacy of Youth Diversionary Programs in NSW: Submission 24, NSW Coalition of Aboriginal Regional Alliances, 2018.
[114] A Pryor, Evaluation Report: BushMob: A socio-cultural approach to youth service delivery in Central Australia, Deakin University, 2009.
[115] Orygen, the National Centre of Excellence in Youth Mental Health, Co-designing with young people: The fundamentals.

and economic circumstances.[116] An example of how the co-design process could be adapted to meet the needs of different cohorts is summarised in Table 4 below.

Figure 2 | Different levels of participation [117]



[116] T Dietrich, J Trischler, L Schuster & S Rundle-Thiele, Co-designing services with vulnerable consumers, Journal of Service Theory and Practice, 2017.
[117] Government of Western Australia Mental Health Commission, Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025, Government of Western Australia.

Table 4 | Adapting co-design processes for different cohorts [118]

Step	Conventional process	Adapted process for different cohorts
Resourcing	• Conventional participants are capable of innovating independently and thus, generic design tools are sufficient. • Conventional participants can source required information on their own.	• Some participants may not be able or willing to innovate independently and thus, topic-specific design tools are required. • Experts play a role in sourcing required information for some participants.
Planning	• Experts communicate with conventional participants directly on matters such as organising meetings.	• The condition of vulnerability may preclude or render impractical direct communication. • Experts communicate with intermediaries such as government bodies and non-government organisations rather than with some participants directly.
Recruiting	• Conventional participants self-select to participate, driven by a strong motivation to innovate.	• Some participants may not have the motivation to contribute, particularly on sensitive topics. • Recruitment requires close collaboration with intermediaries, and can be a lengthy and resource-intensive process. • Incentives for some participation may be required.
Sensitising	• Conventional participants tend to be knowledgeable about the co-design process and the topic.	• Some participants often need to be introduced to the co-design process and the topic.
Facilitation	• Conventional participants can design or innovate independently and therefore, the facilitator can adopt a more passive consulting role. • The co-design session can be highly user-driven.	• The facilitator needs to provide time for some participants to build trust, and become familiar with the objectives of the co-design session. • The facilitator needs to guide some participants through individual activities. • Co-design tools need to be selected based upon the potential to empower participants and encourage collaboration and creativity – card sorting and collage making can be particularly useful.
Evaluation	• Focus on ideas that deliver consumer value, feasibility and originality when evaluating.	• Focus on ideas that deliver transformation, consumer wellbeing and social change when evaluating.

[118] T Dietrich, J Trischler, L Schuster & S Rundle-Thiele, Co-designing services with vulnerable consumers, Journal of Service Theory and Practice, 2017.

2.2.2 Adopt a warm referral approach to build trust within the community

"To be vouched for by Elders and community leaders is key to young people accessing our services."

- Interjurisdictional service provider

A lack of trust, particularly in non-Aboriginal-specific services, is a significant barrier to service entry within Aboriginal communities.[119] Adopting a 'warm referral approach' is a common approach to addressing this issue. Research shows that for Aboriginal young people, a service being "known and trusted within the community" is a primary facilitator of access.[120] Aboriginal communities can often be distrustful of new services due to past experiences of services not appropriately addressing the needs of the community, not being appropriately delivered, and not investing in the community long-term.[121] Given these experiences, Allan and Campbell identified that **giving Aboriginal people – including young people – "choice over when and how services are provided is a critical ethical issue."**[122]

A warm referral approach helps build trust by **"removing the need to make appointments that fit with the counsellor's or agency's schedule"** and **"[shifting] the power balance from counsellor to community."**[123] It involves service staff engaging with the local community by attending community events they are invited to by local community groups as described in Case Study 8. By inviting service staff to these events, local community groups implicitly "vouch" for the service.[124] Attending these events provides service staff with the opportunity to meet with local community members, answer questions about themselves and the service, and provide information on AOD and/or co-occurring issues in a non-stigmatising way.[125] By engaging with the entire local community, service staff not only build rapport and trust with young people that may be seeking treatment, but also with family members and friends of young people who may have a need for treatment. These family members and friends can then encourage the young person to enter the service.[126]

"We had to build up trust with the parents… before we could even reach the young people."

- Interjurisdictional service provider

[119] National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, 2014.
[120] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Health Foundation, 2015.
[121] National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, 2014.
[122] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.
[123] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.
[124] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.
[125] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.
[126] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.

> *A Nan had a large family, she was the matriarch looking after all the grandchildren; the eldest three were sniffers and in trouble with the police. All the other services (Child Safety, Youth Justice) were there all the time. She was overwhelmed and telling them to go away. She identified us – the VSM [Volatile Substance Misuse] service – as one of the few services she would work with. She began to tell the other services 'Go through them' and we worked together. What did it take? Heaps of cups of tea. A worker who just hung in there, not judgemental, with very regular contact, helping take the load off her. The elderly lady relaxed and came on board – she talked with her grandsons and was able to exert some influence. The young ones saw Nan respecting the youth worker, so they started to respect her too. They started to be there at home when she came. The 'softly approach' worked – one by one they got more positive energy and changed.*

Source: Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.

A critical aspect of a warm referral approach is consistency. There must be a regular and reliable pattern of contact with the community, to ensure that young people have ease of access to the service provider. As highlighted by a drug and alcohol counsellor interviewed by Allan and Campbell, **"it's important to be there every week, regular, reliable, even if nothing happens, you still go every week so when they're ready you're there."**[127]

A warm referral approach also involves a service providing an "open door [...] where community members feel free to drop in for a chat, to use the Internet or phone."[128] This can provide young people and other local community members with an opportunity to familiarise themselves with staff and the environment before committing to entering the service.

[127] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.
[128] E Robinson, D Scott, V Meredith, L Nair & D Higgins, Good and innovative practice in service delivery to vulnerable and disadvantaged families and children, Child Family Community Australia, 2012.

Case Study 8 | Lyndon Community Outreach Service

LYNDON COMMUNITY OUTREACH SERVICE

Lyndon Community, New South Wales

Approach

The Lyndon Community Outreach Service sought to increase the use of AOD services in a rural location in central west New South Wales. Counsellors recognised that usual pathways into care – including formal referrals, phone calls, and appointments for one-on-one counselling in health care facilities – were barriers to service entry for many Aboriginal people. For example, to call a service, make an appointment and turn up for a one-on-one discussion with a stranger can be challenging and potentially culturally inappropriate for Aboriginal people.

The counsellors adopted a soft entry approach (also known as a warm referral approach) via an Aboriginal Community Controlled Health Service (ACCHS). The counsellors were invited to a range of events run by the ACCHS including an Aboriginal women's sewing group that was run over 12 months, three family camps for two-three days each, and several community barbeques with information stalls. The same counsellors attended all ongoing sessions and groups.[129]

Outcomes

An evaluation of the soft entry approach adopted by Lyndon Community Outreach Service revealed that over an 18-month period, 58 soft entry events were attended by the counsellors, and 298 people were engaged in conversations about their own or someone else's AOD use. Of these 298 people, 149 were Aboriginal, which represented an 82 per cent increase in contacts with Aboriginal people than the previous 18-month period.

The evaluation concluded that the soft entry approach had achieved the aim of making AOD services easier to reach for Aboriginal people, especially women.[130]

2.2.3 Embed culture in all aspects of the service model

> *"Culture is the key protective factor which must be present in all strategies, programs and services in which Aboriginal people participate, whether run by governments, non-government organisations or private companies."*

Source: F Davey, M Carter, M Marshall, W Morris, K Golson, P Torres, M Haviland & R O'Byrne-Bowland, Kimberley Aboriginal Caring for Culture Initial Consultation Report, Kimberley Aboriginal Law and Cultural Centre, 2019.

The embedding of culture is recognised in the literature as a key aspect of effective service models for Aboriginal young people.[131] The National Indigenous Drug and Alcohol Committee found that "interventions that integrate culturally specific practices [...] have been shown to be more effective."[132] Similarly, a study by Smith, Rodriguez and Bernal identified that the more specific a treatment is to its clients' cultural backgrounds, the more effective it is.[133] Embedding Aboriginal culture in all aspects of

[129] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.
[130] J Allan & M Campbell, Improving Access to Hard-to-Reach Services: A Soft Entry Approach to Drug and Alcohol Services for Rural Australian Aboriginal Communities, Social Work in Health Care, 2011.
[131] C M Doran, I Kinchin, R Bainbridge, J McCalman & A Shakeshaft, Effectiveness of alcohol and other drug interventions in at-risk Aboriginal youth, Sax Institute, 2017.
[132] National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, 2014.
[133] T B Smith, M D Rodriguez & G Bernal, Culture, Journal of Clinical Psychology, 2011.

service models is key to not only attracting Aboriginal young people to services, but also ensuring that they stay engaged and feel like they belong.[134]

Service models can embed Aboriginal culture in their activities in various ways including by, though not limited to:

- **Using traditional treatment methods** including traditional medicines, bush tucker and healers, along with clinical treatment methods.[135] The Aboriginal concept of healing is more holistic than its Western counterpart – it encompasses social, emotional, mental, physical, cultural and spiritual dimensions.[136] Therefore, clinical treatment methods alone can be insufficient to improve Aboriginal young people's wellbeing. Incorporating traditional treatment methods can help "true healing to take place."[137]
- **Incorporating cultural activities and education** such as smoking ceremonies, taking trips "on Country" or spending time with local Elders. These enable Aboriginal young people to connect with themselves and their cultural heritage.[138] The Yiriman Youth Justice Diversion Program is a diversionary program in the Fitzroy Valley for Aboriginal young people which draws on various cultural activities such as caring for Country, to reduce re-offending behaviour. This program is explained in Case Study 9. Another key example is the Jaru Pirrijirdi Programs which are described below in Case Study 11 – they encourage cultural connection through weekly bush trips which give young people an opportunity to spend time on country and hear stories from local Elders.[139] The Rongo Ātea Youth Alcohol and Drug Service takes a similar route for Māori young people – this is discussed further in Case Study 10.

[134] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.
[135] National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, 2014.
[136] P Dudgeon, T Calma & C Holland, What works in Aboriginal and Torres Strait Islander suicide prevention?, InPsych, 2016.
[137] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.
[138] C M Doran, I Kinchin, R Bainbridge, J McCalman & A Shakeshaft, Effectiveness of alcohol and other drug interventions in at-risk Aboriginal youth, Sax Institute, 2017.
[139] Walpiri Youth Development Aboriginal Corporation, Annual Report 2017-18, 2019.

Case Study 9 | Yiriman Youth Justice Diversion Program

YIRIMAN YOUTH JUSTICE DIVERSION PROGRAM

The Kimberley Aboriginal Law and Cultural Centre, Western Australia

Approach

The Kimberley Aboriginal Law and Cultural Centre runs a unique diversionary program in the Fitzroy Valley for Aboriginal young people who are considered of 'medium risk' of adverse justice outcomes. This program, called the Yiriman Youth Justice Diversion Program, seeks to coordinate effort between the community, police and local magistrates. The Yiriman Youth Justice Diversion Program involves two types of interventions targeted at reducing reoffending behaviour:

- a five-day camel trek accompanied by Elders and mentors with support from Kimberley Community Alcohol and Drug Services staff
- a six-week 'caring for Country' work readiness programme for youth with little or no work experience.[140]

Outcomes

A three-year evaluation of the Yiriman Project was undertaken between 2010-2013. The evaluation showed through case studies that many young people have used the project as a stepping-stone to move into positions of leadership within their community. They and others claim that Yiriman has been of central importance in this regard. There was also evidence to suggest that Yiriman helped bolster the health of older people in the community and other generations, in addition to the young people it directly served.[141]

Case Study 10 | Rongo Ātea Youth Alcohol and Drug Service

RONGO ĀTEA YOUTH ALCOHOL AND DRUG SERVICE

Te Rūnanga o Kirikiriroa Trust, New Zealand

Approach

Rongo Ātea Youth Alcohol and Drug Service is the first kaupapa[142] Māori youth AOD residential treatment service in New Zealand. It is a purpose built, 16 bed residential centre located next to Kirikiriroa Marae that is a 24-hour, seven day a week, ten-week abstinence-based treatment service for young people aged between 13-18 years.

The service incorporated a broad range of Māori, including *pōwhiri* (a traditional welcome), *karakia* (prayer/chant), *kapa haka* (performing arts), and *noho marae* (a marae stay). During their time at Rongo Ātea, young people were able to participate in, and experience a *noho marae*, alongside recovering adult clients from the Higher Ground residential AOD treatment service. This particular aspect of the service was unique; it integrated cultural practices, Māori *tikanga* such as the practice of *pōwhiri*, alongside contemporary treatment such as the 12-step recovery therapy.

Outcomes

An evaluation of Rongo Ātea found that young people considered the *noho marae* as a positive learning experience, with one young person sharing that, "national recovery hui [gathering]... yeah, that is pretty cool."[143] The evaluation describes the *noho marae* as "a prime example of providing a 'true' cultural experience steeped in cultural protocols such as *pōwhiri*, *whakawhānaungatanga*, *waiata*, *kotahitanga*, *hakari* and *poroporoaki*."[144] Having a recovery forum (12-step meeting) within an environment like a *noho marae* appears to have allowed a space for young people to feel comfortable and willing to become involved in their own therapeutic processes.[145]

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[140] Kimberley Aboriginal Law and Cultural Centre, Yiriman Youth Justice Workshop, 2011.
[141] J Palmer, 'We know they healthy cos they on country with old people': demonstrating the value of the Yiriman Project, Community Development Programme, Murdoch University, 2016.
[142] Kaupapa refers to the collective vision, aspiration and purpose of Māori communities.
[143] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.
[144] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.
[145] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.

Other ways that service models can embed Aboriginal culture which have been discussed elsewhere in this literature review include:

Ensuring Aboriginal culture is represented in the physical space	Section 2.1.2
Engaging meaningfully with the local community in the design of the service model	Section 2.2.1
Involving Elders and local community leaders in the introduction of the service to the community	Section 0
Employing Aboriginal staff and ensuring that all non-Aboriginal staff thoroughly understand, respect and adhere to cultural differences	Section 2.3.1
Involving young people's families and carers	Section 2.4.2

Existing cultural frameworks (i.e. those that have been established or endorsed by Aboriginal leaders in particular communities) are valuable tools in the design and delivery of service models. Cultural frameworks provide funders, commissioners, and service providers with guidance on how best to embed culture within a service, and in turn, improve outcomes for the clients of the service. Several cultural frameworks have been created by Aboriginal leaders in the Kimberley which could be used to inform the design and implementation of the proposed Kimberley Youth Service. One such framework is the 'Cultural Domains of Action' framework, currently in the process of being developed by the Kimberley Aboriginal Law and Cultural Centre. The purpose of the framework is to support government and other supporting organisations to develop policies, practices and strategies relating to Aboriginal people in the Kimberley that have "culture… at their core."[146] It identifies ten cultural domains of action,[147] which capture the various types of activities that Aboriginal Community-Controlled Organisations (ACCOs) deliver to transmit and strengthen culture among Aboriginal people and groups in the Kimberley.[148] Frameworks such as these should be used to inform decision-making on what activities the Kimberley Youth Service will deliver, to ensure Aboriginal young people have regular and meaningful opportunities to connect with culture.

2.2.4 Are delivered by culturally competent organisations

The provision of a culturally safe service requires, in the first instance, that the service provider has cultural awareness and competence embedded throughout its organisation. Walker, Schultz and Sonn identified that cultural competence needs to be understood within a "nested system" that operates simultaneously at the individual, professional, organisational and system levels.[149] A lack of cultural competence at the organisational-level can undermine culturally competent staff, and in turn, compromise the outcomes of clients.[150] It follows that the organisation selected to deliver Aboriginal-specific services, or services that

[146] F Davey, M Carter, M Marshall, W Morris, K Golson, P Torres, M Haviland & R O'Byrne-Bowland, Kimberley Aboriginal Caring for Culture Discussion Report, Kimberley Aboriginal Law and Cultural Centre, 2020.
[147] The 'Cultural Domains of Action' framework identifies nine cultural domains of action, with Culture and Language sitting at the centre of, but separate from, those domains. However, for the purpose of simplicity, we have included Culture and Language as one of the cultural domains of action.
[148] F Davey, M Carter, M Marshall, W Morris, K Golson, P Torres, M Haviland & R O'Byrne-Bowland, Kimberley Aboriginal Caring for Culture Discussion Report, Kimberley Aboriginal Law and Cultural Centre, 2020.
[149] R Walker, C Schultz & C Sonn, Chapter 12: Cultural Competence – Transforming Policy, Services, Programs and Practice, Working Together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, N Purdie, H Milroy & R Walker (eds.), 2014.
[150] R Walker, C Schultz & C Sonn, Chapter 12: Cultural Competence – Transforming Policy, Services, Programs and Practice, Working Together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice, N Purdie, H Milroy & R Walker (eds.), 2014.

will cater to a majority Aboriginal cohort, must be committed to and demonstrate cultural competence at both an organisational level and an individual staff level.

To demonstrate cultural competence at the organisational-level, service providers should recognise and respect the central importance of culture and identity to Aboriginal people and communities; safeguard the importance of culture and identity; and support Aboriginal people and communities to strengthen their culture and identity to promote social and emotional wellbeing.[151] Service providers demonstrate these elements of cultural competence at four distinct levels of the organisation:

- **Vision and values:** The vision and values of an organisation define why it exists and thereby, shape all aspects of the organisation – from what services it delivers through to which organisations it partners with.[152] Organisations need to set the standard by ensuring that their vision and values demonstrate a commitment to improving cultural competence and safety. This aligns with the recommendations of the Australian Health Ministers' Advisory Council's national *Cultural Respect Framework 2016 – 2026*, which recommends that organisations ensure that a "formal organisational commitment to improving cultural safety and responsiveness is visible in all aspects of core business, including vision and mission statements, organisational principles and values, and continuous improvement activities."[153]
- **Governance:** An organisation's governance sets out who is responsible for making decisions, how they are made, and how those decisions are held accountable.[154] The *Cultural Respect Framework* identifies governance structures that support the membership of, and partnerships with Aboriginal communities as an essential element of a culturally competent organisation.[155] The Kimberley Aboriginal Law and Cultural Centre note that involving Aboriginal people on a Board, Steering Committee or Working Group to guide or implement processes is, by itself, insufficient.[156] This representation should be supplemented by the incorporation of cultural protocols and processes (e.g. kinship and familial considerations) into the governance and structure of the organisation as a whole, to ensure that clients and staff experience the organisation and its services as culturally safe and secure.[157]
- **Policies and processes:** The policies and processes of an organisation set standards for what activities are undertaken and how. Policies and processes should align with cultural protocols and reflect cultural competency.[158] For example, policies and processes should recognise and respect cultural obligations, and kinship and familial considerations. Similarly, policies and processes for training should put the same importance on cultural competency as other types of skill-acquisition.[159]
- **Service delivery:** The organisation must ensure that services are designed and delivered in a way that is culturally safe and secure. Sections 2.2.1 to 2.2.3 provide more detail on how organisations should approach the design and delivery of culturally safe and secure services.

[151] National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, 2014.
[152] Nous Group, Organisational Architecture Framework.
[153] Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee, Cultural Respect Framework 2016 – 2026, Australian Health Ministers' Advisory Council.
[154] Reconciliation Australia & Australian Indigenous Governance Institute, Understanding Governance, Indigenous Governance Fact Sheets.
[155] Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee, Cultural Respect Framework 2016 – 2026, Australian Health Ministers' Advisory Council.
[156] F Davey, M Carter, M Marshall, W Morris, K Golson, P Torres, M Haviland & R O'Byrne-Bowland, Kimberley Aboriginal Caring for Culture Discussion Report, Kimberley Aboriginal Law and Cultural Centre, 2020.
[157] F Davey, M Carter, M Marshall, W Morris, K Golson, P Torres, M Haviland & R O'Byrne-Bowland, Kimberley Aboriginal Caring for Culture Discussion Report, Kimberley Aboriginal Law and Cultural Centre, 2020.
[158] K Doyle, Measuring cultural appropriateness of mental health services for Australian Aboriginal peoples in rural and remote Western Australia: a client/clinician's journey, International Journal of Culture and Mental Health, 2011.
[159] K Doyle, Measuring cultural appropriateness of mental health services for Australian Aboriginal peoples in rural and remote Western Australia: a client/clinician's journey, International Journal of Culture and Mental Health, 2011.

2.3 Capable

CAPABLE

Effective service models have enough staff, with the right capability and capacity to meet the needs of young people effectively and efficiently.

Effective service models:

- Employ capable staff who understand the needs of young people and how to meet them
- Collaborate with other services to leverage existing capability and capacity

2.3.1 Employ capable staff who understand the needs of young people and how to meet them

It is essential for services for young people to have capable staff who understand the needs of young people and how to meet them. Services with staff that have limited skills, training and capability is a significant barrier to young people engaging with a service.[160]

The literature highlights the importance of having staff with the right skills and knowledge (with dual-skilled staff being particularly important) to provide evidence-based interventions, tailored to young people's needs.[161] **Research also shows that it is valuable to have workers with lived experience, who can "easily relate with service [clients] through their shared experiences, and demonstrate the possibility of living well [following treatment]."**[162] Young people involved in the Rongo Ātea Youth Alcohol And Drug Service shared that they appreciated "that some staff members were open to sharing their stories and experiences that were very similar, and they could identify where the young people were coming from."[163] Case Study 11 provides an example of a successful peer-driven programs for Aboriginal young people with AOD issues and other complex needs.

[160] C M Doran, I Kinchin, R Bainbridge, J McCalman & A Shakeshaft, Effectiveness of alcohol and other drug interventions in at-risk Aboriginal youth, Sax Institute, 2017.
[161] Orygen, the National Centre of Excellence in Youth Mental Health, Fact sheet for clinical professionals who work with young people: Key principles underpinning youth mental health models, 2018; D Howe, S Batchelor, D Coates & E Cashman, Nine key principles to guide youth mental health: development of service models in New South Wales, Early Intervention in Psychiatry, 2014.
[162] Orygen, the National Centre of Excellence in Youth Mental Health, Fact sheet for clinical professionals who work with young people: Key principles underpinning youth mental health models, 2018.
[163] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.

Case Study 11 | Jaru Pirrijirdi Programs

JARU PIRRIJIRDI PROGRAMS

Walpiri Youth Development Aboriginal Corporation, Northern Territory

Approach

The Jaru Pirrijirdi (Strong Voices) Programs endeavour to help young people aged 16-25 find meaningful activity and opportunities to discuss their concerns and visions for the future, to address the problems underlying petrol sniffing and other forms of substance misuse. Although the program was first delivered in Yuendumu, it is now delivered in three more locations: Nyirrpi, Willowra and Lajamanu.[164]

There are three progressive levels of involvement in these programs.

1. **Level 1:** Jaru trainees run activities for young people aged five-25 in the community. They may, for example, supervise the pool table, video games or other similar activities.
2. **Level 2:** After three-six months, Jaru trainees help to run cultural, educational and life skills activities.
3. **Level 3:** Senior Jaru trainees mentor other young people and "take on meaningful and responsible positions in their community."[165]

Young people who have engaged in Jaru training and education are supported to find further employment and/or community leadership roles.[166]

Outcomes

The success of the Jaru Pirrjirdi Program in Yuendumu resonated loudly in other Warlpiri communities. At the express invitation of these communities, Jaru Pirrjirdi Programs were begun in Willowra in 2005, Nyirrpi in 2008, and Lajamanu in 2009.[167] An evaluation of the programs in 2007 highlighted that the most impressive component was the care and mentoring offered to younger people in the community. They found that Jaru mentors are credible to young people because they have experienced many of the same difficulties.[168]

In 2017-18, there were 765 active Jaru trainees across the four sites.[169]

The literature also highlights the importance of staff having the right skills and knowledge to ensure that services for Aboriginal young people and their families and carers are culturally safe and secure.[170] For example, uncertainty about whether headspace staff would be welcoming or understanding of Aboriginal young people and the specific issues that they face, was identified as a major barrier to Aboriginal young people accessing headspace services.[171] To ensure that services are culturally safe, effective service models include:

- **Employ Aboriginal staff.** Employing Aboriginal staff is recognised in the literature as key to providing a cultural safe environment and experience for Aboriginal young people,[172] with the Youth Empowered Towards Independence identifying that, "the people most able or equipped to provide a culturally safe atmosphere are people from the same culture."[173] The Kids on Country program, which is run by

[164] Walpiri Youth Development Aboriginal Corporation, Annual Report 2017-18, 2019.
[165] P d'Abbs & S MacLean, Volatile Substance Misuse: A Review of Interventions, Australian Government Department of Health and Ageing, 2008.
[166] Walpiri Youth Development Aboriginal Corporation, Youth Services, Walpiri Youth Development Aboriginal Corporation, https://wydac.org.au/home/youth-services/.
[167] R Bignell, Submission to the Select Committee on Youth Suicides in the NT, Walpiri Youth Development Aboriginal Corporation, 2011.
[168] P d'Abbs & S MacLean, Volatile Substance Misuse: A Review of Interventions, Australian Government Department of Health and Ageing, 2008.
[169]Walpiri Youth Development Aboriginal Corporation, Annual Report 2017-18, 2019.
[170] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.
[171] D Rickwood, N Telford, K Mazzer, G Anile, K Thomas, A Parker, S Rice, A Brown & P Soong, Service Innovation Project Component 2: Social Inclusion Model Development Study, headspace National Youth Mental Heath Foundation, 2015.
[172] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014
[173] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.

Millenium Kids and Ngadju Elders in Coolgardie in the Goldfields, noted that employing local Aboriginal people had a significant impact on the outcomes of the service.[174] Kids on Country chose to upskill local Aboriginal community members, rather than bring in external staff. Employing local people who are already trusted and familiar with the Coolgardie Aboriginal community allowed Kids on Country to gain the consent of and legitimacy in the community required for engagement. Additionally, this local employment strategy gives opportunity and aspiration to the wider community, and allows vulnerable Aboriginal youth to engage with people they feel comfortable with.[175]

While research suggests that "a less credentialed Aboriginal or Torres Strait Islander person who [is] part of the community and familiar with local culture and community [is] generally more effective in providing treatment than a more highly qualified non-Indigenous person,"[176] there should ideally be **"an integration of both clinical competence and cultural competence**."[177] Westerman notes that "where non-Indigenous workers are employed to meet clinical standards, Aboriginal or Torres Strait Islander co-workers can help ensure cultural safety standards are also met."[178]

- **Ensure that non-Aboriginal staff are culturally competent.** Research shows that non-Aboriginal staff can play a key role in services for Aboriginal young people. Preuss and Napanangka Brown from the Northern Territory-based Mt Theo Program found that non-Aboriginal staff are often able to "gain and manage necessary resources, and liaise between government agencies and communities […] to an extent beyond which most remote Aboriginal people are willing or able to do."[179] Moreover, non-Aboriginal staff's lack of strong Aboriginal kinship obligations enable them to work with young people from all Aboriginal family groups equally, even where local Aboriginal staff may be unable to do so.[180] However, to play this key role in services for Aboriginal young people, non-Aboriginal staff must be committed to and demonstrate cultural competence, meaning that they:
    - recognise and respect the central importance of culture and identity to Aboriginal people and communities
    - work in ways that safeguard the importance of culture and identity
    - support Aboriginal people and communities to strengthen their culture and identity to promote social and emotional wellbeing.[181]

    While non-Aboriginal staff can develop cultural knowledge and awareness through formal training, it is not in itself enough to develop cultural competence.[182] The literature highlights the importance of providing non-Aboriginal staff with cultural experiences and education that incorporates Aboriginal perspectives,[183] and opportunities to interact with, build relationships with, and learn from Aboriginal

[174] Commissioner for Children and Young People Western Australia, Kids on Country program – Coolgardie, Engaging with Aboriginal Children and Young People Toolkit https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kids-on-country-program-coolgardie/.
[175] Commissioner for Children and Young People Western Australia, Kids on Country program – Coolgardie, Engaging with Aboriginal Children and Young People Toolkit https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kids-on-country-program-coolgardie/.
[176] D Graym, A Stearne, M Bonson, E Wilkes, J Butt & M Wilson, Review of the Aboriginal and Torres Strait Islander Alcohol, Tobacco and Other Drugs Treatment Service Sector: Harnessing Good Intentions, National Drug Research Institute, 2014.
[177] T G Westerman, Engaging Australian Aboriginal Youth in Mental Health Services, Australian Psychologist, 2010.
[178] T G Westerman, Engaging Australian Aboriginal Youth in Mental Health Services, Australian Psychologist, 2010.
[179] K Preuss & J Napanangka Brown, Stopping petrol sniffing in remote Aboriginal Australia: key elements of the Mt Theo Program, Drug and Alcohol Review, 2006.
[180] K Preuss & J Napanangka Brown, Stopping petrol sniffing in remote Aboriginal Australia: key elements of the Mt Theo Program, Drug and Alcohol Review, 2006.
[181] National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, 2014.
[182] R Bainbridge, J McCalman, A Clifford & K Tsey, Cultural competency in the delivery of health services for Indigenous people, Closing the gap clearinghouse, Australian Institute of Health and Welfare & Australian Institute of Family Studies, 2015.
[183] K Preuss & J Napanangka Brown, Stopping petrol sniffing in remote Aboriginal Australia: key elements of the Mt Theo Program, Drug and Alcohol Review, 2006.

staff and community members.[184] Encompass Family and Community suggested that training could involve, for example, yarning circles with Aboriginal community members for non-Aboriginal staff to ask questions and gain a clearer understanding.[185]

2.3.2 Collaborate with other services to leverage existing capability and capacity

"Collaboration is fundamental to our [...] survival."

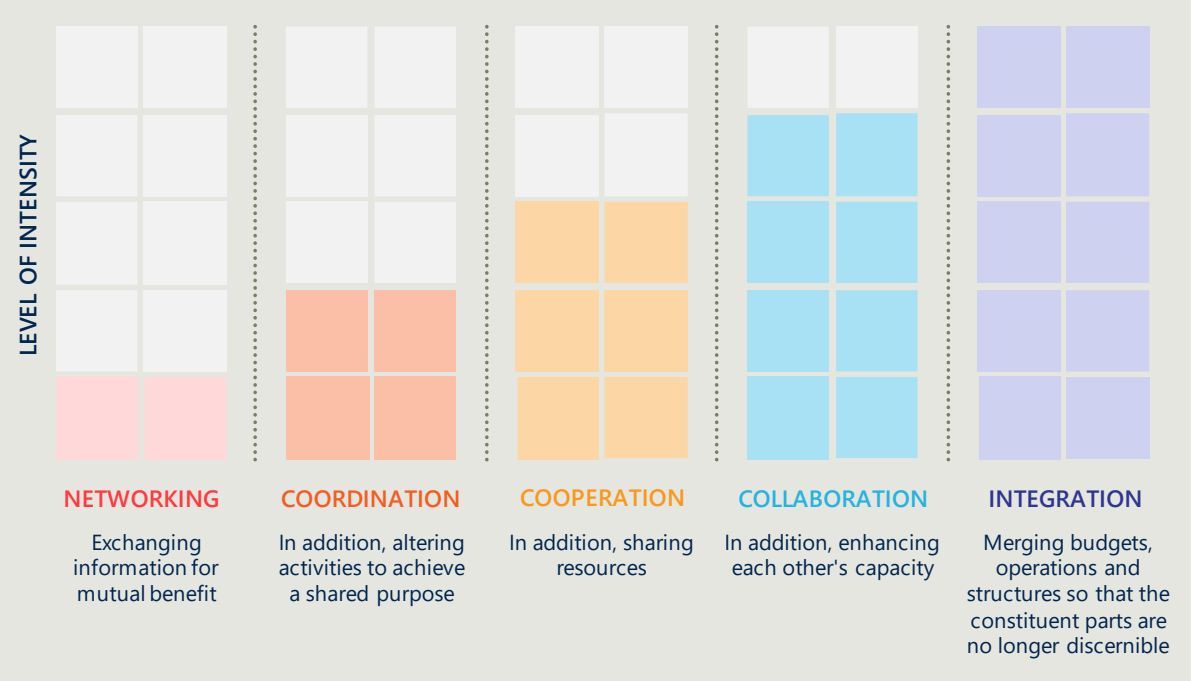
- Interjurisdictional service provider

The importance of services working together around the needs of young people is well-recognised.[186] As explained in Section 2.4.1 below, service models targeting AOD and/or co-occurring issues in young people tend to fail if they do not meet the needs of the young person 'as a whole'.[187] This means that service models must address not only young people's AOD and/or co-occurring issues, but also their cultural and social support needs. However, few service models have the resources required to be comprehensive enough to do so.[188] Therefore, most services rely on establishing relationships with other services to meet all the needs of young people.

There are several types of relationships that services can pursue with one another, which vary in terms of intensity.[189]

[184] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.
[185] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.
[186] S E Hetrick, A P Bailey, K E Smith, A Malla, S Mathias, S P Singh, A O'Reilly, S K Verma, L Benoit, T M Fleming, M R Moro, D J Rickwood, J Duffy, T Eriksen, R Illback, C A Fisher & P D McGorry, Integrated (one-stop shop) youth health care: best available evidence and future directions, Medical Journal of Australia, 2017.
[187] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[188] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[189] A T Himmelman, Collaboration Defined: A Developmental Continuum of Change Strategies, Himmelman Consulting, 2002; D Mashek. Capacities and Institutional Support Needed along the Collaboration Continuum [presentation], Academic Deans Committee of the Clarement Colleges, 2015.

Figure 3 | Five types of relationships[190]



- **Networking** refers to the exchanging of information for mutual benefit.[191] This could involve service providers sharing information about what types of services they deliver with other service providers, so that young people and families can be given accurate information on what services are available.
- **Coordination** refers to the exchanging of information and altering of activities for mutual benefit and to achieve a shared purpose.[192] This could involve service providers aligning their assessment and admission processes, so that young people do not have to go through the same process multiple times. This is particularly important in ensuring that young people do not have to repeat the same (often traumatic information) many times, to different people.
- **Cooperation** refers to the exchanging of information, altering of activities and sharing of resources for mutual benefit and to achieve a shared purpose.[193] This could involve services sharing staff with other services to better meet the needs of young people. Case Study 12 provides an example of a service that has several cooperative relationships with other services.
- **Collaboration** refers to the exchanging of information, altering of activities, sharing of resources, and enhancing of capacity for mutual benefit and to achieve a shared purpose.[194] This could involve service providers delivering training and shadowing opportunities to other service providers, to enhance their capacity to support young people. Case Study 13 provides an example of a service that is underpinned by collaboration between various agencies and organisations.
- **Integration** refers to the merging of budgets, operations and structures, so that the constituent parts are no longer discernible.[195]

There is no single best type of relationship – they accomplish different goals and require different levels of commitment and resources. It is important for service providers to pursue the type of relationship that will

[190] D Mashek. Capacities and Institutional Support Needed along the Collaboration Continuum [presentation], Academic Deans Committee of the Clarement Colleges, 2015.
[191] A T Himmelman, Collaboration Defined: A Developmental Continuum of Change Strategies, Himmelman Consulting, 2002.
[192] A T Himmelman, Collaboration Defined: A Developmental Continuum of Change Strategies, Himmelman Consulting, 2002.
[193] A T Himmelman, Collaboration Defined: A Developmental Continuum of Change Strategies, Himmelman Consulting, 2002.
[194] A T Himmelman, Collaboration Defined: A Developmental Continuum of Change Strategies, Himmelman Consulting, 2002.
[195] A T Himmelman, Collaboration Defined: A Developmental Continuum of Change Strategies, Himmelman Consulting, 2002.

not only help them to achieve their goals, but also be feasible to maintain. The literature identifies four key questions for service providers to explore when selecting the type of relationship.

1. **What does each service provider want to accomplish by working together?**
2. **Which type of relationship is necessary to accomplish those goals?**
3. **Are there resources available for this type of relationship? If not, can those resources be accessed?**
4. **Is there sufficient trust and commitment to support this kind of relationship?**[196]

Case Study 12 | Volatile Substance Use Program

VOLATILE SUBSTANCE USE PROGRAM

Council for Aboriginal Alcohol Program Services (CAAPS), Northern Territory

Approach

The Volatile Substance Use (VSU) program provides a 16-week residential program for young people aged between 14-24 who are experiencing issues around volatile substances and AOD. In addition to addressing these issues, VSU aims to build young people's life skill capacity and improve their numeracy and literacy. VSU also provides intensive case management services.[197]

CAAPS has identified collaboration as fundamental to the survival of VSU. CAAPS has developed relationships with a wide range of referral agencies and other service providers, including:

- the NT Department of Health's Top End and Central Health Services
- Aboriginal Medical Services
- an Aboriginal male counselling service
- a non-government organisation that provides AOD counselling
- the NT Department of Housing (which provide outreach workers for young people in VSU who are at risk of homelessness)
- Menzies School of Health Research
- local education providers.

Outcomes

Between July 2018 – June 2019, 44 young people and three family members participated in the VSU program. 16 young people were able to complete the program, with one young person's guardian sharing that, **"I was absolutely blown away to see that confidence that just shone out of her when I arrived at CAAPS on Thursday. I can see that she has completely come into her skin! Confident, exuberant, chatty, happy and healthy looking. What a joy to see her laughing and smiling and engaging in conversation, selfies, confident in her surroundings. It is just a joy to see these young people have come into their own and had the chance to discover who they are as individuals in a safe place. Thank you."**[198]

CAAPS is currently working to improve VSU – they have engaged a consultant to provide a comprehensive evaluation of the staffing, funding, and structure of the program.[199]

[196] M Axner, Chapter 24: Section 3. Promoting Coordination, Cooperative Agreements, and Collaborative Agreements Among Agencies, Community Toolbox, https://ctb.ku.edu/en/table-of-contents/implement/improving-services/coordination-cooperation-collaboration/main.
[197] Council for Aboriginal Alcohol Program Services Corporation, Annual Report 2019.
[198] Council for Aboriginal Alcohol Program Services Corporation, Annual Report 2019.
[199] Council for Aboriginal Alcohol Program Services Corporation, Annual Report 2019.

Case Study 13 | Kununurra Empowering Youth Program

KUNUNURRA EMPOWERING YOUTH PROGRAM

East Kimberley District Leadership Group, Western Australia

Approach

The Kununurra Empowering Youth (KEY) program is led by the East Kimberley District Leadership Group to address high youth incarceration rates in Kununurra during school holiday periods (particularly during the December-January holidays). KEY aims to engage youth within Kununurra during these periods especially, targeting at-risk Aboriginal youths to reduce anti-social behaviour.[200]

The KEY working party consists of government agencies from all levels, not-for-profit organisations, local ACCOs, and volunteers. They sought to identify and implement mutually reinforcing activities,[201] meaning activities that would coordinate with and support the activities delivered by other agencies or organisations involved in the collaborative arrangement.

Activities that were identified and implemented had a strong recreational focus; they included a range of sporting events as well as pool parties, bush-tucker trips and performing art evenings.

Outcomes

Anecdotal statements from KEY activity facilitators have stated attendance at KEY events as very high.[202] An internal review by KEY of the last school holiday period in 2017 showed that 23 out of the 30 identified 'high-risk' young people in the Kununurra region engaged in the program activities.[203] Broad engagement in the program was high, with many young people reporting they attended multiple events. [204]

Further, the Western Australian Commissioner for Children and Young People highlighted that the KEY program has shown **"the effectiveness of achieving small social change by targeting mutually reinforcing activities for young people, their families, agencies and community… People can do things with limited resourcing with the KEY project demonstrating the value of building relationships between agencies, organisations and other local stakeholders, to share resources."[205]**

[200] Commissioner for Children and Young People Western Australia, Kununurra Empowering Youth, Engaging with Aboriginal Children and Young People Toolkit, https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kununurra-empowering-youth/#overview.
[201] Commissioner for Children and Young People Western Australia, Kununurra Empowering Youth, Engaging with Aboriginal Children and Young People Toolkit, https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kununurra-empowering-youth/#overview.
[202] Government of Western Australia, Collaboration the KEY to youth wellbeing, News Centre, 2017, https://regionalservicesreform.wa.gov.au/news/collaboration-key-youth-wellbeing.
[203] Commissioner for Children and Young People Western Australia, Kununurra Empowering Youth, Engaging with Aboriginal Children and Young People Toolkit, https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kununurra-empowering-youth/#overview.
[204] Commissioner for Children and Young People Western Australia, Kununurra Empowering Youth, Engaging with Aboriginal Children and Young People Toolkit, https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kununurra-empowering-youth/#overview.
[205] Commissioner for Children and Young People Western Australia, Kununurra Empowering Youth, Engaging with Aboriginal Children and Young People Toolkit, https://www.ccyp.wa.gov.au/our-work/resources/aboriginal-and-torres-strait-islander/engaging-with-aboriginal-children-and-young-people-toolkit/section-5-case-studies/kununurra-empowering-youth/#overview.

2.4 Quality

QUALITY

Effective service models adopt practices that are based on the best available evidence in order to deliver high **quality** outcomes for young people.

Effective service models:

- Are comprehensive and integrated to meet the needs of the young person as a whole
- Engage families and carers in young people's care, where possible and appropriate
- Provide appropriate aftercare to help young people exiting the service to sustain positive outcomes

2.4.1 Are comprehensive and integrated to meet the needs of the young person as a whole

"It's a life transition program, really."

- Interjurisdictional service provider

Research shows that service models that target AOD and/or co-occurring issues in young people tend to fail if they do not take a comprehensive and integrated approach to service delivery to meet the needs of the young person 'as a whole'.[206] There is a strong association between AOD and/or co-occurring issues in young people and other risk factors such as offending history, homelessness and housing security, and family conflict or violence.[207] For example, the Australian Institute of Health and Welfare found that young people under youth justice supervision are up to 30 times more likely than other young people to require an AOD treatment service.[208] Similarly, Whitesell, Bachand, Peel and Brown identified that witnessing violence can increase the risk of a young person developing an AOD issue by up to three times.[209] Figure 4 summarises the various risk factors that are linked with AOD and/or co-occurring issues in young people. Services for young people with AOD and/or co-occurring issues cannot achieve meaningful, sustained change without adopting a comprehensive and integrated approach that addresses these other risk factors.[210]

[206] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[207] P Crane, J Buckley & C Francis, A framework for youth alcohol and other drug practice, Dovetail, 2012; A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[208] Australian Institute of Health and Welfare, Overlap between youth justice supervision and alcohol and other drug treatment services: 1 July 2012 to 30 June 2016, 2018.
[209] M Whitesell, A Bachand, J Peel & M Brown, Familial, Social and Individual Factors Contributing to Risk for Adolescent Substance Use, Journal of Addiction, 2013.
[210] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.

Figure 4 | Risk factors associated with AOD and/or co-occurring issues in young people [211]

INDIVIDUAL	FAMILY	SCHOOL	COMMUNITY
Anti-social attitudes and behaviour	Child neglect or abuse	Academic challenges	Association with offending peers
Early initiation to AOD use	Family conflict and violence	Aversion to or perceived irrelevance of school	Association with peers with AOD issues
Loss of cultural identity	Family history of AOD issues	Bullying or feeling unsafe	Availability of AOD
Low levels of literacy and numeracy	Family offending history	Lack of academic and personal support	Community disorganisation
Low self-esteem	Family rejection	Learning difficulties	Discrimination
Offending history	Favourable attitudes towards AOD use	Negative school climate and culture	Favourable attitudes towards AOD use
Poor health and mental health	Homelessness and transience	Peer rejection	Lack of recreational and social activities
Poor social skills	Lack of supervision and support	Suspension and exclusion	Lack of support services
Traumatic life events	Poor discipline practices	Truancy	Socioeconomic disadvantage

To meet the needs of young people as a whole, effective service models deliver a range of services to not only address their **therapeutic needs**, but also **cultural** and **social support needs**.[212]

- **Therapeutic needs** refer to young people's AOD and/or co-occurring issues. It is critical for service models to treat young people's AOD issues and co-occurring issues in an integrated manner.[213] Research suggests that young people's AOD use and mental health issues are often interlinked, and the benefits of treatment for one issue are diminished when the other goes untreated.[214] An integrated approach to treating young people's AOD and co-occurring issues requires the service provider to develop a single treatment plan that accounts for both the young person's AOD issues and co-occurring issues. Treatment for both issues can be delivered from one site by the same service provider or across multiple sites by two or more service providers – so long as a cohesive approach to treatment is adopted.[215]
- **Cultural needs** refer to young people's need for cultural connection. The extent to which Aboriginal young people are connected to traditional culture varies – not all young people will have or want to have cultural connection.[216] However, research finds that increased cultural connection appears to be

[211] P Crane, J Buckley & C Francis, A framework for youth alcohol and other drug practice, Dovetail, 2012; Alaska Division of Behavioural Health, Risk and Protective Factors for Adolescent Substance Use (and other Problem Behaviour), 2011; National Institute on Alcohol Abuse and Alcoholism, Alcohol Alert, US Department of Health and Human Services, 2000; C Spooner & K Hetherington, Social Determinants of Drug Use, University of New South Wales, 2004; Australian Government Department of Health, 5.3 The systems approach and AOD use, Historical publications, 2004.
[212] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[213] D Baker & F Kay-Lambkin, Two at a time: alcohol and other drug use by young people with a mental illness, Orygen, the National Centre of Excellence in Youth Mental Health, 2016.
[214] D Baker & F Kay-Lambkin, Two at a time: alcohol and other drug use by young people with a mental illness, Orygen, the National Centre of Excellence in Youth Mental Health, 2016.
[215] D Baker & F Kay-Lambkin, Two at a time: alcohol and other drug use by young people with a mental illness, Orygen, the National Centre of Excellence in Youth Mental Health, 2016.
[216] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.

directly related to improved resilience and wellbeing in Aboriginal young people.[217] It is therefore critical that service models provide Aboriginal young people with the opportunity to connect or reconnect with culture, by integrating culture throughout a young person's care. How effective service models do this is discussed in Section 2.2.3.

- **Social support needs** encompass a wide range of the complex needs that young people with AOD and/or co-occurring issues tend to have, including issues of family conflict or violence, homelessness, problems at school, and offending behaviour. The literature recognises that these needs are inextricably linked with young people's AOD and/or co-occurring issues.[218] The latter cannot be resolved without addressing the former and vice versa. There are a range of ways that effective service models meet young people's social support needs. Some service models provide social support (e.g. education or housing support) as part of their offering. A key example of this is the Council for Aboriginal Alcohol Program Services' Deadly Clever Program, which provides literacy and numeracy classes to young people attending the VSU Program (also run by the Council for Aboriginal Alcohol Program Services).[219] However, most service models do not have enough resources to be this comprehensive and therefore, rely on collaboration with other service providers.[220] This is discussed further in Section 2.3.2.

This comprehensive and integrated approach is adopted by the VSU Program in the Northern Territory, which is discussed in Case Study 12. Among other interventions, the program delivers counselling and psychoeducation to address the therapeutic needs of young people. It also incorporates cultural activities and provides young people with the option to invite family members to stay with them while they are in the residential facility to meet their cultural needs. Finally, the program provides life skills training, literacy and numeracy help and housing support to meet their social support needs.

This approach was also adopted by the New Zealand-based Rongo Ātea Youth Alcohol and Drug Service described in Case Study 10. It delivers a range of interventions which aim to nurture young people's *taha tinana* (physical health), *taha hinengaro* (mental health), *taha wairua* (spiritual health), and *taha whānau* (familial health). An evaluation of Rongo Ātea noted that this comprehensive and integrated approach was often mentioned by young people when talking about what worked well.[221]

2.4.2 Engage families and carers in young people's care, where possible and appropriate

It is well recognised that connections to family and family stability have a significant influence on a young person's resilience. Research by Kilpatrick et al. showed that the family environment is a major risk factor for AOD use and psychological issues in young people.[222] Similarly, Whitesell, Bachand, Peel and Brown identified that of children who experience maltreatment, 16 per cent presented with AOD issues.[223] It follows that involving families in the treatment of AOD and/or co-occurring issues in young people is a key component of success.[224] The involvement of a young person's family in their care can lead to

[217] L Wexler, The Importance of Identity, History, and Culture in the Wellbeing of Indigenous Youth, The Journal of the History of Childhood and Youth, 2009.
[218] YouthAOD Toolbox, Client-centred & holistic, YouthAOD Toolbox, https://www.youthaodtoolbox.org.au/client-centred-holistic.
[219] Council for Aboriginal Alcohol Program Services Corporation, Annual Report 2019.
[220] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[221] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.
[222] D G Kilpatrick, R Acierno, B Saunders, H S Resnick, C L Best & P P Schnurr, Risk factors for adolescent substance abuse and dependence: data from a national sample, Journal of Consulting and Clinical Psychology, 2000.
[223] M Whitesell, A Bachand, J Peel & M Brown, Familial, Social and Individual Factors Contributing to Risk for Adolescent Substance Use, Journal of Addiction, 2013.
[224] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.

improvement in family functioning, by strengthening protective factors and reducing risk factors in the family system, thereby reducing the likelihood of relapse following treatment.[225] Copello, Velleman and Templeton found that treatments involving a person's family **"show, in the long term, an increase in the number of days spent abstinent compared to interventions that do not."**[226] Additionally, involving families and carers in young people's care has also been found to increase their engagement with the service.[227]

Involving families and carers in young people's care is particularly important for Aboriginal young people – given the importance of Aboriginal family and kinship, and their connection to culture.[228] Research by Sharifian supports this, finding that for many Aboriginal children and young people, **"Family is the centre of existence; everything and everyone is about Family and every experience ends in Family."**[229]

Effective service models engage families and carers in young people's care in various ways, where possible and appropriate. In the first instance, families and carers can help identify young people with AOD and/or co-occurring issues, and motivate them to access a service (as described in Section 0).[230] Once young people enter treatment, families and carers can be engaged in a number of ways, including by:

- **Participating in planning the young person's care:** Generally, families and carers can provide unique insight into young people and their AOD and/or co-occurring issues. Involving families and carers in the planning process as partners can not only improve the quality of the plan that is developed, but also give families and carers a sense of ownership over their children's treatment.[231]
- **Maintaining regular contact with the young person:** If treatment involves a residential component, families and carers can be invited to maintain regular contact with the young person, either through face-to-face visits or phone calls.
- **Participating in activities:** Cultural and recreational activities can provide an opportunity for families and carers to connect with the young person. An interjurisdictional service provider highlighted that they provide families and carers with the opportunity to not only participate in, but also lead these activities.
- **Engaging in family therapy:** Family therapy is an evidence-based intervention for young people with AOD issues.[232] It targets the interaction patterns between family members that permit or encourage the young person's AOD and/or co-occurring issues.[233] For families and carers, this intervention will address their functioning as individuals and in their caregiver role, and their parenting practices and skills.[234]

[225] C L Rowe, Family Therapy for Drug Abuse: Review and Updates 2003 – 2010, Journal of Marital & Family Therapy, 2012.
[226] A G Copello, R B Velleman & L J Templeton, Family interventions in the treatment of alcohol and drug problems, Drug and Alcohol Review, 2005.
[227] H B Waldron, S Kern-Jones, C W Turner, T R Peterson & T J Ozechowski, Engaging resistant adolescents in drug abuse treatment, Journal of Substance Abuse Treatment, 2007.
[228] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014; National Indigenous Drug and Alcohol Committee, Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples, Australian National Council on Drugs, 2014.
[229] F Sharifian, Cultural Conceptualisations in English Words: A Study of Aboriginal Children in Perth, Language and Education, 2005.
[230] A G Copello, R B Velleman & L J Templeton, Family interventions in the treatment of alcohol and drug problems, Drug and Alcohol Review, 2005.
[231] S Hornberger & S L Smith, Family involvement in adolescent substance abuse treatment and recovery: What do we know? What lies ahead?, Children and Youth Services Review, 2011.
[232] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.
[233] YouthAOD Toolbox, Family Focussed Interventions, YouthAOD Toolbox, https://www.youthaodtoolbox.org.au/family-focussed-interventions.
[234] A Bruun & P Mitchell, A resource for strengthening therapeutic practice frameworks in youth alcohol and other drug services, YSAS, 2012.

Upon exiting the service, family involvement is critical to maintaining positive results achieved during treatment.[235] This is discussed further in Section 2.4.3.

However, it is important to understand that not all young people can have, or want, their family to be involved in their care. For example, young people with AOD and mental health issues may also have family members with AOD and/or co-occurring issues, or be concerned with family conflict and violence. This was the case for some young people in the Rongo Ātea Youth Alcohol and Drug Service, who found that contact with their family throughout the treatment was an obstacle to their progress.[236]

"It's about the young person's comfort with family being involved."

- Interjurisdictional service provider

> *"No contact with the family would have been good… I just couldn't handle that. It would have helped me… if I didn't keep ringing them… and all I can hear them saying is 'oh we're having a bong'."*

Source: M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.

In these situations, involving family can be difficult or stressful for the young person.[237] Encompass Family and Community recommended that "in such cases, while work may occur with a young person individually, understanding their family context remains important. It may be possible to support the young person in strengthening connections with at least one 'safe' family member."[238]

2.4.3 Provide appropriate aftercare to help young people exiting the service to sustain positive outcomes

Effective and ongoing aftercare is critical to the long-term success of services for young people with AOD and/or co-occurring issues.[239] While many treatments have shown promise in producing immediate changes in young people's AOD use, relapse in the first year post-treatment remains a major concern.[240] A study by the Recovery Research Institute found that for young people between 12 to 17 years old, relapse rates are high with between 55 and 90 per cent drinking alcohol or using other drugs within the first year post-treatment.[241] Research also demonstrates that aftercare reduces the likelihood of relapse in young

[235] C L Rowe, Family Therapy for Drug Abuse: Review and Updates 2003 – 2010, Journal of Marital & Family Therapy, 2012.
[236] M Kapuaahiwalani-Fitzsimmons, Critical Success Factors in Kaupapa Māori AOD Residential Treatment: Māori Youth Perspectives [thesis], University of Otago, 2014.
[237] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.
[238] Encompass Family and Community, Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People, Dovetail, 2014.
[239] R J Williams, S Y Chang & Addiction Centre Adolescent Research Group, A Comprehensive and Comparative Review of Adolescent Substance Abuse Treatment Outcome, American Psychological Association, 2000.
[240] R Gonzales, A Ang, D A Murphy, D C Glik & M D Anglin, Substance Use Recovery Outcomes among a Cohort of Youth Participating in a Mobile-Based Texting Aftercare Pilot Program, Journal of Substance Abuse Treatment, 2014.
[241] A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.

people,[242] and the longer aftercare can be provided, the better the outcomes experienced by the young person will be.[243]

The evidence base on the appropriate aftercare for young people with AOD and/or co-occurring issues should involve is still developing.[244] However, several key themes have emerged in the existing literature.

- **Aftercare should be flexible.** Young people should be able to access aftercare flexibly through a range of modes to ensure that it is available to young people who cannot meet in-person. There is evidence to support the efficacy of delivering aftercare via outreach into young people's homes,[245] via telephone call,[246] or via mobile text.[247] Case Study 14 shows how technology can be utilised to deliver aftercare in a flexible manner.
- **Aftercare should be fun.** Research identifies that young people tend to enter aftercare unmotivated and resistant, unless they are leaving a lengthy residential service.[248] To illustrate, one young person involved in a study by Nash et al. identified that "I went in and like, at first I didn't want to be there."[249] Therefore, engaging in fun activities was identified by young people in Nash et al.'s study as key to their aftercare attendance.[250]

> *"I mean, the fun is so important because as people get into program they are like, 'How do I have fun sober?' And it turns out you have a lot more fun sober because you can remember it at the end."*

Source: A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.

- **Aftercare should involve peer and adult role models.** Nash et al. found that involving other young people in recovery and adults who can be "recovery role models" in a young person's aftercare can help the young person to "begin to perceive sobriety as more appealing than alcohol or drug use."[251] Repeated exposure to these young people and adults' recovery stories can inspire hope in the young person and motivate them to avoid relapsing.[252]

[242] S D Whitney, J F Kelly, M G Myers & S Brown, Parental Substance Use, Family Support and Outcome Following Treatment for Adolescent Psychoactive Substance Use Disorders, Journal of Child & Adolescent Substance Abuse, 2002; K C Winters, A M Botzet & T Fahnhorst, Advances in Adolescent Substance Abuse Treatment, Current Psychiatry Reports, 2011.
[243] R H Moos & B S Moos, Long-term influence of duration and intensity of treatment on previously untreated individuals with alcohol use disorder, Addiction, 2002.
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[245] R Gonzales, M Hernandez, D A Murphy & A Ang, Youth Recovery Outcomes at 6 and 9 Months Following Participation in a Mobile Texting Recovery Support Aftercare Pilot Study, American Journal of Addiction, 2015.
[246] R Gonzales, M Hernandez, D A Murphy & A Ang, Youth Recovery Outcomes at 6 and 9 Months Following Participation in a Mobile Texting Recovery Support Aftercare Pilot Study, American Journal of Addiction, 2015.
[247] R Gonzales, M Hernandez, D A Murphy & A Ang, Youth Recovery Outcomes at 6 and 9 Months Following Participation in a Mobile Texting Recovery Support Aftercare Pilot Study, American Journal of Addiction, 2015; R Gonzales, A Ang, D A Murphy, D C Glik & M D Anglin, Substance Use Recovery Outcomes among a Cohort of Youth Participating in a Mobile-Based Texting Aftercare Pilot Program, Journal of Substance Abuse Treatment, 2014.
[248] A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.
[249] A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.
[250] A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.
[251] A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.
[252] A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.

> *And I came to, you know, believe that it had to work, you know, for one reason because I saw the proof in front of me, you know. These people used the same way I did, and now their life is OK… They're smiling and laughing and having fun and I'm still miserable.*

Source: A Nash, M Marcus, J Engebreston & O Bukstein, Recovery from Adolescent Substance Use Disorder: Young People Describe the Process and Keys to Success in an Alternative Peer Group, Journal of Groups in Addiction and Recovery, 2015.

- **Aftercare should involve families.** Family involvement can be key to successful aftercare, with research demonstrating that the degree of family support that a young person receives in their post-treatment environment is an important predictor of long-term treatment success.[253] Similarly, a study by Whitney et al. found that higher ratings of family helpfulness by young people were associated with lower rates of post-treatment substance use.[254] In addition to helping the young person to feel supported, family involvement in aftercare can improve family cohesion, aiding in the young person's recovery.[255]
- **Aftercare should be holistic.** It is important that aftercare not only focusses on helping young people to manage their AOD and/or co-occurring issues, but also on helping them to reintegrate into their community. This is critical given that frequently cited causes of relapse include a lack of relevant infrastructure to support people leaving treatment and the existence of AOD use triggers in communities.[256] Ensuring that young people can cope on their own outside of treatment will increase their chances of avoiding relapse.

> *It's not just about addiction – it's about relationships, accommodation, getting a job. These were my questions when I finished residential treatment… Recovery is not just about being AOD-free, it is about becoming a citizen.*

Source: P Parsonage & F Greenman, Addiction & Aftercare: Final Project Report, AOD Provider Collaborative, 2013.

[253] J M Jenson & J K Whittaker, Parental involvement in children's residential treatment: From preplacement to aftercare, Children and Youth Services Review, 1987.
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[255] S D Whitney, J F Kelly, M G Myers & S Brown, Parental Substance Use, Family Support and Outcome Following Treatment for Adolescent Psychoactive Substance Use Disorders, Journal of Child & Adolescent Substance Abuse, 2002.
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Case Study 14 | Educating and Supporting Inquisitive Youth in Recovery

EDUCATING AND SUPPORTING INQUISITIVE YOUTH IN RECOVERY (ESQYIR)

Project ESQYIR, United States of America

Approach

The ESQYIR text messaging program aims to assist youth with recovery and self-regulating key areas associated with relapse during the initial three months after-treatment. This is done through three types of text messaging: daily self-monitoring and feedback texts, a daily wellness recovery tip, and substance abuse education and social support resource information on weekends.

- **Self-monitoring text messages** focussed on the following core areas associated with youth relapse post-treatment – low confidence, stress, negative mood, not engaging in recovery goal-directed behaviours, and continued substance use.
- **Feedback text messages** consisted of positive appraisal messages, motivational/inspirational messages, stress management tips, and coping advice.
- **Daily wellness texts** provided a recovery tip of the day focused on general health/wellness. The text prompt said: "Today's a new day in your recovery, think about the change ur working towards…[wellness tip]."
- **Substance abuse education texts** were on specific drug effects/consequences that were tailored to individual participants' primary substances they reported receiving treatment for.[257]

Outcomes

A pilot study was conducted on the ESQYIR text messaging program in 2014. From January 2012 through July 2013, a total of 80 young people were recruited from outpatient and residential treatment programs, geographically dispersed throughout Los Angeles County, California. The pilot study revealed that young people who participated in the texting mobile pilot intervention were significantly less likely to relapse compared to young people who received aftercare as usual. These findings suggest that mobile texting could provide a feasible way to engage youth in recovery after AOD treatment, to aid with reducing relapse and promoting lifestyle behaviour change.[258]

[257] R Gonzales, A Ang, D A Murphy, D C Glik & M D Anglin, Substance Use Recovery Outcomes among a Cohort of Youth Participating in a Mobile-Based Texting Aftercare Pilot Program, Journal of Substance Abuse Treatment, 2014.
[258] R Gonzales, A Ang, D A Murphy, D C Glik & M D Anglin, Substance Use Recovery Outcomes among a Cohort of Youth Participating in a Mobile-Based Texting Aftercare Pilot Program, Journal of Substance Abuse Treatment, 2014.

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