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A therapeutic model for working with traumatised children on Aboriginal communities.

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Abstract

Aboriginal children in Australia are over-represented in both the child protection and juvenile justice systems. Using Western therapeutic models of practice with Aboriginal people who live in remote communities can be highly problematic. Moreover, the historical legacy of past and present legislation, government interventions and racist service provision needs to be acknowledged and addressed prior to any service implementation. This paper presents a therapeutic model of practice that incorporates Aboriginal concepts of healing and spirit within a creative therapeutic framework. It will demonstrate how the model works through principles of community engagement and capacity building, enabling the provision of a culturally derived therapeutic intervention that involves a synergy of both Aboriginal and Western based healing practices. The findings from the implementation of the TeaH model, affirm the need to incorporate Aboriginal concepts of healing, spirit and creative therapies into mainstream practice with Aboriginal people.

Keywords: trauma, healing, therapeutic services, remote communities, medical model, spirit

Introduction

The cumulative effects of colonisation, such as loss of land, language, culture and spiritual identity and the continual forced removal of children, which contributes to intergenerational trauma, has led to high levels of disadvantage among Indigenous Australians (Steering Committee for the Review of Government Service Provision, 2014), which can impact on children’s life experiences. For example, it is anticipated that the numbers of Aboriginal and Torres Strait Islander
children in out-of-home care nationally will almost triple by 2035 (Attorney-General of Australia, 2016), and a significant number of these children will participate in criminal activities and likely become incarcerated (Guthridge, Silburn, & He, 2017). Aboriginal children are more likely to experience a combination of other traumatic events such as illness, family violence, incarceration, financial stress, death, illness or suicide of family members (Atkinson, 2013). And, as Dudgeon (2015) points out, the levels of Indigenous youth suicide across the entire Top End has reached crisis levels.

The Mental Health Council of Australia (2014) have highlighted the urgency of reform, but state that governments tend to maintain the status quo by tinkering with existing systems, rather than moving from statutory to early family support, community involvement and prevention services. Likewise, the council recognised that whilst principles of community involvement is an accepted wisdom across the country, it rarely happens in practice (Mental Health Council of Australia, 2014). Concerns regarding the unmet need for appropriate therapeutic services for Aboriginal children who have experienced trauma is highlighted in numerous commission reports, and should provide the impetus for the federal government to look at service provision in remote areas (Attorney-General for Australia, 2016; Crime and Misconduct Commission, 2004; Northern Territory Government, 2007). The foundations of the TeaH model were formulated as a consequence of this unmet need. At the core of the TeaH model as outlined in this article, is community involvement and a recognition of the trans-generational trauma present within Aboriginal communities. A presentation of the TeaH model occurred at the Australian Childhood Foundation 3rd International Childhood Trauma Conference in 2018. The purpose of this article is to provide a more comprehensive account of the TeaH model whilst outlining the key learning from model implementation.
Neoliberalism, Communities & Healing

The neoliberal paradigm is founded upon the premise that the market is the most efficient mechanism upon which to organise human life and society (Clarke, 2005). Neoliberalism has had a profound effect on remote communities in Australia in many ways. Like colonialism before it, neoliberalism is based on an individualistic philosophy, which runs contrary to the collective nature of community life, which is an important aspect of Indigenous culture (Garond, 2014). Wolfe (2006) states that the underlying motivation of colonialism was access to land and resources, and it could be argued that the neoliberal paradigm is underpinned by this same philosophy. Native Title for example, which advocates for individual/family ownership rather than community ownership has worked to divide communities, whilst allowing further access to land and resources by multi nationals and governments (Harvey, 2007). According to Coburn (2000), neoliberalism undermines social cohesion and trust, which are the foundations of a strong community. This can further compound the existing trans-generational trauma because communities experience further fragmentation with families pitted against each other as a consequence of income inequalities, which in turn produces powerbrokers and gatekeepers that help maintain both the financial and power based status quo.

Likewise, the competitive nature of government funding of services ensures that the underlying principles of competition and organisational self-interest remain paramount, hence the services that fit neatly into this agenda are supported and promoted (Carroll & Greano, 2013). Funding cycles are also notoriously short and politically motivated, hence communities have often experienced a complete absence of consultation in the provision and cessation of services (Bowen, 2016). The unique context of each community must be factored into both community engagement and
service provision and inform how a service should be provided. As a consequence, engagement can be a lengthy process, which sits uncomfortably with short-term funding cycles and a regime of immediate quantitative outputs.

**A Paradigm Shift**

For decades, government funding has supported therapeutic interventions that fall within the medical model, in the face of worsening outcomes and ever-higher rates of suicide (Australian Government, 2013). The *National Strategic Framework for Mental Health for Aboriginal and Torres Strait Islanders* (Commonwealth of Australia, 2017) highlighted the importance of the social determinants of health and culture to mental health outcomes, yet it advocates for funding these same models. The siloed structure of service provision in, for example, alcohol and other drug (AOD) and mental health services, negates and denies Aboriginal holistic healing practices. For example, a siloed structure belies the strong links between self-medicating by using AOD and comorbid Post Traumatic Stress Disorder (Brady, Killeen, Brewerton, & Lucerini, 2000). To Marsh, Cote-Meek, Young, Najavits and Toulouse (2016, p. 1) ‘…strengthening cultural identity, incorporating traditional healing practices, encouraging community integration, and inviting political empowerment can enhance and improve mental health and substance use disorders in Aboriginal populations’.

The Healing Foundation (2014) identified a number of important factors that should be incorporated into any healing program within the Aboriginal context. These factors include: a recognition of past trauma, service based on local culture and values that are underpinned by community empowerment, capacity building and social justice, the involvement of Elders and that spirituality is core to the model. The *TeaH*
model incorporates all of these aspects. One of the key principles of the TeaH model is integrity built on trust, because for Aboriginal people, relationships underpin the success of any service (Price, Roberston, & McDonald, 2011), hence integrity, trust and relationship provide the foundations for all levels of engagement.

Elders from Central Australia contend that, “When a child becomes sick or sad, it is because their spirit has gone. If a child is hit or hurt, their spirit becomes misplaced and uncentred. They lose their sense of self” (Peters, Tjilari, & Ginger, 2010). As traditional healers (Ngangkari) they explained that children are born with the spirit that holds itself in culture and language. Suicide occurs when their spirit is broken. The concept of the spirit is intrinsic to Aboriginal healing and hence is embedded into the TeaH model.

Critical reflection in both practice and personal beliefs was integral to the development of TeaH, as was questioning Western-based assumptions and theories in order to ensure that the fundamental principles of the service was maintained and that the service remained culturally based. For example, the therapy space, the length of time per session and who needs to be present are cultural factors to be considered, and being on country can be healing in itself, and so the client should dictate the space. It is also problematic to assume that a certain place is considered ‘safe’ for a particular client and that a theory base delivered in the West is not underpinned by covert racist assumptions. Likewise, the concept of hour-long sessions at a certain time often does not work within the community context, therefore, the length and timing of a session needs to be flexible.

The make-up of the TeaH team includes a male Aboriginal Elder/artist/healer and a female creative therapy practitioner who both specialise in working with child trauma and abuse. The mix of Aboriginal/non-Aboriginal and male/female is
important in that it ensures that the service is culturally appropriate as, due to the nature of the remit, there are gendered divisions that need to be considered when working in Aboriginal communities. The success of the team’s make-up as outlined above, was later confirmed in the evaluation report (Office of Children and Families, 2013). How this plays out in terms of service provision is guided by the cultural context particular to each community, hence the need for flexibility and fluidity.

**Foundations of the TeaH model**

The scarcity of therapeutic services for remote Aboriginal people in the NT was highlighted in the *Little Children are Sacred Report* in 2007 (Northern Territory Government, 2007), out of which a federally funded service was commissioned to develop an evidenced-based model that would be transferable across remote communities in the NT. The model was based on recommendations derived from a plethora of literature and Royal Commission reports about best practice. The model worked on several levels, but at its core, were principles of community engagement and capacity building, through which a culturally embedded therapeutic service was provided to children and young people traumatised by abuse (Moss & Lee, 2017).

The service aim was to provide a multi-level community response to child abuse and neglect, whilst providing a culturally appropriate therapeutic service to children and young people (Successworks, 2011). The service was delivered to 90 remote communities across the NT. Despite vigorous evaluations by the funding body in 2011 and the Office of Children and Families in 2013, which found it to be successful (SuccessWorks, 2011), the political nature of the funding mechanism in the NT meant that the service was withdrawn in 2014 without community consultation, and the ten-year funding provided by the Federal Government was diverted.
elsewhere. The *TeaH* team, who were part of the original service, have taken recommendations from both of these reports to inform and enhance the current *TeaH* model.

**The *TeaH* Model**

When implementing the *TeaH* model, the initial stages of engagement includes a scoping exercise as a way of understanding the specificities of the community such as: who the stakeholders are, who provides leadership and who the power holders are. It is also important to understand the underlying factors that could impede service provisions and be cognizant of inclement weather (rainy season), sorry business and school holidays.

There are several stages to model implementation.

Stage 1 involves ongoing community consultation which includes regular meetings with the Elders and Traditional Owners, as well as the communities strong men and women and the service providers. It is through this ongoing engagement that the community is able to ascertain the trustworthiness and integrity of the service providers (Moss, Faulkner, & Horwood, 2009). Regular and frequent visits need to occur as a way for the community to perceive the service as reliable (Office of Children and Families, 2013).

At Stage 2, requests for services are substantially increased with reciprocity and capacity building taking several forms. The community and the service providers are offered a range of workshops devised to heighten understanding about abuse and trauma, whilst providing two-way learning in keeping children safe by highlighting the strengths in the community. It is through the ongoing engagement highlighted above, that community members and service providers decide which workshops best
suit their community and who needs to be involved. The types of educational workshops offered to the adults of the community include: strategies for keeping children safe, training on trauma and abuse and how to support children and recognise trauma related behaviours, understanding vicarious trauma, Fetal Alcohol Syndrome Disorder, problem sexual behaviours and creative therapy workshops. Interactive adolescent workshops about relationships, abuse, family violence, jealousy and shame are also offered, as are creative arts, puppetry and dance for younger children, which are based on themes such as keeping safe. These workshops are conducted in collaboration with the schools, families and Elders, and include community and cultural stories relevant to the chosen subject matter, which are weaved into the workshops. They provide a vehicle for community stories around keeping children safe narrated in the local language. The language used is an important consideration because English is often a second, third or fourth language in remote communities in the NT. Among the creative media utilised such as art, music and dance, twelve hand-made marionettes were created as both an engagement tool and as part of the therapeutic process.

The therapeutic work with children and young people begins in Stage 3. The young people are either self-referred or referred by service providers, schools or their families. The use of creative therapies with children is well documented (Case & Dalley, 1992; Malchiodi, 1999). Atkinson’s (2013) research highlighted that trauma practice with Aboriginal people identified the ‘strongest tools’ in recovery were stories, art, music, dance, play and performance, as these allow for healing that transcends language and narrative. These stories and modalities provide linkages to community, country, culture and identity, and TeaH utilises all of these forms of
media. Van der Kolk (2014) highlights how developmental trauma inhabits the body and so replaying the trauma narrative can impede recovery by addressing trauma on a solely cognitive level. Perry’s (2006) theoretical framework, which takes into account the nature of neurodevelopment and the age at which the trauma occurred, is also integrated into the TeaH model. Perry (2006) identified the effect of abuse on the growing brain and highlighted the use of sensory experience and creative therapies in healing. There are also a number of synergies between creative therapies and Aboriginal culture, which include relationship, connection, silences, body language, symbolism, narrative and creativity itself.

**Researching the model**

*TeaH* received two short-term Charles Darwin University research grants in 2017/18 that enabled the team to visit a community to gather evidence about the model’s transferability because much of the data from the original federally funded program was inaccessible for further analysis. The initial grant was used to engage an artist to design and make the 12 aforementioned hand-made marionettes that were created specifically for community work.

The research took place in a very small community (approximately 200 people). The community is considered remote, but due to its perceived accessibility to a major centre, it is denied a number of services such as services for youth, a resident doctor and aged care services. There is no public transport and so community members either need a motor vehicle or have the ability to walk 14 km in order to catch public transport into the nearest town some 120 km away. Twenty-five percent of the community are aged 0-17 years and only seven percent are over 60. Whilst there is a primary school, there is no high-school and so high-school aged students
have to travel long distances to attend school. The dropout rate for high-school children, as reported by the council and other community members, is very high.

Communities are dynamic by nature and it is important to understand the particular dynamics at work in each community at a particular time. The issues presented below are not unique. As evidenced by numerous incidences that had occurred over time, the community remained fractured as a consequence of who was officially afforded Traditional Owner status, as this meant that substantial financial capital is retained by one group and not shared across the community. The community is highly politicised with a number of gatekeepers that needed to be engaged in order to ensure service access and to gain community support. Gatekeepers are generally defined as someone that controls access (“Gatekeeper”, n.d.). In the context of remote communities, there are a number of possible reasons as to why certain powerful individuals and other service providers obstruct access to the community for new services such as, the legacy of past services not following through and the denial of abuse and/or collusion with the perpetrators (McCallum, 2010). Many of the young men in this community are unemployed, culturally disengaged and have a high level of substance abuse. According to the Australian Institute of Health and Welfare’s (AIHW, 2012, p. 1) ‘[e]xtensive research demonstrates that there are considerable overlaps between homelessness, child abuse, neglect and criminal activity’. A number of children had been removed from the community and put into foster care, and the recent removal of several children further impacted on the loss and trauma experienced across the community. There were also no youth services available, which according to the Elders, council members and other service providers may be a contributing factor to further disengagement and offending behaviours. During one visit for example, five youths had stolen and smashed a vehicle. To Dawes (2007,
crimes become normalised in some families with generations of family members being involved in the system which only serves to ingrain the idea that going to prison is a ‘rite-of-passage in becoming a man’. Given the multitude of factors that could affect engagement and the limited time available as per funding requirements, it was clear that the project would need to prioritise engagement activities along with service provision, and progression to Stage 3 was unlikely. There were several occasions where sorry business postponed scheduled visits, which had further impact on the limited timeframes allowed for by the funding body.

As requested by the Elders, clinic and school staff, TeaH provided weekly sessions to the clinic and to the school. The clinic had four staff, two of whom were very experienced and had worked in the remote context for many years. Experiential learning workshops looked at trauma, vicarious trauma, Fetal Alcohol Syndrome Disorder and Arts Therapy. The level of unaddressed vicarious trauma experienced by all members of staff came to the fore as they shared their stories. According to Van der Kolk (2014), group work with traumatised adults can provide comfort and connection, which was clearly the case for the clinic staff. They started to recognise vicarious trauma in themselves and they were provided with strategies to deal with it. The small team had ongoing issues with trust and disconnection within the team for some time. The sharing of these sessions and the artwork they produced allowed for connection at a deeper level, which in turn enhanced team functionality. Staff began to identify trauma and recognise the behavioral indicators of trauma in some of the children in the community because of the workshops. TeaH also provided a program at the school which included drawing activities, music and culturally based puppet shows.
Evaluative feedback

Embedded in the model is action learning principles that provided a continuous feedback loop that then informs the service. Flexibility was paramount in order to rapidly adapt to community need. A realist approach (Kazi, 2003; Tilley, 2000) was utilised in the evaluation framework as it specifies ‘...the crucial contextual conditions for the intervention, the change-inducing mechanisms that will be triggered by the intervention, and the anticipated outcomes pattern that will be generated by triggering these mechanisms’ (Tilley, 2000, p. 104).

Feedback from the community was overwhelmingly positive. For example, written feedback from clinic staff highlighted the lack of trauma training health workers receive and the increased self-awareness and growth they experienced as a consequence of the workshops on an individual and group level. Clinic staff stressed the need to extend TeaH services to all remote communities and they highlighted how this new leaning would inform their own practice as health workers.

Considerations

There is no doubt that the time limitations as dictated by the funding had a detrimental impact on the complete roll out of the service. Honesty about the funding source and duration of service provision to community members from the beginning was vital. Factors particular to this community such as, the power dynamics as a consequence of the communities financial arrangements, lengthened the engagement phase. Understanding the power dynamics and the layers of trauma particular to a community is paramount. Due to a range of social factors, this particular community was experiencing a lack of strong cultural male leadership. In other communities, it was the strong male and female Elders, which worked in the service’s favour as they
advocated for the services and worked with the *TeaH* team. As is the case for the majority of remote communities, remoteness, inclement weather and sorry business can be inhibiting factors, as is the expense of travelling to very remote areas, as all of these factors can prevent timely, regular visits that help build relationship, trust and engagement.

Further roll out of *TeaH* would undoubtedly require a longitudinal funding commitment by Governments. In order to break the cycle of trauma, child removal and suicide, Indigenous concepts of holistic healing and spirit along with community development and capacity building need to be incorporated into mainstream service delivery models.

**Conclusion**

As evidenced in this paper, in order to improve health and well-being outcomes for Indigenous Australians, funding bodies must consider holistic and historical factors whilst incorporating Indigenous healing practices and paradigms into service provision. The political nature of limited funding types and cycles must be overtly acknowledged to allow for systemic change to occur in order to address deteriorating health outcomes.

A recent press article (Burnie, 2019) announced that a major public hospital in Adelaide has engaged Ngangkari healers to work with their Indigenous patients, and the article highlights that Indigenous people are more likely to seek medical help as a consequence. According to Dr Simon Jenkins, "If you don't address the spirit of the Aboriginal people in the healing process then they are far less likely to engage in the healthcare system" (Burnie, 2019). We contend that unless this occurs within mental health services the current health gap and suicide rates will continue to escalate.
References


Office of Children and Families. (2013). *Responding to childhood trauma in remote Aboriginal communities of the Northern Territory: An internal evaluation of*


