Mental Health Commission of New South Wales

Aboriginal Social and Emotional Wellbeing Models of Care

Literature Review

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1 Introduction

The Mental Health Commission of NSW (the Commission) intends to develop a preliminary Aboriginal Social and Emotional Wellbeing (SEWB) model of care based on documented examples of good practice across NSW. As a part of this project, a literature review has been undertaken in order to examine the current good practice models of care that are being utilised within Australia. A non-clinical, narrative model of care is being considered as one possible approach. The scope of the literature review was to include government and non-government examples, indigenous and non-indigenous examples, and overseas indigenous examples.

1.1 Guiding principles

In order to identify what constitutes best practice in Australia, existing academic reviews, assessments and government studies were reviewed to establish the work that has been done to date on the SEWB of Aboriginal people and the current direction of research. Research over the last decade has formed a comprehensive understanding of the challenges faced by Aboriginal and Torres Strait Islander people in relation to mental health issues and their SEWB (Commonwealth of Australia, 2017; Newton et al, 2015; Australian Health Ministers’ Advisory Council, 2017; Anderson et al, 2015; Bhui et al, 2007). Recent studies have also identified culturally specific considerations that are fundamental to addressing the SEWB of Aboriginal people (Swan & Raphael, 1995; Togni, 2016; Parker & Milroy, 2014; Dudgeon et al, 2014).

The Ways Forward: National Aboriginal and Torres Strait Islander Mental Health Policy National Consultancy Report (Ways Forward report) was delivered in 1995 and remains the largest systematic review of indigenous views, priorities and gaps in the delivery of mental health services to Aboriginal populations across Australia. Although there has been a significant amount of work and research undertaken in the subsequent 22 years and the nature of policy and program gaps has changed, the report established a set of key principles that should guide the development of any Aboriginal and Torres Strait Islander mental health model.

The following guiding principles are taken from the Ways Forwards report (Swan & Raphael, 1995) and are amended as required (Togni, 2016; Parker & Milroy, 2014; Dudgeon et al, 2014) to be suitable for measuring what constitutes ‘best practice’ and assessing the relative merits and gaps of selected models of care.

1. Aboriginal people have a unique, holistic concept of health that incorporates physical, mental, emotional, cultural and spiritual health. The concept further conceptualises SEWB as being contingent on the relationship between the individual, the community and country. In this manner, an individual cannot achieve positive mental health outcomes without positive connections with their country, their identity and their broader community.

2. Self-determination is a critical component to both appropriately addressing the mental health needs of Aboriginal people and in lessening some of the risk factors that contribute to Indigenous mental ill health. As well as being a fundamental human right, the development, delivery and responsibility for services by Aboriginal people ensures that their distinct cultural, economic and political understandings are appropriately considered.

3. Culturally valid understanding must shape the development and delivery of services.
4. The Indigenous experience of trauma and loss that accompanies a legacy of colonisation and previous government legislation has enormous effect on the current generation of Aboriginal people. These unique social, historical and political factors that negatively influence the SEWB of Aboriginal people are a major cause of loss and grief and should be considered in any mental health service initiative.

5. The human rights of Aboriginal people must be recognised and respected, particularly those human rights relevant to mental illness.

6. Racism, stigma, environmental adversity and social disadvantage experienced by Aboriginal people constitute ongoing stressors and impact in negative ways on the SEWB. Any strategies to improve SEWB must address these structural issues.

7. The centrality of Aboriginal families and kinship; the broad concept of family and bonds of reciprocal affection, responsibility and sharing; and the centrality of these connections to fundamental understandings of identity must be recognised.

8. Aboriginal Australian culture consists of numerous language groups, kinships and tribes. Aboriginal people live a variety of urbanised or traditional lifestyles across urban, rural and remote settings, and frequently move between these ways of living. Importantly, although the differences between Aboriginal experiences needs to be considered, there is a fundamental shared experience of Aboriginal people across Australia and demonstrable similarity in mental health risk factors and distress. The recognition of difference should not exclude the consideration of initiatives that might be applicable across multiple language groups, kinships and tribes.

9. The strength and resilience of Aboriginal people must be recognised, respected, encouraged and appreciated.

1.2 Narrative Therapy

In past consultations, the Commission heard about the importance of narrative in supporting Aboriginal social and emotional wellbeing.

Narrative therapy is a form of psychotherapy that focuses on an individual’s perspective of their lives, views problems as separate from people and emphasises the strengths, knowledge and values that people have and can utilise to confront the stressors they face. The components of narrative therapy that are considered most relevant to the SEWB of Aboriginal people are summarised below in order to better inform an assessment of the relevance to an appropriate MOC for Aboriginal and Torres Strait Islander people (hereafter referred to as Aboriginal people).

Mainstream psychological treatments generally don’t account for cultural differences and so pose a barrier for Aboriginal people when it comes to identifying issues and engaging with treatments (Garvey, 2008; Agius & Hamer, 2003). The practice of narrative therapy involves exploring the stories we all have about our lives, the meaning that we give to our experiences and the implications that these narratives have on our behaviour. Our narratives include stories about the past, present and future; our families and relationships; individuals, communities and culture (Morgan, 2000).

Narrative therapy endeavours to build a research partnership between the practitioner and client whereby there is no pre-conceived view of what is healthy and what is deviant, and so the cultural meaning of issues can be examined and prioritised in healing outcomes. The practice allows for the consideration of institutional, historical and social issues on the SEWB of Aboriginal people, but also
allows for the possibility of reconnecting with a legacy of strength and drawing those skills into the present.

Of particular value to Aboriginal people, the narrative concept prioritises a culturally familiar tradition of story-telling by which to examine, challenge and resolve understandings. It privileges stories of identity and culture, builds strong stories through connection and cultural strengths and identifies the client as an expert in their own story. The process allows the client to tell their own story in their own words, serving to place issues in the context of Aboriginal culture and realities that might otherwise be beyond the understanding of practitioners. In placing an Aboriginal voice and understanding at the centre of the process, narrative therapy immediately allows for the decolonisation of a process that unintentionally imposes a Western prioritised narrative of its own.

The interconnectedness of stories and the shared meaning of events, so fundamental to the indigenous holistic worldview (Garvey, 2008) is a central aspect of narrative therapy. The idea that all things are connected means that family and community response to renegotiating narratives is important, and so kinship connections can comprise a fundamental aspect of testing new narratives and the broader healing process (Agius & Hamer, 2003).

Narrative therapy is fundamentally holistic, allowing for a detailed description of interrelated aspects of life that contribute to an experience. Spiritual and cultural meanings are considered with as much reverence as health and trauma in terms of how they inform an individual’s life. A consideration of the comorbidity of factors influencing a situation allows for an appropriate consideration of other treatment options, but also allows for new understandings of the narrative to emerge. Narrative practices have been adopted and adapted by Aboriginal practitioners and community workers across Australia, with prominent Aboriginal practitioners consistently noting that it is these common elements between narrative theory and the Aboriginal tradition of story-telling that allows Aboriginal people to engage with a process that is fundamentally Aboriginal in concept (Wingard & Lester, 2001; Johnson, 2015; Draham-Butler, 2015; Agius, 2015).

2 Methodology

The literature review was undertaken with a purposive research methodology. The online database PubMed was searched with various combination of the following keywords: narrative therapy, mental health; models of care; best practice; indigenous; social and emotional wellbeing; indigenous models; cultural competency; model evaluations; and overview. Given the parameters of the literature review and the time constraints, priority was given to existing overviews and evaluations of models of care in order to better assess current best practice within the mental health industry. The review of literature was further limited to English language publications within the last five years, on the assumption that the most recent literature would be the best reflection of current models, and that recent comprehensive overviews would identify any earlier work essential to the current review.

In order to ensure that the literature review captured the substantial amount of evidence and outcomes documented in the grey literature, additional references were sourced through the Australian Indigenous HealthInfoNet, an online resource maintained by Edith Cowan University’s Level II Research Centre. The National Aboriginal and Torres Strait Islander health plan 2012 – 2023 and the National strategic framework for Aboriginal and Torres Strait Islander peoples’ mental health and social and emotional wellbeing 2017 – 2023 and any subsequent reviews and reports on these plans were reviewed in detail as the primary contemporary funding sources, studies and reviews for indigenous mental health models in Australia. Additional resources were identified and provided by
the Mental Health Commission as being of particular relevance to the review and these models were incorporated into the comparison of best practice models within Australia.

The review parameters determined that a review of models should include best practice models of care including:

- Indigenous and non-indigenous
- Government and non-government
- Within Australia and overseas

Models for review and comparison were subjectively selected based on their relevance to the the Commission’s project goal and their ability to cover the key criteria outlined in the literature review parameters. The review of overseas indigenous models of care was deliberately limited to New Zealand, given the similarity of mental health concerns and the similarity of cultural considerations.

There has been some work in recent years on defining success in indigenous mental health programs and community managed programs. These reviews have consistently observed difficulties in this kind of assessment due to the rarity of well-designed evaluations for individual projects, but one review by the Child Family Community Australia (Anderson et al, 2015) has reviewed internal evaluations, case studies and program descriptions across 40 indigenous managed studies (CFCA review) to define the factors that support effective Indigenous community managed programs.

Key indicators of good practice were established by the Commission in consultation with Aboriginal leaders to measure the value and success of the proposed Model of Care. In order to assess the relative merits of each MOC in how it might meet the the Commission’s indicators, a set of criteria have been applied to each indicator. The below criteria are drawn from current understandings of what constitutes a culturally sensitive model of care and draw on the meaningful insights presented in the CFCA review (Anderson et al, 2015; Commonwealth of Australia (Department of Health), 2017; Swan and Raphael, 1995; Australian Health Minister’s Advisory Council, 2017).

- Empowering communities
  - Facilitating community control over program
  - Prioritising indigenous worldview
  - Aboriginal participation in development, implementation and delivery of programs
  - Bottom-up development (people affected by decisions are controlling decisions)
- Building Capacity
  - Facilitating community ownership of programs
  - Employing local Aboriginal staff
  - Harnessing and supporting existing Aboriginal services and leaders
  - Balance between governance standards and community values
- Stability over time
  - Governance structure
  - Establishing trusting partnerships
  - Flexibility in implementation timeline
  - Sustainable funding
- Building Case for Investment into MOC
  - Does the model of care demonstrate measurable success
  - Does the model of care fill any existing gaps in the current system
  - Is narrative therapy a consideration of the model
Each model was considered initially with regard to identifying the key factors for success according to the established guiding principles, and subsequently reviewed for key learnings that might be applied to the Commission’s model of care, according to their indicators. In each case, a traffic light system was used to assess the performance of the model against the set of criteria as per the below table.

<table>
<thead>
<tr>
<th>Colour</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Performs well. Criterium is directly addressed, is a primary consideration of the model and delivers best practice or provides direct opportunity for improvement against this criterium.</td>
</tr>
<tr>
<td>Orange</td>
<td>Performs adequately or has the potential to perform well with time or additional resources. The criterium is not a central component of the model, but the model does not completely ignore or contradict the criterium.</td>
</tr>
<tr>
<td>Red</td>
<td>The criterium is not a consideration of the model, the model has no direct application to the criterium or the model contradicts the goal of the criterium.</td>
</tr>
</tbody>
</table>

Table 1: Definition of traffic light system to assess performance of models against guiding principles and indicators.

Rather than attempting a comprehensive review of indigenous health models of care outside of Australia, the literature review has concentrated on a well-documented and published model incorporating narrative therapy into the treatment of Maori children and adolescents. The comparison was considered the most culturally appropriate, given the similarity of mental health and social disadvantages shared by Maori and Australian Aboriginal cultures; the shared experience and historical trauma associated with recent colonisation; and the complexities involved in dealing with a single culture made up of many individual language groups with occasionally disparate cultural and societal laws.

2.1 Limitations of the Literature Review

The current review was necessarily restricted by time and budget and cannot be considered a comprehensive, systematic review of the literature that exists on the topic. Further research could expand on the many models of care that are concentrating on specific challenges facing Aboriginal people within the field of mental health such as alcohol and drug addiction; suicide prevention; or depression, all of which returned a substantial body of additional literature.

The incorporation of cultural competency and considerations into the delivery of mental health services is increasing, and there are myriad models of care in Aboriginal SEWB that could have been examined. Most models have not been subject to review or assessment due to their infancy or lack of assessable data, and priority has necessarily been given to models of care that have had some analysis of results.

The review is considered sufficient to adequately identify current trends and indigenous models of care being implemented within Australia and New Zealand and to inform the Commission’s ongoing research into measuring the relative success of adopting these strategies when interacting with Aboriginal and Torres Strait Islander people across the Mental Health Industry.
3 Models of Care

The models of care that were reviewed as part of this study were chosen based on the scope of their current application, their relevance to the Commission’s stated objectives and to meet the key criteria of the literature review. The National Strategic Framework was considered in particular detail in order to understand how the selected models fall within the Commonwealth’s strategic direction and to identify any deficiencies in the outcomes and actions identified within the plan. It is proposed that this process would allow for the development of a more meaningful, complementary model that fits into the Commonwealth’s strategic direction, but might fill some of the gaps in the Commonwealth’s identified implementation strategy.

- National strategic framework for ATSI peoples’ mental health and SEWB
- Stay Strong Care Plan
- Empowered Communities
- Uti Kulintjaku
- Alive and Kicking Goals
- Tātaihono (NZ)
- Aboriginal Mapping

Although a number of non-indigenous models of care were examined as a part of the literature review, none of them performed well enough against the Guiding Principles to be considered ‘best practice’ when it comes to addressing the SEWB of Aboriginal people. This seems to confirm the fundamental basis of developing a separate, culturally appropriate model of care for addressing the mental health and SEWB of Aboriginal people.

3.1 National strategic framework for Aboriginal and Torres Strait Islander peoples’ mental health and SEWB (2017-2023)

The National strategic framework for Aboriginal and Torres Strait Islander peoples’ mental health and social and emotional wellbeing (NSF) sets out a stepped model of care that is considered applicable to mainstream health services but has a particular focus on ensuring that the model is culturally appropriate for Aboriginal people. In a stepped model of care such as this, treatment is delivered on an escalating basis dependant on need. The model ensures that the most effective and least resource intensive treatment is delivered to clients first.

The NSF draws on the Ways Forward report in establishing nine guiding principles and an existing SEWB conceptual framework (Gee et al, 2010; 2013; 2014) to develop a set of Action Areas. The Action Areas comprise each of the escalating steps within the model of care, and a set of outcomes are established within each level of the system. For each outcome (Appendix 1), the NSF sets out a rationale, a series of key strategies and some example actions through which it proposes to meet the desired outcome. The strategy develops on the identified priority of prevention, early intervention and rehabilitation and the changing needs through life cycle, as established in the previous National Framework (SHRG 2004).

3.1.1 Measurement criteria

The NSF is considered an example of best practice because of its framework, its prioritisation of Aboriginal people’s participation and leadership, a well-established context and review of relevant issues and the continued development of a strategy based on key learnings from previous strategies.
and performance reports. Although there are serious limitations to assessing the success of the NSF as a model of care, it provides a clear strategic plan to focus the implementation of mental health and SEWB initiatives.

Given the detailed implementation process that is included within the Framework, it is appropriate to consider the NSF as a MOC in and of itself, although it’s use as a strategic direction document is also taken into account. A detailed examination of how the Australian Government proposes to implement the NSF is provided below as a crucial step in identifying how current and future models fit within the National Priorities in Aboriginal SEWB and identifying any gaps in the NSF that might be addressed in the development of future models.

3.1.1.1 SEWB within a holistic context of SEWB, physical, cultural and spiritual health
There is a strong focus on holistic care across many of the Action Areas, with the earlier steps of the model prioritising practical initiatives related to employment, education, parenting programs and proactive substance abuse intervention (i.e. Outcome 2.2, 2.3). These early stages also identify the role of culture, connection and elder involvement as integral to preventing adverse mental health conditions (i.e. Outcome 2.1, 2.4). There is a slightly higher emphasis within the later Action Areas of the model (i.e. Outcome 3.1, 3.2, 4.3, 5.2) on the co-ordination of frontline, specialist and support services.

3.1.1.2 Self-determination
Self-determination is a strong focus across all Action Areas within the NFS. The model identifies the necessity of co-design (i.e. Outcome 1.3), Aboriginal people’s ownership of programs (i.e. Outcome 1.1, 2.2, ) and supporting Aboriginal organisations (i.e. Outcome 1.1, 1.3, 2.1, 2.2, 3.1) as crucial across all levels of prevention and treatment. Building the capacity of Aboriginal Community Controlled Health Services is highlighted throughout the NFS as an example of supporting Aboriginal organisations to provide mental health and SEWB services within their own communities. The NSF promote active participation in ongoing research to empower communities (i.e. Outcome 1.2).

3.1.1.3 Culturally valid understandings informing the development, management and delivery of services
Ensuring cultural competency across the delivery of service was identified through the provision of resources and strategies to increase Aboriginal employment (i.e. Outcome 1.1, 4.2) and increase the education and training opportunities for Aboriginal mental health workers (i.e. Outcome 1.1). The cultural competence of non-indigenous practitioners is also identified as a strategy for improving culturally appropriate delivery of service (i.e. Outcome 1.1, 4.2). According to the NFS, a major aspect of the cultural validity of SEWB models of care is in ensuring that Aboriginal people have access to culturally appropriate treatment and care (i.e. Outcome 1.1, 1.2, 3.1, 4.1) and that they are comfortable accessing mental health services (i.e. Outcome 3.3, 4.1, 4.2)

3.1.1.4 The effect of historical trauma
The effect of historical trauma is directly addressed in the Third Action Area (Build capacity and resilience in people and groups at risk), through advocating family tracing and reunion programs for
members of the Stolen Generation (i.e. Outcome 3.1), and seeking to prevent reactivation of trauma from childhood institutionalisation (i.e. Outcome 3.2).

3.1.1.5 Human rights of Aboriginal people
The human rights of Aboriginal people is perhaps most obviously addressed through attempts at Closing the Gap between Aboriginal populations and mainstream society. In the NSF, this is addressed through establishing research and evaluation criteria to properly measure the differences between cultures, changes in variables and the effect of interventions (i.e. Outcome 1.2, 4.1, 4.2). The development of appropriate assessment tools and clinical pathways for Aboriginal people is addressed at length within the NSF and across all levels of the model (i.e. Outcome 1.2, 3.3, 4.1, 4.2, 5.1, 5.2), as well as endeavours towards ensuring equal access to services and treatments (i.e. Outcome 4.2, 5.1, 5.2, 5.3)

3.1.1.6 The effect of racism, stigma, environmental adversity and social disadvantage
The effect of racism isn’t directly addressed through any of the NSF model’s Outcomes, Key Strategies or Example Actions. The effect of stigma is indirectly addressed through a number of strategies and actions promoting community education and awareness of risk factors, sources of strength and general mental health literacy (i.e. Outcome 2.2, 2.4, 3.3). The effects of environmental adversity and social disadvantage are addressed through strategies and actions aimed at supporting the unification of families separated due to the Stolen Generation policy, government department intervention and young people in juvenile detention (i.e. Outcome 2.2) and through the provision of resources to intervene against inter-generational disadvantage (i.e. Outcome 2.3)

3.1.1.7 The centrality of family and kinship to SEWB
The concept of family and kinship relationships within the community as being central to the SEWB of Aboriginal people is only peripherally referenced within the NSF, although there are specific strategies and actions that emphasise the support role of elders (i.e. Outcome 2.1, 2.4) and the potential for individual men’s and women’s groups to be appropriate forums for encouraging SEWB (i.e. Outcome 2.1)

3.1.1.8 The diversity of Aboriginal groups across Australia
Although no specific actions are identified for the differential requirements of communities across Australia, the focus of the NSF on increasing the capacity of Aboriginal Community Controlled Health Services allows for each community to design programs and make decisions relevant to their own priorities.

3.1.1.9 The strengths and resilience of Aboriginal people
The NSF model highlights strength and resilience of Aboriginal people through the identification of families as coping mechanism (i.e. Outcome 2.2), support for traditional healing practices (i.e. Outcome 3.1), encouraging the development and application of help-seeking behaviour and focus on recovery (i.e. Outcome 3.3, 5.2), and advocating strategies and actions that prioritise client participation in treatment plans (i.e. Outcome 4.2, 4.3, 5.1, 5.2). There are key elements of drawing
on culture, connections and country to create a strong foundation that are not considered at all as part of the NSF.

3.1.2 Key Progress Indicators

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowering Communities</td>
<td></td>
<td>The NSF model draws directly on the Guiding Principles identified as necessary for a successful Aboriginal SEWB Model of Care, but certainly has a stronger focus on governance related principles that are more obviously within the Australian Government’s remit and control. Thus, the strongest focus of the MOC is on resource support of existing Aboriginal organisations, the education and training of staff in cultural competency, promoting education and awareness initiatives within communities, the development of assessment tools and clinical pathways, and prioritising client participation in treatment plans. Importantly, although specific actions are identified in terms of where resources and advocacy should be concentrated, individual programs and models required to link actions, strategies and outcomes are not detailed as part of this model.</td>
</tr>
<tr>
<td>Building Capacity</td>
<td></td>
<td>The NSF has a clear focus on encouraging the co-design and Aboriginal ownership of programs across Aboriginal SEWB and mental health. The NSF also supports the capacity building of Aboriginal people through education, training and employment opportunities and of Aboriginal Community Controlled Health Services. Although the model identifies clear goals in relation to Empowering Communities and Building Capacity, there is no definitive action associated with those ambitions.</td>
</tr>
<tr>
<td>Stability Over Time</td>
<td></td>
<td>Any measurement of the NSF’s stability over time will be contingent on programs and models of care identifying the NSF as the guiding document in their inception, development and delivery; identifying key measurement criteria for success and recording them over the delivery of the program; and reporting results in a manner conducive to such assessments.</td>
</tr>
<tr>
<td>Business Case for MOC</td>
<td></td>
<td>The NSF encourages actions and outcomes that support some of the guiding principles, but there are noticeable gaps in how the Commonwealth proposes to address the effect of historical trauma; the effect of racism, stigma, environmental adversity and social disadvantage; the centrality of family and kinship; and the strength and resilience of Aboriginal people. These key guiding principles are areas that are potentially well-addressed through the development of a narrative therapy MOC.</td>
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Table 2: Performance of the National Strategic Framework against the Commission’s key progress indicators.
3.2 Australian Integrated Mental Health Initiative ‘Stay Strong Care Plan’

The Australian Integrated Mental Health Initiative (AIMhi), a research programme undertaken by the Menzies School of Health Research included a research project between 2003 – 2008 aimed at improving outcomes in indigenous mental health. The project included the development and testing of a brief motivational intervention or ‘Motivated Care Planning’ (MCP) model that was driven by local Aboriginal perspectives on emotional and social wellbeing and focused specifically on a strength and resilience strategy, increased education and family engagement. Ultimately, a set of culturally appropriate resources were developed to facilitate the delivery of the MCP model by Aboriginal Health Workers, nurses, GPs and other health professionals working in clinical and community settings. The model and associated resources are marketed as the ‘Stay Strong Care Plan’ (SSCP).

The model is focused on treatment of Aboriginal people that are already seeking mental health assistance and is offered concurrently with ‘treatment as usual’. The model is specifically designed to increase mental health outcomes for Aboriginal people in a remote setting. The model and subsequent trial of the MCP strategy was the culmination of research that established baseline measurements in indigenous mental health; identified and developed culturally appropriate resources and means of communication; and developed training in culturally appropriate approaches to mental health for remote service providers.

Subsequent development of the SSCP resources includes the AIMhi Stay Strong App, which is an online platform by which to access the existing Stay Strong tools, thereby increasing the accessibility of the model and ensuring the delivery is simple, intuitive and suitable for Aboriginal clients in a clinician supported delivery.

3.2.1 Measurement criteria

The SSCP was selected for review as an example of best practice MOC because it is widely accepted, meets Medicare requirements for mental health treatment plans and performed reasonably well against many of the guiding principles, with very strong performance in some of the categories that are often poorly considered in other models of care.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
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<tbody>
<tr>
<td>Holistic Context</td>
<td></td>
<td>Strong emphasis on family; consideration of what makes us strong includes culture, country and kinship connections</td>
</tr>
<tr>
<td>Self-determination</td>
<td>Red</td>
<td>Aboriginal co-design, training for Aboriginal staff, building capacity of AHCCC</td>
</tr>
<tr>
<td>Culturally valid understanding</td>
<td>Green</td>
<td>Driven by Aboriginal people at every stage of development, management and delivery</td>
</tr>
<tr>
<td>Effect of historical trauma</td>
<td>Red</td>
<td>No specific reference</td>
</tr>
<tr>
<td>Human rights</td>
<td>Red</td>
<td>Development of appropriate assessment tools and clinical pathways</td>
</tr>
<tr>
<td>Effect of racism, social</td>
<td>Red</td>
<td>No specific reference</td>
</tr>
<tr>
<td>disadvantage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centrality of family and</td>
<td>Green</td>
<td>Strong focus on family involvement and support</td>
</tr>
<tr>
<td>kinship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diversity of cultures</td>
<td>Orange</td>
<td>Specifically developed for local community with regionally specific images, music, language; but designed primarily for remote users</td>
</tr>
<tr>
<td>Strength and resilience</td>
<td>Green</td>
<td>A primary focus of the model</td>
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</table>

Table 3: Performance of the AIMhi Stay Strong Plan against the identified Guiding Principles.
The SSCP is further identified as an example of best practice given the measurable success of a controlled pilot study that tested part of the plan - the MCP. The study utilised mixed methods, incorporating sequential and concurrent phases of data collection (Nagel & Thompson, 2010) during a randomised controlled trial. The RCT design collected quantitative and qualitative data that allowed a broad examination of the MCP’s effect, with sensitivity to the meaning of data collected and what contributed to the success or failure of the model. Participants (49) and carers (37) from 3 communities participated in the study, which consisted of two one-hour sessions, focused on goal setting, psychoeducation and engagement with families. Outcomes were measured from both the client and clinician perspectives and suggested that the MCP improved the mental health of participants and that the improvement was sustained over time (Magel & Thompson, 2009; 2010).

Since the initial RCT, the AIMhi assert that the “AIMhi SSCP is already being used by health and community services across Australia” (Menzies School of Health Research website), but there is no statistical data on the roll out, delivery or relative success of the model. There is no assessment of whether the model demonstrates similar levels of success outside of remote environment in which it was tested, or if the addition of a digital app has increased access or improved results.

The ability to consider the model’s adherence to guiding principles in the context of the results of the RCT allows a much more thorough examination of the reasons for the model’s success. The key factors identified in this study were:

- Recognising the importance of family
- Involvement of Aboriginal people in the development of the model and the resources
- Culturally appropriate delivery
- Focus on strength and resilience, goal setting rather than identifying ‘problem’
- An understanding of the complexity of comorbidity and social disadvantage
- Holistic approach in recognising worries, strengths and goals

Results suggest that the strength and resilience focus of both the MCP and the SSCP led to a marked improvement in SEWB, even when external factors were unchanged, exemplifying the importance of strength and resilience focus even without goal resolution.
### 3.2.2 Key Progress Indicators

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
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<tbody>
<tr>
<td>Empowering Communities</td>
<td>The SSCP model was developed with consultation of Aboriginal communities at every step of the process. Local Aboriginal Mental Health Workers were consulted to develop an understanding of local perspectives and were involved in research and development of tools. Holistic indigenous worldview is well represented in the service—focus on family; identify elements of culture, country and connection that support SEWB; whole of life approach to strengths and stress; openness to the complexity of a clients’ concern rather than identifying predetermined ‘problem’ are all elements that prioritise the indigenous worldview.</td>
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<tr>
<td>Building Capacity</td>
<td>The model builds capacity within the Aboriginal community through the training of Aboriginal staff to deliver the model, providing the SSCP resources to Aboriginal service providers to better recognise and manage SEWB issues within their communities, and providing tools that balance the governance requirements for mental health practice with culturally appropriate assessment and intervention (i.e. the inclusion of the Kesslar K-10 scale and the Whooley version of PHQ 2 as part of an assessment and care plan that also considers the impact of Aboriginal culture, history and contemporary circumstances.</td>
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</tr>
<tr>
<td>Stability Over Time</td>
<td>The model is not highly dependent on continued funding or research, and so appears to have relative stability. Strong partnerships between the researchers and individual local health districts has seen the successful roll out of the SSCP and associated resources across Australia. Given that the model was funded through a research grant and that it is a model used in conjunction with existing therapy options, there is no immediate imperative for the model to be implemented anywhere and there are no associated time or reporting constraints.</td>
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<tr>
<td>Business Case for MOC</td>
<td>The model is not explicitly one of narrative therapy. The MCP is a complementary treatment plan that specifically focuses on family support and obligations as an element of that treatment. However, the plan draws on many of the success factors attributed to narrative therapy treatment—the strength and resilience focus, the inclusion of an ‘audience’ in the treatment process, the ‘goal setting’ that implicitly allows for alternative treatment therapies to be considered, even if that is not explicitly stated as a consideration of this step. The model has demonstrated success through both quantitative and qualitative measurements. A model utilising the key factors of success identified for the SSCP model would certainly meet the guiding principles enshrined in the NSF, but would also go some way to addressing the gaps identified in the NSF’s action plan.</td>
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*Table 4: Performance of AIMhi’s Stay Strong Care Plan against the Commission’s key progress indicators.*
3.3 Empowered Communities Project

Empowered Communities is a set of national reforms for an Indigenous Empowerment agenda. The model harnesses all the resources that are available for Aboriginal services and makes them available for communities to use and develop their own programs, simultaneously empowering individuals, families and communities; and bypassing the third-party involvement that would otherwise dilute the available resources and funding.

The project was initiated by a group of Aboriginal leaders from eight regions across Australia, who have developed a social policy model that focuses on the primacy of local knowledge in determining development agendas and what the priorities for service are within each community. The model aims to build strong relationships within and between communities at a local, state and commonwealth level but recommends that the most appropriate role for national and regional institutions is in supporting local development agendas.

The Empowered Communities model is summarised below:

- In each region, all government funding allocated towards programs (welfare; family services; domestic violence; Alcohol and other drugs; employment and training; health; housing; and education) are consolidated into a single account;
- These resources are used for holistic development of individuals, families and communities within the region;
- The use of resources is negotiated between community leaders and government;
- Communities and community organisations ‘opt in’ to participate in the plan; and
- An external third-party monitors expenditure and productivity gains.

The Empowered Communities reforms are currently being implemented in seven regional locations, in partnership with the Commonwealth Government, with each region having established local operations for approximately the last 12 months. The Central Coast and Inner Sydney are two of the participating regions within NSW.

3.3.1 Measurement criteria

The Empowered Communities was selected for review as an example of best practice MOC because it is a model with Commonwealth buy-in, currently being tested in a range of urban, rural and remote communities across the country, performed well against the established guiding principles and can be considered in light of how the model could support existing programs developed and implemented within the same communities as per the Uti Kulintjaku Project below.
Table 5: Performance of the Empowered Communities Framework against the identified Guiding Principles.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic Context</td>
<td>Green/Brown</td>
<td>Fundamentally considers that the holistic consideration of issues is necessary for the advancement of Aboriginal people</td>
</tr>
<tr>
<td>Self-determination</td>
<td>Green/Brown</td>
<td>Involves Indigenous people in deciding how funding and resources are spent within their community. Model is entirely driven and owned by Aboriginal people</td>
</tr>
<tr>
<td>Culturally valid understanding</td>
<td>Green/Brown</td>
<td>Driven by Aboriginal people at every stage of development, management and delivery</td>
</tr>
<tr>
<td>Effect of historical trauma</td>
<td>Red/Pink</td>
<td>No specific reference</td>
</tr>
<tr>
<td>Human rights</td>
<td>Red/Pink</td>
<td>No specific reference</td>
</tr>
<tr>
<td>Effect of racism, social disadvantage</td>
<td>Green/Brown</td>
<td>Allows for the priorities of Aboriginal people to be considered in service development and delivery</td>
</tr>
<tr>
<td>Centrality of family and kinship</td>
<td>Green/Brown</td>
<td>Allows for the priorities of Aboriginal people to be considered in service development and delivery</td>
</tr>
<tr>
<td>Diversity of cultures</td>
<td>Red/Pink</td>
<td>Is fundamentally community driven, but is a model that can be universally adapted</td>
</tr>
<tr>
<td>Strength and resilience</td>
<td>Red/Pink</td>
<td>Allows for the priorities of Aboriginal people to be considered in service development and delivery</td>
</tr>
</tbody>
</table>

Although a lot of ground work for Empower Communities has been undertaken over the last five years, the implementation stage of the model is largely in its infancy. The regional implementation is currently focused on building the Empowering Communities backbone organisations, establishing effective relationships and community engagement, developing the local priorities and assessing the current state of service within each of the regions.

Each of the regions has reported on the first twelve months of implementation, providing a snapshot of progress to date. Success at this early stage has been measured relative to development and:

- Involvement of Aboriginal people in the development of the model
- Involvement of Aboriginal people in deciding how funding should be allocated
- Holistic approach in the services that contribute to Aboriginal well being
- The primacy of individual communities in determining service priorities

Initial progress reports demonstrate how the Empowering Communities model can be differentially applied to suit the needs of communities from an array of lifestyles, locations and service needs.
3.3.2 Key Progress Indicators

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowering Communities</td>
<td>The Empowering Communities performs strongly against some of the criteria that will be used to evaluate the Commission’s model of care, and much of that can be drawn on in the development of a narrative therapy focused model of care.</td>
<td></td>
</tr>
<tr>
<td>Building Capacity</td>
<td>The primary advantage of the model is the level of Aboriginal involvement in its development and implementation. The project has been initiated by Aboriginal leaders and it is those leaders who have taken the consultation and roll out to the individual communities. The model itself also allows for local prioritisation of program and service needs and identified individuals and families as the key agents for social change.</td>
<td></td>
</tr>
<tr>
<td>Stability Over Time</td>
<td>The model builds capacity within the Aboriginal community through the development of Aboriginal organisations, allowing a clear indigenous voice in the distribution of funds and services according to local needs, supporting existing local Aboriginal services and programs and finding a balance between community values and the governance and reporting requirements that come with commonwealth and state government funding.</td>
<td></td>
</tr>
<tr>
<td>Business Case for MOC</td>
<td>The model redistributes existing reliable sources of funding and is not dependent on additional grants for its implementation. The focus on developing strong partnerships, the realistic reporting requirements and the flexibility in timelines and governance expectations suggests that if the model proves successful in its implementation, it is likely to have some longevity. The model further emphasises the principle of mutual responsibility between participants, organisations and funders. Developing a narrative therapy model of care that is more aligned with the indigenous worldview, allows individuals and families to take ownership of mental health concerns within their communities.</td>
<td></td>
</tr>
</tbody>
</table>

Table 6: Performance of the Empowered Communities Framework against the Commission’s key progress indicators.
3.4 Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council (NPYWC)’s Uti Kulintjaku Iwara Model

Uti Kulintjaku Iwara means ‘to think and understand clearly’. The Uti Kutlintjaku Iwara model focuses on developing a shared understanding of mental health between Aboriginal people and mental health professionals. The project stemmed from the observation by Anangu traditional healers that there was a difference in the way mental health terminology was understood in English and in Ngaanyatjarra or Pitjantjatjara and that this misunderstanding was having ramifications on the ability to express emotions in response to stress or grief and the ability to ask for help in difficult times.

A team of 17 senior Anangu women and 8 non-indigenous team members with experience in mental health used language as a starting point for developing a bi-cultural understanding of mental health. As the program developed, a model emerged that incorporated holistic and emotional support for the Anangu women as personal issues with trauma arose, along with a process of reflection and evaluation that allowed participants to place their experience within a broader framework of understanding.

The group met in a series of ten 3-4 day workshops over three years. The project was led by Anangu women, with support from the non-indigenous team members and was conducted primarily in Aboriginal language, with a deliberate freedom of flow to align with the Anangu way of doing things. The initial phase of the project explored mainstream mental illness labels, diagnoses and treatments, consistent with the women’s desire to understand mental health from the Western perspective, but also focused discussion on traditional healers, a comparison of European and non-European responses to stress, and emotions and emotional response through time.

The model has been found to encourage clear thinking about issues, enables a safe way to discuss issues, encourages healing, fosters individual, group and community empowerment and promotes education about ways to enhance SEWB. A multi-lingual compendium of words and phrases was developed, along with a range of resources which are used within the local health services.

At a local level, the model has developed a team of senior Aboriginal women who are confident talking about mental health and engaging with their community about complex SEWB issues. The model has resulted in increased understanding of Western mental health within the Aboriginal community and increased cultural competency within the local health services. The model emphasises the importance of culture in enhancing Aboriginal SEWB and the necessity of drawing on the indigenous worldview and understanding from both Aboriginal and Western knowledge systems in developing appropriate assessments and tools for use with Aboriginal clients.

3.4.1 Measurement criteria

The Uti Kulintjaku Iwara model was selected for review as an example of best practice MOC because it performed strongly against many of the identified guiding principles, it has achieved broad recognition within Australia, receiving awards and commendations including the 2015 NT Administrator Medal in Primary Health Care and mention of resulting resources in the National Children’s Commissioner’s 2014 report as an effective resource to overcome language barriers.
The Uti Kulintjaku Iwara model has also been subject to some evaluation, with a development evaluation approach established at the outset of the project and a dedicated evaluator assigned to the project team. The ongoing, reflective evaluation process has been critical to defining success within the model and in identifying the key components of that success.

The model demonstrated a range of success over the three years of its development, most notably the increased cross-cultural understandings of mental health; more positive interactions between mental health professionals and the broader Anangu community due to the language resources; the ability to articulate feelings and experiences; the personal empowerment and growing confidence of the Anangu women involved; and the self-identification of the women as leaders who can affect change within their community.

The success of the model and its effect on the SEWB of the local community has been attributed primarily to:

- Led by Aboriginal people
- Explores and is informed by Aboriginal worldview and understandings of SEWB
- Collaborative approach between Aboriginal and Western approaches to healing
- Involved the Anangu women in design, implementation and evaluation of model
- Incorporated processes to enable healing, growth and empowerment
- Capacity building of individuals, group and services

The fundamental valuing of Anangu and Western knowledge systems, and the construction of a greater shared understanding has allowed the development of a model that has far broader reaching effects on the SEWB of the individuals and the community they work within.
3.4.2 Key Progress Indicators

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowering Communities</td>
<td>As with other reviewed models, the model has been designed, developed and implemented with robust Aboriginal participation. The NYPWC initiated the project and traditional healers from within the organisation were fundamental in deciding how the model was structured. However, the model also applies a primacy to Aboriginal language and perceptions of SEWB and explores how those concepts can fit within the Western mental health assessment and treatment framework.</td>
<td></td>
</tr>
<tr>
<td>Building Capacity</td>
<td>The model clearly builds enormous personal capacity within the Anangu women participating in the project, but it also provides a training opportunity for established cultural leaders within the community to build awareness and mental health literacy within their communities. The model forms the basis of a broader initiative to develop opportunities for employment of the Anangu women in designing and implementing ways of developing the model to strengthen SEWB within the local community.</td>
<td></td>
</tr>
<tr>
<td>Stability Over Time</td>
<td>The model employs a respectful partnership between Aboriginal knowledge holders and mental health professionals to develop a mutually beneficial pathway to better mental health awareness, assessment and treatment options. The project is collaborative by design and over the course of developing the model, new partnerships and collaborations within the mental health and SEWB field arose and were strengthened. The flexibility of timing and the manner in which workshops are relatively self-directed according to local needs and issues lends support to the stability of the program over time. However, the project team identified the primary reason for sustainability of the project is that: 'people are talking about mental health, and this is a lasting conversation. This will be a legacy – the language and the talking – because it suits Anangu. It’s what they do best.' (Project interpreter, 2014 – quoted in Tongi (2016) pp275).</td>
<td></td>
</tr>
<tr>
<td>Business Case for MOC</td>
<td>Although the Uti Kulintjaku Iwara model does not apply narrative therapy as its focus, there are important elements that are shared by both the current model and a narrative therapy model that have been identified as key to its success. The focus on two-way learning; the emphasis on the process as the outcome; the discussion, exploration and priority of indigenous worldviews; the examination of stories, history and how different cultures have identified and responded to stress; the group as an audience to negotiate new behaviours and responses; and the role of medical and psychological treatments within a cultural understanding of issues are all inherent concepts that are made explicit in a model of narrative therapy. Moreover, the elements of narrative therapy that run through the current model enhance the strength, resilience and personal capacity of identified cultural leaders in the field of mental health. If the model can be considered at least in part a training program targeting Aboriginal leaders, then the model does not have to be reactive to SEWB crises within the community, but preventative.</td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Performance of the Uti Kulintjaku model against the Commission’s key progress indicators.
3.5 Alive and Kicking Goals

Alive and Kicking Goals is a suicide prevention program initiated by players from the Broome Saints Football Club (BSFC) in response to the disproportionately high rates of youth suicide in the Kimberley. Supported by the Broome Men’ Outreach Service, the players were trained in suicide prevention and leadership skills in order to become Peer Educators. The entire project was developed and managed by the players themselves and the model took a holistic approach to the training, concentrating on recognising risk factors and warning signs, healthy coping strategies and a variety of strategies for dealing with at-risk youth within their communities. The program also recognised the need for individual and group support for the peer educators, and so a component of their training focused on mental health awareness and self-care.

The model prioritises connection with community, a focus on strength and resilience, understanding trauma and the ongoing effects of multiple suicides in the community removing the stigma associated with suicide and help-seeking. Upon the completion of training, Peer Educators deliver a range of activities, workshops, mentoring and counselling services across the Kimberley. The project has released a series of video resources and an app (iBobbly) for Aboriginal suicide prevention in 2013.

3.5.1 Measurement criteria

The AKG model was selected for review as an example of best practice MOC because it performed strongly against most of the guiding principles, it has been successful for nearly a decade within the Kimberley community and has achieved a series of awards. The model has attracted Commonwealth funding, employs a team leader and three paid peer educators and has expanded in its scope and reach.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic Context</td>
<td><img src="Honda" alt="Green" />_Holistic Context</td>
<td>Highlights the importance of community connections, cultural risk factors and strengths; importance of strong Aboriginal leaders</td>
</tr>
<tr>
<td>Self-determination</td>
<td><img src="Honda" alt="Green" />_Self-determination</td>
<td>Model is entirely driven and owned by Aboriginal people; training for young men to deal with community issues</td>
</tr>
<tr>
<td>Culturally valid understanding</td>
<td><img src="Honda" alt="Green" />_Culturally valid understanding</td>
<td>Aboriginal led at every stage of initiation, development and implementation; prioritises indigenous worldview</td>
</tr>
<tr>
<td>Effect of historical trauma</td>
<td><img src="Honda" alt="Green" />_Effect of historical trauma</td>
<td>Provides support for Peer Educators to deal with historical trauma; emotional support to address trauma</td>
</tr>
<tr>
<td>Human rights</td>
<td><img src="Honda" alt="Red" />_Human rights</td>
<td>No specific reference</td>
</tr>
<tr>
<td>Effect of racism, stigma, social disadvantage</td>
<td><img src="Honda" alt="Green" />_Effect of racism, stigma, social disadvantage</td>
<td>Promotes education; removes stigma associated with mental health</td>
</tr>
<tr>
<td>Centrality of family and kinship</td>
<td><img src="Honda" alt="Orange" />_Centrality of family and kinship</td>
<td>Allows for the prioritisation of Indigenous worldview; importance of Aboriginal leaders in influencing discussion and attitude</td>
</tr>
<tr>
<td>Diversity of cultures</td>
<td><img src="Honda" alt="Orange" />_Diversity of cultures</td>
<td>Is centred on local issues and individuals; but is a model that can be adapted to most local circumstances</td>
</tr>
<tr>
<td>Strength and resilience</td>
<td><img src="Honda" alt="Green" />_Strength and resilience</td>
<td>Resilience focused; explores risk factors and coping mechanisms</td>
</tr>
</tbody>
</table>

Table 9: Performance of the Alive and Kicking Goals model against the identified Guiding Principles.
The AKG model is currently the subject of longitudinal research that has not been reported yet, but qualitative measures of its success have been published in various forums, and the key success of the model can be attributed primarily to:

- The model was led and driven by Aboriginal people
- Implemented by local Aboriginal leaders
- Training incorporated processes to enable healing, growth and empowerment
- Capacity building of individuals, group and services

The focus of this model on empowering young Aboriginal leaders to take control of the SEWB issues within their own community is at the core of the program’s success.

### 3.5.2 Key Progress Indicators

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowering Communities</td>
<td>Program initiated entirely by Aboriginal youth from the BSFC, who were given complete control over the development of the training program and subsequent MOC. Although the model has attracted the support of partner organisations, decision making about the program remains with the Aboriginal participants.</td>
<td>The AKG model builds great capacity amongst the Aboriginal people undertaking the training, and provides the community with a range of workshops, mentoring and counselling services that address the critical levels of stress within the region, and increase general levels of mental health awareness.</td>
</tr>
<tr>
<td>Building Capacity</td>
<td>The AKG model builds great capacity amongst the Aboriginal people undertaking the training, and provides the community with a range of workshops, mentoring and counselling services that address the critical levels of stress within the region, and increase general levels of mental health awareness.</td>
<td></td>
</tr>
<tr>
<td>Stability Over Time</td>
<td>The model has proven sustainability, continuing to develop and win awards nearly a decade after its inception. The project has developed strong partnerships with UNSW and the Black Dog Institute. Both the training program and the delivery of community events are flexible enough to be sustainable, even during periods of competing priorities. Participants have identified the key to the program’s success is that it is fundamentally Aboriginal driven and adapted to the Kimberley experience, ‘we need to do it our way, Aboriginal people talking our way to our people, otherwise it won’t work.’ (Peer Educator, 2012 – quoted in Tighe &amp; McKay (2012) pp244).</td>
<td></td>
</tr>
<tr>
<td>Business Case for MOC</td>
<td>The AKG model shares elements with a narrative therapy framework that are crucial to the model’s success. The training program for PE’s has a similar focus on two-way learning and an emphasis on indigenous worldview and the training group provided an in-built audience to test learnings and new responses. The AKG training program highlights the importance of individual history and experience in the learning and implementation of healthy coping strategies, the journey of personal healing for the participants and their subsequent ability to share protective behaviours with the community. The model has a secondary benefit of increasing mental health literacy, removing stigma and producing peer educators that are already well-respected sports players, which allows the model to be an effective preventative tool within Aboriginal communities rather than reacting to mental health crises.</td>
<td></td>
</tr>
</tbody>
</table>

Table 10: Performance of the Alive and Kicking Goals model against the the Commission’s key progress indicators.
3.6 Aboriginal Mapping: Beginning with a strong story

A simple model has been established by Justin Butler, an Aboriginal narrative therapist, applying the concept of narrative therapy mapping (White, 2007) to the indigenous context. The author poses a series of identity based questions designed to situate the individual within a map of physical, familial and cultural connections upon meeting Aboriginal people:

- Who is your mob (Where is your traditional country);
- Where is that country (Where is that in Australia? What are the boundaries?); and
- Who is your family (How might we be connected through family?)

In this manner, the focus is immediately upon the telling of identity into history, prior to colonisation. Butler argues that this starting point in itself is a means by which to resist colonisation by countering the disconnection that was the indigenous colonisation experience and instead focusing on the survival of indigenous culture, identity and belonging.

Narrative practice in this model is espoused as the means by which Aboriginal people are acknowledged as ‘experts in their own lives’. Aboriginal mapping is a way to attribute stories of identity and connection to the individual, and so an individual’s narrative begins from a position of strength and equality, balancing the expertise of mental health practitioners and the cultural expertise of the individual.

The model is fundamentally based on the identification of indigenous strengths. Butler builds on the early identification of a person’s ‘strong story’, and considers the way in which that can be a source of resilience in dealing with hardship. The process of Aboriginal mapping further asks Aboriginal people to expand on these fundamental understandings of cultural identity with stories of ancestors and family. In grounding an individual’s narrative to a long, rich history of cultural identity, Butler extends the consideration of connection from the past as a way of shaping resilience into the future.

3.6.1 Measurement criteria

The Aboriginal Mapping model was selected for review as an example of best practice MOC because it performed strongly against most of the guiding principles, and because it utilises a well-established narrative therapy model of mapping by an Aboriginal therapist with a firsthand understanding of how to tailor that model specifically for Aboriginal people.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic Context</td>
<td>✔️</td>
<td>Strong emphasis on connections; consideration of what makes us strong includes cultural, country, community</td>
</tr>
<tr>
<td>Self-determination</td>
<td>✗</td>
<td>Model does not sit within a defined indigenous structure, but identified strength of Aboriginal counsellor in building kinship connections</td>
</tr>
<tr>
<td>Culturally valid understanding</td>
<td>✔️</td>
<td>Prioritises indigenous world view; implementation of narrative therapy mapping by Aboriginal therapist</td>
</tr>
<tr>
<td>Effect of historical trauma</td>
<td>✔️</td>
<td>Explicitly sets individual narratives within framework including historical influences</td>
</tr>
<tr>
<td>Human rights</td>
<td>✗</td>
<td>Development of appropriate assessment tools and clinical pathways</td>
</tr>
<tr>
<td>Effect of racism, stigma, social disadvantage</td>
<td>✔️</td>
<td>Explicitly sets individual narratives within framework including social influences</td>
</tr>
<tr>
<td>Centrality of family and kinship</td>
<td>✔️</td>
<td>Explicitly acknowledges importance of kinship in setting strong story</td>
</tr>
<tr>
<td>Diversity of cultures</td>
<td>✔️</td>
<td>Individually tailored to individuals and their community, regardless of region</td>
</tr>
<tr>
<td>Strength and resilience</td>
<td>✔️</td>
<td>Resilience focused; emphasis on building strong story</td>
</tr>
</tbody>
</table>

Table 11: Performance of the Aboriginal Mapping model against the identified Guiding Principles.
Although the effect of the model has not been subject to measurable testing, the author observes a strong correlation between the identity focused questions, remembered stories and the development of a strong narrative. According to the author, the success of the model can be attributed primarily to:

- Focus on family and kinship as strong identifiers
- Focus on strength and resilience as the primary narrative
- Prioritisation of indigenous worldviews

The model establishes a clear link between narrative therapy and Aboriginal worldviews. The specific questions that are posed to tailor narrative therapy mapping for Aboriginal people contribute to the structuring of fundamentally strong stories that can be drawn on to address future stressors.

### 3.6.2 Key Progress Indicators

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowering Communities</td>
<td>Green</td>
<td>The model places a clear emphasis on the indigenous worldview, utilising narrative therapy to identify Aboriginal people as experts in their own story, but further emphasising Aboriginal kinship networks as instrumental in mapping identity and strong storylines that can be drawn on in subsequent stages of the mapping process.</td>
</tr>
<tr>
<td>Building Capacity</td>
<td>Green</td>
<td>The Aboriginal mapping model tacitly places some emphasis on the value of Aboriginal therapists in helping Aboriginal people to define their identity and relate that to the narrative therapy process. Butler acknowledges that identity and connection to culture is a specific skillset of Aboriginal people (Butler, 2017: 23). Although the model does not necessitate an Aboriginal counsellor, the intricate nature of the connection between people, country and kin likely put an Aboriginal practitioner in a stronger de-centred and influential position than non-indigenous therapists. Certainly, any non-indigenous therapists undertaking a similar model will need to have a solid cultural understanding of the complex kinship networks that form an individual’s identity.</td>
</tr>
<tr>
<td>Stability Over Time</td>
<td>Green</td>
<td>There is little to draw on in assessing the model’s longevity, except to point out that there is no obvious flaw or dependency of the model that is likely to limit its sustainability.</td>
</tr>
<tr>
<td>Business Case for MOC</td>
<td>Green</td>
<td>The narrative therapy framework that underpins the model is one that clearly aligns with Aboriginal worldviews and is central to identifying and building strong stories. Importantly, the model’s focus on restructuring the indigenous perception of historical trauma and intra generational social disadvantage fills a fundamental gap that is left by most of the SEWB models in practice across NSW today.</td>
</tr>
</tbody>
</table>

*Table 12: Performance of the Aboriginal Mapping model against the the Commission’s key progress indicators.*
3.7 Tātaihono

Tātaihono is an approach to mental health assessment and treatment that combines science and traditional knowledge to develop a model of care that has a far more holistic concept than has been traditionally applied, focusing on mind, spirit, body and family as equal components to effective mental health treatment. Although the holistic Maori view of health (incorporating spirituality, land, language and family) has been incorporated into government frameworks and Maori models of service delivery since the 1980’s, the acceptance and incorporation of traditional healers into Western medical approaches has been slow.

Tātaihono refers to a close working relationship between an indigenous healer and a Western psychiatrist (NiaNia et al, 2017 :34). There are many ways in which indigenous healing practices can be unintentionally devalued in such partnerships, including the attempt to scientifically explain the manifestation of cultural ill health or the traditional healing that may be applied. An important component of the relationship therefore, ensures that neither is considered of greater inherent value and it is this that differentiates Tātaihono from previous attempts at including traditional perspectives in treatment plans.

The model emphasises the need for traditional and Western healers to consider different possibilities in mind through a process of narrative enquiry. Keeping alternative explanation in mind allows combinations of cultural and medical causes and treatments to be considered. A shared understanding of the problem is developed during initial consultation, and a multidisciplinary team is consulted on the assessment. The team includes kaumātua (tribal elders / traditional knowledge experts), a Maori consumer consultant and clinicians to ensure that cultural explanations are given the same due consideration as psychiatric diagnoses.

3.7.1 Measurement criteria

The Tātaihono model was selected for review as an example of best practice MOC because it performed strongly against most of the guiding principles, and because it shows how a narrative model that genuinely encompasses traditional healing might be used in the clinical assessment and treatment of Aboriginal people.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic Context</td>
<td>✔️</td>
<td>Strong emphasis on connections; considers spiritual, physical and family as critical to SEWB</td>
</tr>
<tr>
<td>Self-determination</td>
<td>✔️</td>
<td>Model sits within Indigenous controlled organisation, leadership within program by indigenous experts</td>
</tr>
<tr>
<td>Culturally valid understanding</td>
<td>✔️</td>
<td>Prioritises indigenous world view; indigenous implementation of narrative therapy mapping</td>
</tr>
<tr>
<td>Effect of historical trauma</td>
<td>✔️</td>
<td>Explicitly sets individual narratives within framework including historical influences</td>
</tr>
<tr>
<td>Human rights</td>
<td>✔️</td>
<td>Development of appropriate assessment tools and clinical pathways</td>
</tr>
<tr>
<td>Effect of racism, stigma, social disadvantage</td>
<td>✔️</td>
<td>Explicitly sets individual narratives within framework including social influences</td>
</tr>
<tr>
<td>Centrality of family and kinship</td>
<td>✔️</td>
<td>Explicitly acknowledges importance of family and kinship in assessment and treatment</td>
</tr>
<tr>
<td>Diversity of cultures</td>
<td>✔️</td>
<td>Is individually tailored to individuals and their community, regardless of region</td>
</tr>
<tr>
<td>Strength and resilience</td>
<td>✔️</td>
<td>Resilience focused; emphasis on control over cultural and spiritual matters.</td>
</tr>
</tbody>
</table>

Table 13: Performance of the Tātaihono model against the identified Guiding Principles.
Several articles and some detailed case studies have been published reflecting on the value of the Tātaihono model from the perspective of the young people seeking assistance, their families, the traditional healer and the clinical psychologist involved in their care. This detailed exploration of assessments, treatments and the effect of the Tātaihono model is a rare measure within the field of narrative therapy and demonstrates the value of qualitative research in the field. The success of the model was inherent in each of the case studies and key factors that contribute to that are:

- The prioritisation of indigenous worldviews;
- Indigenous leaders within a multidisciplinary team;
- Focus on family as support and as an audience for alternative ways of being;
- Collaborative approach between Indigenous and Western approaches to healing; and
- Focus on strength and resilience as the primary narrative.

The model emphasises the indigenous worldview as being a vital part of assessment and treatment in SEWB and mental health care. Spiritual and cultural concerns are considered as equally viable explanations for ill health as are psychological diagnoses.

### 3.7.2 Key Progress Indicators

The model provides perhaps the strongest example of community empowerment, building capacity, stability over time and the use of narrative therapy for informing the development of a narrative focused indigenous MOC.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Performance</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowering Communities</td>
<td></td>
<td>The model places a clear emphasis on the indigenous worldview, with traditional healers, elders and family working alongside Western psychologists to assess the balance of cultural or spiritual concerns with the psychological diagnoses. The explicit valuing of indigenous views and practices allows for a better understanding of cultural protocols and knowledge within the Western mental health industry. The model involved an ongoing collaboration that is driven by clinicians and traditional healers currently practicing in the field of indigenous SEWB and so can be constantly amended and clarified as new evidence and therapies are explored.</td>
</tr>
<tr>
<td>Building Capacity</td>
<td></td>
<td>The Tātaihono model specifically requires the involvement of indigenous therapists, and values their expertise as part of the SEWB assessment and treatment process. The incorporation of indigenous healers into a multi-disciplinary team allows for the upskilling of Aboriginal people in the Western assessment tools and treatment options in order to better inform the possible care plans that they may apply to community members. The Tātaihono model has been developed within the context of Te Whare Mārie, a specialist Maori mental health service where it is expected that clinicians incorporate the Maori worldview into their clinical work.</td>
</tr>
<tr>
<td>Stability Over Time</td>
<td></td>
<td>The model has proven sustainability, with continued development and refinement of the model and publication of case studies throughout its implementation. The model is based on strong partnerships between members of the multidisciplinary care team, and has proven to have longevity beyond the departure of individual healers and therapists who initiated the model.</td>
</tr>
<tr>
<td>Business Case for MOC</td>
<td></td>
<td>The narrative therapy framework that underpins the model is one that clearly aligns with Aboriginal worldviews and is central to understanding the influence of cultural and spiritual beliefs on the SEWB of Aboriginal people. Importantly, the model’s focus on restructuring the indigenous perception of historical trauma and intra generational social disadvantage fills a fundamental gap that is left by most of the SEWB models in practice across NSW today.</td>
</tr>
</tbody>
</table>

*Table 14: Performance of the Tātaihono model against the Commission’s key progress indicators.*
4 Discussion

An examination of MOC in use across Australia and New Zealand has demonstrated that there are elements that consistently contribute to the success of individual programs, regardless of the scope and focus of the model. These can be broadly summarised into the following categories:

- Holistic approach;
- Collaborative approaches;
- Indigenous participation; and
- Strength and resilience focus.

A holistic approach to models of care is considered to be one that prioritises the indigenous worldview. This includes considerations of connection with country, language, community and culture, but also holds family and kinship to be a central component of Aboriginal SEWB. The importance of a holistic approach to Aboriginal SEWB is fundamental to Aboriginal people feeling comfortable accessing services (Carey, 2013; Australian Health Ministers’ Advisory Council, 2017) and ensuring that services appropriately address the comorbidity of factors that often influence Aboriginal SEWB (Nagel & Thompson, 2010; Commonwealth of Australia, Department of Health, 2017).

A collaborative approach between indigenous and western healing assessments and techniques ensures a culturally appropriate model of care that Aboriginal people are comfortable accessing and engaging with (Australian Health Ministers’ Advisory Council, 2017). The consideration of traditional practices as equal to Western psychology alleviates the inequalities inherent in using inappropriate assessment tools (Newton et al, 2015; Thomas et al, 2010; and Carey, 2013) and allows for cultural interpretations and meanings to be heard and acted upon in conjunction with mainstream therapies (Butler 2017; Agius & Hamer, 2003; and NiaNia et al, 2017).

Indigenous participation is held to be a fundamental component to the success of programs targeting Aboriginal people (Swan & Raphael, 1995; Morley, 2015), and was considered a key aspect of success in every model that was examined. Indigenous involvement is necessary at every stage of design, development and implementation, not only to ensure that the model is culturally appropriate but also to build community empowerment and capacity of individuals and organisations within the community. The precise nature of indigenous involvement varies dramatically between models, with some being entirely indigenous initiated and led (i.e. Empowered Communities and Alive and Kicking Goals), some being initiated by Western practitioners or policy makers, with appropriate levels of indigenous consultation and decision making at every stage of the development (i.e. Stay Strong Care Plan), and some being genuinely co-designed, with indigenous and Western practitioners attempting mutual understandings of each other’s area of practice (i.e. Uti Kulintjaku and Tataihono). The important criteria in determining the level of indigenous participation is less the nature of involvement and more the feeling of ownership of the final model.

A focus on strength and resilience has a clear impact on how Aboriginal people engage with models and programs. As an immediate effect, models that focus on strength and resilience help to remove the stigma associated with mental health issues and help-seeking (Tighe & McKay, 2012), but also removes the focus from what is ‘wrong’ to the skills and values that may be applied to stressful situations (Anderson et al, 2015; Chino & DeBruyn, 2006). Concentrating on strengths and strength building rather than the diagnosis of a predetermined ‘problem’ allows for a more appropriate consideration of the comorbidity of stressors that create a difficult situation and the social, political and historical factors that influence Aboriginal SEWB, all of which are crucial to appropriate diagnosis and resolution (Nagel & Thompson, 2010; Agius & Hamer, 2003; Butler, 2017). A further consideration
of the success of some of the models includes building the long-term strength and resilience of communities as well as individuals. The capacity of programs such as Utu Kulintjaki and Alive and Kicking Goals to produce community leaders with significant mental health literacy increases community education and awareness of SEWB risks and skills and allows communities to become proactive in addressing SEWB rather than just reacting to individual crisis situations.

Interestingly, the key elements that have been attributed to the success of MOC across Australia and NZ are elements that are inherent within a narrative therapy approach to SEWB. Although only two of the models explicitly utilise narrative therapy within their framework, many best practice models are implicitly utilising elements of narrative therapy already. The use of narrative therapy components within disparate models emphasises the value of a narrative therapy model in allowing existing services and treatment plans to be options within a SEWB care plan, without applying cultural supremacy to Western psychological treatments.

Perhaps one reason that narrative therapy has not been the focus of models across Australia is the lack of quantitative data that supports a scientific measurement of success. It needs to be considered that the application of strict, clinical measurements of value are not appropriate to assessing indigenous models of care, and assessment should instead concentrate on individual, personal changes that Aboriginal people have measured and reported in their own lives. Published case studies and qualitative research results exist that demonstrate the relevance and success of narrative therapy for Aboriginal people. The highly personalised nature of a narrative MOC necessitates that cultural validation, Aboriginal engagement with the process, and compliance with traditional customs and knowledge should be considered an important measure of a model’s success (Newton et al, 2015).

5 Conclusion

A review of best practice models of care across Australia and New Zealand would appear to support the development of a model of care for Aboriginal SEWB based on narrative therapy. Models that incorporate narrative therapy or aspects thereof show consistently positive results and appear to be preferentially accessed by Aboriginal people that have historically found more Western approaches to be confronting and culturally meaningless.

The review of currently successful MOC allows for a specific understanding of how a narrative therapy model could be developed that fits directly into the indicators identified by the Commission’s as being critical to measuring a model’s long-term success.

**Empowering Community:** Key factors comprise including Aboriginal people into the design, development and implementation of the model of care; and seeking contributions and feedback from the individual clients, practitioners and staff that are practicing within the Aboriginal mental health industry.

**Building Capacity:** Key factors include the engagement of Aboriginal staff in the delivery of services catering to Aboriginal people; supporting existing Aboriginal services; upskilling and building confidence of indigenous healers and leaders to improve awareness and skills within communities.

**Stability:** Key factors include flexibility within the model in terms of timelines for implementation, reporting requirements and adaptability to individual communities; and low reliance on external funding sources.

**Business Case:** Elements of narrative therapy are highlighted as the strongest characteristics within successful models of care; qualitative data has demonstrated the effect of narrative therapy on
individuals and a substantial increase in access compared to more mainstream services and treatments; narrative approach offers a culturally appropriate response to SEWB that is largely not available elsewhere in mainstream practice; and analysis of existing models demonstrates that a narrative model of care provides the best fit to the established guiding principles for developing Aboriginal SEWB strategy.

A narrative therapy model of care has the inherent capacity to meet all of the criteria identified in the Guiding Principles and therefore fits well within the Commonwealth strategic direction (Commonwealth of Australia, 2017) for Aboriginal SEWB. Moreover, the specific consideration of narrative therapy as a model of care allows for the application of specific programs, resources and training that address some of the gaps where the National Strategic Framework provides a system of principles without any specific criteria for meeting them, such as with the effect of historical trauma; the effect of racism, stigma, environmental adversity and social disadvantage; the centrality of family and kinship; and the strength and resilience of Aboriginal people.

6 References


Appendix 1: Stepped care model of Action Areas and Outcomes detailed in the National strategic framework for Aboriginal and Torres Strait Islander peoples’ mental health and social and emotional wellbeing 2017-2023.

The Mental Health and Social and Emotional Wellbeing Framework in Action

Vision
For Aboriginal and Torres Strait Islander people, families and communities to achieve and sustain the highest attainable standard of social and emotional wellbeing and mental health supported by mental health and related services that are effective, high quality, clinically and culturally appropriate, and affordable.

Actions Area and Outcomes
These Action Areas and Outcomes are based on a stepped care model of primary mental health care service delivery.

**ACTION AREA 1 – Strengthen the Foundations**
- **Outcome 1.1:** An effective and empowered mental health and social and emotional wellbeing workforce.
- **Outcome 1.2:** A strong evidence base and a social and emotional wellbeing and mental health research agenda under Aboriginal and Torres Strait Islander leadership.
- **Outcome 1.3:** Effective integration and partnerships between Primary Health Networks and Aboriginal Community Controlled Health Services and other health services.

**ACTION AREA 2 – Promote Wellness**
- **Outcome 2.1:** Aboriginal and Torres Strait Islander communities and cultures are strong and support social and emotional wellbeing and mental health.
- **Outcome 2.2:** Aboriginal and Torres Strait Islander families are strong and supported.
- **Outcome 2.3:** Infants get the best possible developmental start to life to support good mental health and wellbeing.
- **Outcome 2.4:** Aboriginal and Torres Strait Islander children and young people get the services and support they need to thrive and grow into mentally healthy adults.

**ACTION AREA 3 – Build Capacity and Resilience in People and Groups at Risk**
- **Outcome 3.1:** Access to traditional and contemporary healing practices.
- **Outcome 3.2:** Equality of mental health outcomes is achieved across the Aboriginal and Torres Strait Islander population.
- **Outcome 3.3:** Mental health and related problems are detected at early stages and their progression prevented.

**ACTION AREA 4 – Provide Care for People who are Mildly or Moderately Ill**
- **Outcome 4.1:** Aboriginal and Torres Strait Islander people living with a mild or moderate mental illness are able to access culturally and clinically appropriate primary mental health care according to need.
- **Outcome 4.2:** Culturally and clinically appropriate specialist mental health care is available according to need.
- **Outcome 4.3:** Effective client transitions across the mental health system.

**ACTION AREA 5 – Care for People Living with a Severe Mental Illness**
- **Outcome 5.1:** That the human rights of Aboriginal and Torres Strait Islander people living with severe mental illness are respected.
- **Outcome 5.2:** Aboriginal and Torres Strait Islander people in recovery are able to access support services in an equitable way, according to need, within a social and emotional wellbeing framework.
- **Outcome 5.3:** Aboriginal and Torres Strait Islander people living with psychosocial disability are able to access the National Disability Insurance Scheme and other support services in an equitable way, according to need, and within a social and emotional wellbeing framework.