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TeaH (Turn 'em around Healing): a therapeutic model for working with traumatised children on Aboriginal communities

Michelle Moss[1] and Anthony Duwun Lee[2]

[1]Health Science, College of Health and Human Sciences, Charles Darwin University, Casuarina Campus, Northern Territory, Australia and [2]Flinders University CDU Campus, College of Health and Human Sciences, Charles Darwin University, Darwin, Northern Territory, Australia

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Author for correspondence: Michelle Moss, Email: michelle.moss@cdu.edu.au

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.

Introduction

The cumulative effects of colonisation, such as loss of land, language, culture and spiritual identity and the continual forced removal of children, which contribute to intergenerational trauma, have 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, He, & Silburn, 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 have reached crisis levels.

The Mental Health Council of Australia (2014) has highlighted the urgency of reform, but states 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 are 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 are 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).

A therapeutic programme called Turn 'em around Healing (TeaH) was developed in response to this unmet need by providing therapeutic care to children experiencing trauma in Aboriginal communities. 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 and 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

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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, even 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 AODs 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 were 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. 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 within a Westernised frameworks 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, was 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 10-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 include 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 provision 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 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, 12 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 that 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 reasons why service providers and individuals who hold a level of power obstruct a new services' access to the community, including 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 (AIHW, 2015, 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, p.126), 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 medical 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 behavioural 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 learning 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 were vital. Factors particular to this community, such as the power dynamics as a consequence of the community's 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 wellbeing 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.

Author ORCIDs. Michelle Moss 0000-0002-7524-964X

References

Atkinson, J. (2013). *Trauma-informed services and trauma-specific care for indigenous Australian children* (Resource Sheet no. 21). Retrieved from Australian Institute of Health and Welfare https://www.aihw.gov.au/getmedia/e322914f-ac63-44f1-8c2f-4d84938fcd41/ctg-rs21.pdf.aspx?inline=true.

Attorney-General for Australia. (2016). *Royal commission into the protection and detention of children in the Northern Territory*. Canberra: Government of Australia.

Australian Government, Department of Health. (2013). *National Aboriginal and Torres Strait Islander suicide prevention strategy*. Canberra: Australian Government.

Australian Institute of Health and Welfare. (2015). *Australia's welfare 2015* (Australia's Welfare Series no. 12, cat. no. AUS189). Retrieved from https://www.aihw.gov.au/getmedia/692fd1d4-0e81-41da-82af-be623a4e00ae/18960-aw15.pdf.aspx?inline=true.

Bowen, D. (2016). In People Culture Environment (Ed.), *The Elders report into preventing indigenous self-harm and youth suicide* (pp. 28–29). Retrieved from http://www.cultureislife.org/wp-content/uploads/2015/10/Elders-Report.pdf.

Brady, K., Killeen, K., Brewerton, T., & Lucerini, S. (2000). Comorbidity of psychiatric disorders and posttraumatic stress disorder. *Journal of Clinical Psychiatry*, *61*(Suppl. 7), 22–32.

Burnie, R. (2019). *Aboriginal healers treat patients alongside doctors and nurses at Lyell McEwin Hospital*. Retrieved from https://www.abc.net.au/news/2019-02-20/aboriginal-healers-treat-patients-alongside-doctors-and-nurses/10826666.

Carroll, W., & Greano, M. (2013). Neoliberal hegemony and the organisation of consent. In R. Fisher (Ed.), *Capitalism, democracy and the organisation of consent* (pp. 121–134). London: Corporate Watch.

Case, C., & Dalley, T. (1992). *The handbook of art therapy*. London: Tavistock/Routledge.

Clarke, S. (2005). The neoliberal theory of society. In A. Saad-Filho, & D. Johnston (Eds.), *Neoliberalism: A critical reader* (pp. 50–59). London: Pluto Press.

Coburn, D. (2000). Income inequality, social cohesion and the health status of populations: The role of neo-liberalism. *Social Science & Medicine*, *51*(1), 135–146. doi: 10.1016/S0277-9536(99)00445-1.

Commonwealth of Australia. (2017). *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing, 2017–2023*. Retrieved from https://www.pmc.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf.

Crime and Misconduct Commission. (2004). *Protecting children: An inquiry into abuse of children in foster care*. Brisbane: CMC.

Dawes, D. (2007). Risks of reintergration: Young offenders perceptions of making the transition back to their communities, overcoming violence and poverty. *Paper presented at the CROCCS 5th International Conference*, Airlie Beach.

Dudgeon, P. (2015). Introduction. In People Culture Environment (Ed.), *The Elders report into preventing Indigenous self-harm and youth suicide* (pp. 6–7). Retrieved from http://www.cultureislife.org/wp-content/uploads/2015/10/Elders-Report.pdf.

Garond, L. (2014). The meaningful difference of 'Aboriginal dysfunction' and the neoliberal 'mainstream'. *eTropic*, *13*(2), 7–19.

Gatekeeper. (n.d.). In *Merriam-Webster's online dictionary*. Retrieved from https://www.merriam-webster.com/dictionary/gatekeeper.

Guthridge, S., He, V., & Silburn, S. (2017). *A statistical overview of children's involvement with the NT child protection system*. Darwin, NT: Centre for Child Development and Education, Menzies School of Health Research.

Harvey, D. (2007). *A brief history of neoliberalism*. New York: Oxford University Press.

Healing Foundation. (2014). Aboriginal and Torres Strait Islander healing programs: A literature review. Retrieved from http://healingfoundation.org.au/wordpress/wpcontent/files_mf/1392087179ATSIHFLitreview.pdf.

Kazi, M. A. F. (Ed.) (2003). *Realist evaluation in practice*. Retrieved from http://dx.doi.org/10.4135/9781849209762.

Malchiodi, C. (1999). *Medical art therapy with children*. London, UK: Jessica Kingsley Publishers.

Marsh, T., Cote-Meek, S., Young, N., Najavits, L., & Toulouse, P. (2016). Indigenous healing and seeking safety: A blended implementation project for intergenerational trauma and substance use disorders. *The International Indigenous Policy Journal*, *7*(2), 2–12. doi: 10.18584/iipj.2016.7.2.3

McCallum, S. (2010). *Annual report on SARC MOS child and family forums and community practice forums*. Unpublished report for the Federal Governement, Canberra.

Mental Health Council of Australia. (2014). *Submission to the National Mental Health Commission's review of mental health programs and services*. Retrieved from https://mhaustralia.org/sites/default/files/docs/mhca_submission_to_the_nmhcs_review_of_existing_mental_health_programs_and_services_june_2014.pdf.

Moss, M., Faulkner, K., & Horwood, K. (2009). *Mobile outreach service report to the Australian Government of Health and Aging*, Annual report 2008–2009. Unpublished report for the Federal Government, Canberra.

Moss, M., & Lee, A. (2017). Turn 'em around good way: TeaH a therapeutic model for working with traumatised children from Indigenous communities. *Journal of Australian Indigenous Issues*, *20*(3), 15–26.

Northern Territory Government. (2007). *Ampe Akelyernemane Meke Mekarle: Little children are sacred—Report of the Northern Territory Board of Inquiry into the protection of Aboriginal children from sexual abuse*. Retrieved from http://www.inquirysaac.nt.gov.au/pdf/bipacsa_final_report.pdf.

Office of Children and Families. (2013). *Responding to childhood trauma in remote Aboriginal communities of the Northern Territory: An internal evaluation of the Mobile Outreach Service Plus*. Retrieved from https://childdetentionnt.royalcommission.gov.au/NT-public-hearings/Documents/evidence-2017/evidence30june/Exh-662-047.pdf.

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children: The neurosequential model of therapeutics. In N. B. Webb (Ed.), *Working with traumatized youth in child welfare* (pp. 27–52). New York, NY: Guilford Press.

Peters, R., Tjilari, A., & Ginger, T. (2010). *Healing-traditional healing in Central Australia: Ngangkari work-Anangu way*. Paper presented at the Secretariat of National Aboriginal and Islander Child Care National Conference Healing in Practice, Alice Springs.

Price-Robertson, R., & McDonald, M. (2011). *Working with Indigenous children, families, and communities: Lessons from practice* (Child and Family Community Australia Practice Sheet). Retrieved from Australian Institute of Family Studies https://aifs.gov.au/cfca/sites/default/files/publication-documents/ps6.pdf.

Steering Committee for the Review of Government Service Provision. (2014). *Overcoming indigenous disadvantage: Key indicators 2014*. Canberra: Productivity Commission.

SuccessWorks. (2011). *Evaluation of the NT MOS projects: Final evaluation report*. Retrieved from https://childdetentionnt.royalcommission.gov.au/NT-public-hearings/Documents/evidence-2017/evidence30june/Exh-662-043.pdf

Tilley, N. (2000). *Realistic evaluation: An overview*. Paper presented at the Founding Conference of the Danish Evaluation Society.

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the treatment of trauma*. New York: Penguin Books.

Wolfe, P. (2006). Settler colonialism and the elimination of the native. *Journal of Genocide Research*, *8*(4), 387–409. doi: 10.1080/14623520601056240

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