Deficit Discourse and Strengths-based Approaches

Changing the narrative of Aboriginal and Torres Strait Islander health and wellbeing

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National Centre for Indigenous Studies,
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Acronyms

CDA	Critical Discourse Analysis
CSOM	Chronic Suppurative Otitis Media
NCIS	National Centre for Indigenous Studies
OM	Otitis Media

Executive summary

This report explores strengths-based approaches to shifting the deficit narrative in the Australian Aboriginal and Torres Strait Islander health sector. Studies, including a companion report to this one entitled *Deficit Discourse and Indigenous Health: How Narrative Framings of Aboriginal and Torres Strait Islander People are Reproduced in Policy*, have identified a prevalent 'deficit discourse' across Aboriginal and Torres Strait Islander health policy and practice. 'Discourse', in this sense, encompasses thought represented in written and spoken communication and/or expressed through policy and practices. The term draws attention to the circulation of ideas, the processes by which these ideas shape conceptual and material realities, and the power inequalities that contribute to and result from these processes.

'Deficit discourse' refers to discourse that represents people or groups in terms of deficiency – absence, lack or failure. It particularly denotes discourse that narrowly situates responsibility for problems with the affected individuals or communities, overlooking the larger socio-economic structures in which they are embedded.

There is evidence that deficit discourse has an impact on health itself — that it is a barrier to improving health outcomes. For example, Halpern (2015) argues that continual reporting of negative stereotypes and prevalence rates actually reinforces undesired behaviour. Accordingly, there are growing calls for alternative ways to think about and discuss Aboriginal and Torres Strait Islander health and wellbeing.

Crucially, these should not be mistaken for calls to deflate the realities of disadvantage in the socio-economic circumstances faced by Aboriginal and Torres Strait Islander Australians or to deny the health conditions people experience. Discourses of deficit occur when discussions and policy aimed at alleviating disadvantage become so mired in narratives of failure and inferiority that those experiencing the disadvantage are seen as the problem, and a reductionist and essentialising vision of what is possible becomes pervasive. Operating predominantly from a deficit or 'ill-based' approach provides only one side to a multi-faceted story, and inhibits alternative solutions or opportunities that facilitate growth and thriving.

This report is the second in a two-part series examining deficit discourse, and responses to it, in the Australian Aboriginal and Torres Strait Islander health field. The first, *Deficit Discourse and Indigenous Health*, draws on Critical Discourse Analysis to explore the extent and patterning of deficit discourse in the academic, policy and grey literature in this area. This report builds on *Deficit Discourse and Indigenous Health* by reviewing and analysing a growing body of work from Australia and overseas that proposes ways to displace deficit discourse in health, or that provides examples of attempts to do so. The most widely accepted approaches to achieving this come under the umbrella term 'strengths-based', which seek to move away from the traditional problem-based paradigm and offer a different language and set of solutions to overcoming an issue. It is on these approaches that we focus in this report.

Research approach

This report is the result of desk-based research, carried out over six months at the Australian National University's National Centre for Indigenous Studies. The research aims were to:

- Identify national and international methods and approaches that are effective in changing the narrative used to talk about Indigenous peoples' health and wellbeing from a discourse based on deficit and ill-health, to one of strength and resilience.

- Summarise the characteristics of successful programs and initiatives and build the evidence of best practice and the benefits of strengths-based discourse on Aboriginal and Torres Strait Islander peoples' health and wellbeing.
- Make recommendations of future actions to reframe discourse in the Australian Aboriginal and Torres Strait Islander health context.

The primary research methods were:

- Systematic review of the literature on strengths-based (and closely related) approaches to health. This included 82 peer-reviewed scholarly articles and 120 grey literature texts (such as policy documents, health magazines, project reports and discussion papers) deemed to be within the scope of this research. More than 130 websites were also reviewed. A major aspect of this involved defining the key elements of what strengths-based programs and approaches actually are, definitional work that has fed into this report.
- Critical Discourse Analysis of the above materials with the aid of software tools NVivo and Leximancer.
- Identification and analyses of health initiatives in Australia and overseas, explicitly taking a strengths-based approach.

A typology of strengths-based approaches

The research revealed that while the term 'strengths-based approaches' is commonly used, it has multiple and sometimes paradoxical meanings. 'Strengths-based approaches' are not a uniform set of policy and program protocols, nor will they always be an antidote to deficit. To understand the field better, we identified and compared key types of strengths-based approaches, closely related approaches and cross-cutting themes. These approaches and themes include: asset-based approaches, resilience, cultural appropriateness, social determinants of health and ecological theories, protective factors, empowerment, holistic approaches, wellness and wellbeing, strengths-based counselling approaches and positive psychology, decolonisation methodology, and salutogenesis.

Reasons for adopting strengths-based approaches

We found two broad, overlapping sets of justifications for using strengths-based approaches in Aboriginal and Torres Strait Islander health settings:

- Utilitarian justifications, advocating the use of strengths-based approaches on the basis of efficiency in resourcing, funding or similarity to existing approaches.
- Binary justifications, arguing that strengths-based approaches are necessary to correct or counterbalance existing negative stereotypes.

Case studies

We present small international and Australian case studies as examples to highlight the diverse range of health initiatives that draw on strengths-based approaches to differing degrees. In some cases, countering the negative discourses around Indigenous health is an explicit and principal goal of the initiative; in others it is subsidiary to a different goal.

However, due to a paucity of evidence, it remains difficult to judge how successful strengths-based initiatives actually are in shifting discourse, or what kinds of initiatives work best. Many lack evaluations, or their evaluations have not measured the extent to which discourses have altered. Reasons for this include a focus on quantitatively measuring health outcomes rather than shifts in discourse, and the logistical challenges of measuring real-world changes in discourse. Qualitative and mixed-methods approaches can play an important role in helping us to understand more fully the interrelationships between, on one hand, how health and its determinants are conceptualised and framed, and on the other, the achievement of culturally valued health outcomes.

Conclusions

- There is emerging evidence that deficit discourse has an impact on the health and wellbeing of Aboriginal and Torres Strait Islander people.
- The analysis found that 'strengths-based approaches' in Aboriginal and Torres Strait Islander health were the most commonly used, accepted and successful concepts to counter both explicit and implicit deficit.
- A strengths-based approach is not a set of policies or programs, rather it is a conceptual framework for approaching development and intervention.
- Strengths-based approaches are not a simple corollary or antidote to deficit, and can be seen to grow out of the same discursive field. At the same time, by explicitly acknowledging a desire to overcome deficit-based models, a strengths-based approach can be a highly effective method for shifting or changing narratives in Aboriginal and Torres Strait Islander health. It can also be seen to illuminate and provide alternative ways to deal with health issues.
- There are some serious barriers to implementing strengths-based models of development for Aboriginal and Torres Strait Islander health. These include: (a) an often broad, weak or ill-defined conceptual base for research, policy and program design; (b) a tendency in the grey literature in particular to use platitudes or to 'pay lip service' to strengths-based ideation; and (c) a real paucity of strong qualitative evaluation. This includes a lack of formative evaluation design. In addition, there is almost a complete lack of evaluation of actual impact on discourse itself and, in turn, on Aboriginal and Torres Strait Islander health outcomes. Similarly, we found no evaluation techniques specifically designed to measure or demonstrate shifts in the discourse around Aboriginal and Torres Strait Islander health.
- Through the sample of text we analysed using Critical Discourse Analysis, we have been able to identify and create an emerging typology of concepts (and associated literature) that can be used to underpin strengths-based approaches to Aboriginal and Torres Strait Islander health development. This typology may, in conjunction with other and further research, be used as a heuristic device to assist in the design of research, programs and policy aimed explicitly at shifting the current dominant narratives.
- We have identified two 'successful' justifications for using strengths-based approaches to influence a change in the narrative of Aboriginal and Torres Strait Islander health: the utilitarian approach and the binary approach.
- On the sample analysed, the international semantic field of Indigenous health seems to demonstrate a far greater congruence with the epistemology of the strengths-based discourse than the Australian semantic field.
- The Australian semantic field may be significantly underutilising 'binary justifications' (see p. 17) as a way to shift, change or challenge current framings of the Aboriginal and Torres Strait Islander health narrative at a national level.
- In certain circles there is an increasing awareness of strengths-based approaches and we are hopeful that such approaches will continue to be critically explored, developed and implemented, and that recognising the rights, culture, diversity and strengths of Australia's First Peoples will become the norm.

Introduction

In his 2017 'Close the gap speech' to parliament, the Australian Prime Minister, the Hon. Malcolm Turnbull, said that 'while we must accelerate progress and close the gap, we must also tell the broader story of Indigenous Australia – not of despondency and deficit but of a relentless and determined optimism' (Turnbull 2017).

In this speech we may see the first glimmer of a shift in the state policy narrative away from more than two decades of focus on the 'problem' of Aboriginal and Torres Strait Islander affairs (Sullivan 2016). Since the enacting of the 'doctrine of discovery' (Miller et al. 2010),[1] policy discourse on Aboriginal and Torres Strait Islander people has been defined in terms of what they 'lack' in comparison to a utopian, non-Indigenous ideal. One of our greatest challenges is articulating a vision that does not deny our nation's deep inequalities in health outcomes, but that builds policies and programs based on the success, resilience and strength of Aboriginal and Torres Strait Islander health development and aspiration.

One of the ways research can contribute to this vision is by providing evidence and ideas to help reframe contemporary discourse and to challenge the dominant narrative around Aboriginal and Torres Strait Islander health and wellbeing. The research contained in this report represents part of a larger research effort being undertaken at the National Centre for Indigenous Studies (NCIS), concerning discourses of deficit in Aboriginal and Torres Strait Islander affairs. The second of two research reports, the first entitled *Deficit Discourse and Indigenous Health: How Narrative Framings of Aboriginal and Torres Strait Islander People are Reproduced in Policy* (Fogarty, Bulloch et al. 2018), both were authored at the NCIS and funded by the Lowitja Institute (see Methodology and Research Design p. 6). *Deficit Discourse and Indigenous Health* sought to identify dominant discursive patterns in academic and policy texts concerning Aboriginal and Torres Strait Islander health between1984 and 2017. The project's aims were to (a) identify the narrative or discourse that frames Aboriginal and Torres Strait Islander health and wellbeing; and (b) examine the attributes of this narrative or discourse, including the attribution of causes of advantage or disadvantage. By mapping the discursive landscape, the report takes a significant step in understanding how deficit discourse operates in the health and wellbeing sector. It provides the groundwork to then analyse the relationship between this discourse and health and wellbeing outcomes. We encourage people to read the two reports in conjunction with one another.

Building upon *Deficit Discourse and Indigenous Health*, this report identifies research, policy and programs in Australia and overseas that have succeeded in changing or challenging the deficit narrative in Indigenous health. We focus particularly on strengths-based approaches. By reviewing the international literature, identifying and analysing the language of existing strengths-based initiatives, this research undertakes the necessary first step to creating a platform for developing guidelines to shift deficit discourse in the health setting. It also builds on foundational work undertaken on the representation of Aboriginal and Torres Strait Islander health, media and policy frames (McCallum 2011, 2013; McCallum & Waller 2012; Fforde et al. 2013) and on shifting deficit discourse in the education field (e.g. Fogarty, Riddle, et al. 2017; Fogarty & Wilson 2016; Gorringe & Spillman 2008). By documenting and critically analysing existing interventions to reframe Aboriginal and Torres Strait Islander health towards a strengths-based approach, this report aims to provide a deeper understanding of how we can challenge the way in which deficit discourse operates in health and wellbeing settings.

1 The doctrine of discovery is a legal principle which states that while Indigenous peoples continue to 'own' the land of their ancestors, colonists from the invading nation are granted exclusive property rights to the same land. It is the principle on which the legal fiction of Terra Nullius is based.

What is deficit discourse and why is it important?

Discourse is powerful in determining what can and cannot be considered 'truth', and influencing group and individual relationships accordingly. It is more than simply how perceptions are expressed through language. It is 'systems of thoughts composed of ideas, attitudes, courses of actions, beliefs and practices that shape reality by systemically constructing the subjects and the worlds of which they speak' (Kerins 2012:26). 'Deficit discourse', as it is known in the scholarly literature, is a mode of thinking that frames and represents Aboriginal and Torres Strait Islander identity in a narrative of negativity, deficiency and failure (Fforde et al. 2013). Previous research has illuminated the demonstrable impact of racism and discrimination on the health of Australia's First Peoples (Paradies, Harris & Anderson 2008; Anderson 2013). Similarly, decolonising methodologies showing the impacts of colonisation on Aboriginal and Torres Strait Islander communities have been explored extensively in the health literature (Smith 2012; Dudgeon, Milroy & Walker 2014; Sherwood 2013; Geia & Sweet 2015). Yet there has been far less work in the Australian context on the subtlety of deficit discourse, the elements of its construction and reproduction, or its potential impacts on the health and wellbeing of Aboriginal and Torres Strait Islander people.

Deficit discourse is not exclusive to health contexts. Assumptions of deficit have characterised relations between Aboriginal and Torres Strait Islander and other Australians since colonisation. Historically, colonial ideology based in the race paradigm adhered to constructed 'truths' about Aboriginal and Torres Strait Islander people that were underpinned by notions of deficiency, and had very little to do with how they saw themselves (Dodson 1994; Langton 1993; Russell 2001). Such notions were formed in relation to an often ill-defined and utopian non-Indigenous ideal that changed 'Aboriginality' from a daily socio-cultural practice to a 'problem to be solved' (Dodson 1994:3). Recent research has begun to highlight the influence that deficit discourse has to set the agenda and terms of debate in a variety of Aboriginal and Torres Strait Islander issues. Knowledge of the operation of deficit discourse in relation to outcomes in education, for instance, is growing (Gorringe & Spillman 2008; Sarra 2011). Similarly, the social impacts of the related issue of lateral violence have also been examined in recent years (Gooda 2011; Dudgeon, Milroy & Walker 2014).

It is crucial to note that, in analysing and mapping discourses of deficit, our goal is not to 'problem deflate'. There are undeniable, well documented realities of 'disadvantage'[2] in the socio-economic circumstances of Aboriginal and Torres Strait Islander Australians (see, for example, SCRGSP 2003; AIHW 2011). Discourses of deficit, however, occur when discussions and policy aimed at alleviating disadvantage become so mired in narratives of failure and inferiority that Aboriginal and Torres Strait Islander people themselves are seen as the problem, and a reductionist and essentialising vision of what is possible becomes all pervasive.

For example, the Northern Territory Emergency Response, or 'Intervention' as it became known, was premised on the complete failure of remote Aboriginal and Torres Strait Islander communities (Lovell 2014). This 'ground zero' (Fogarty 2007) intervention by the Australian Government was subsequently heavily critiqued for its assumptions about what Aboriginal and

2 For a critique of this term see Bamblett 2015.

Torres Strait Islander people need, and for failing to recognise the many strengths and successes of remote communities. In this way, the agency of Aboriginal and Torres Strait Islander Australians living in remote communities in the NT, and their aspirations for development, were repressed and successful development models ignored (Altman & Fogarty 2010). Similarly, the discourse of causation for the issues challenging these remote communities was moved from social circumstance to a blaming of Aboriginal and Torres Strait Islander people, particularly parents. This in turn allowed for a proliferation of draconian policy approaches that were applied to all people in effected remote communities, regardless of their social, economic and cultural strengths and responsibilities (Lovell 2012; 2014).

In Australia, Aboriginal and Torres Strait Islander health is an equally important area in which deficit discourse operates. In *Deficit Discourse and Indigenous Health*, Fogarty, Bulloch et al. (2018) analyse a sampling of literature and policy documents on Aboriginal and Torres Strait Islander health, and find a number of key tropes of deficit.

These findings extend on earlier scholarly work. For example, Aldrich, Zwi & Short (2007) examined how values and beliefs communicated by politicians over three decades (from 1972–2001) have contributed both to shaping health policy and to influencing health outcomes for Aboriginal and Torres Strait Islander people. Thomas (2004) examined the ways in which Aboriginal and Torres Strait Islander people have, over a century, been entangled in settler–colonial discourses and practices of science, health and medicine. In another study, Bourke et al. (2013) carried out a survey that identified a diversity of perspectives on rural health that draw on deficit discourse as well as multidisciplinary perspectives that acknowledge diversity. Furthermore, in *Deficit Discourse and Indigenous Health*, Fogarty, Bulloch et al. (2018) found that identifying the construction of what Bond (2005:14) calls 'assumed unhealthiness' in Aboriginal and Torres Strait Islander people provides an early step in unpacking deficit discourse in health.

Framing health policy in terms of 'Closing the Gap' certainly appears to carry (and replicate) an implicit assumption of deficit (Bond 2005; Brough, Bond & Hunt 2004). Although the 'Closing the Gap' program in Australia has been critiqued for conceptual weaknesses (Altman 2009; Altman & Fogarty 2010; Pholi 2009), it has never been evaluated in terms of the impact of the discourse utilised. In New Zealand, a similar 'Closing the Gap' policy framing was abandoned during the 1990s and replaced with a strengths-based approach designed to improve outcomes for Maori (Comer 2008; Levy 1999).

Within the expanding field of studies that analyse discourses and representations of Aboriginal and Torres Strait Islander people in texts on health and wellbeing, a developing stream identifies the extent and persistence of deficit discourses. This work is beginning to show that deficit discourse has an impact on health itself (Paradies, Harris & Anderson 2008). Some work also considers potential pathways to changing the narrative. Nelson (2007), for example, uses Critical Race Theory to explore the possibility of reflective approaches by occupational therapy researchers and practitioners. Also looking to possible ways to transform the deficit paradigm, Kowal and Paradies (2005) explore public health practitioners' narratives of Indigenous ill-health, the tensions between 'sameness' and 'difference', and the ambivalence of the 'helper' identity of public health practitioners. They ask how practitioners can bring about improvements in Aboriginal and Torres Strait Islander ill-health, and enable a shift towards working in a discursive space of self-determination. The consistent theme in response to identified discourse of deficit, however, is a call to enact, enable and develop 'strengths-based' approaches to the health and wellbeing of Aboriginal and Torres Strait Islander people.

Strengths-based approaches: A corollary to deficit?

Deficit thinking has been identified as a barrier to improving health outcomes (Australian Indigenous Health InfoNet 2017; Foley & Schubert 2013; Resiliency Initiatives 2013), and there are growing calls for an alternative to the deficit model of thinking in Aboriginal and Torres Strait Islander health and wellbeing (Fogarty & Wilson 2016; Foley & Schubert 2013; Gorringe, Ross & Fforde 2011; Stoneham 2014; Geia & Sweet 2015; SCRGSP 2014). Foley and Schubert (2013) note that in relation to the field of nutrition, for example, there 'is limited evidence to suggest that informing people about their lifestyle risks improves health'. They affirm that while deficit-based research has contributed to important public health nutrition issues, the dominance of deficit-based approaches is harmful (Foley & Schubert (2013). Halpern (2015) further argues that continual reporting of negative stereotypes and prevalence rates actually reinforces undesired behaviour. Operating predominantly from a deficit approach provides only one side to a multi-faceted story, and inhibits the use of alternative solutions or the provision of opportunities that facilitate growth and thriving (Craven et al. 2016; Resiliency Initiatives 2013; Wolf 2016).

Although the dominant discourse is one of 'lack', Fogarty and Wilson (2016) argue that this is not how most Aboriginal and Torres Strait Islander people perceive themselves. For example, in an interview in Ascension magazine ('Australia's First Indigenous & Ethnic Women's Lifestyle Magazine') Jirra Lulla Harvey asserts that the overload of deficit health statistics relating to Aboriginal and Torres Strait Islander people were having a negative impact on her worldview and cultural identity, one which was incongruent with the way she was raised (in Sarago 2017). She states:

> These statistics became like a mantra, and when you hear or say something over and over again you start to believe it. I felt like statistics were defining my cultural identity and that was not how I was raised. It was having a negative affect on the way I viewed my world, and I was worried about the rhetoric of disadvantage governing the lives of young Aboriginal people (Harvey in Sarago 2017).

While disengaging from deficit discourse is fundamental to effecting change in Aboriginal and Torres Strait Islander health outcomes, there are obstacles to such action. These barriers derive from factors such as the tenacity, subtlety and pervasiveness of deficit discourse, its currency in the present political and social climate, and a limited consciousness among policy makers and health practitioners that they are reproducing deficit discourse. As Gooda notes, although it is 'almost intuitive that we should be using a strengths-based approach when addressing Aboriginal and Torres Strait Islander disadvantage', navigating away from a discourse of disadvantage presents significant challenges (Gooda 2009, 2011). The inability to invest in the inherent strengths of Aboriginal and Torres Strait Islander people and communities, and to listen to and trust in their decisions, have been the missing ingredients underpinning the failure of previous approaches to addressing disparities in health (Gooda 2011).

Another challenge in shifting away from deficit to strengths-based models of health lies in the often ill-defined and slippery intellectual understandings of what 'strengths-based' approaches actually are. Furthermore, because these approaches often emerge as a direct response to deficit discourse, they may represent part of the same 'discursive formation' that produces and reproduces deficit. As such, there is a danger that simply advocating strengths-based ways of operating as a corollary to deficit, without carefully considering whether or not the approach is also an active producer of deficit, may have counterproductive outcomes for the health and wellbeing of Aboriginal and Torres Strait Islander people.

In the following sections of this report we delineate the key conceptual elements that comprise 'strengths-based' approaches to Aboriginal and Torres Strait Islander health, and we provide selected case studies of a range of health initiatives that have actively sought to reframe narratives of deficit. First, however, we provide an outline of our research approach.

Methodology and research design

As mentioned, this is a companion report to *Deficit Discourse and Indigenous Health* (Fogarty, Bulloch et al. 2018), which provides the first step to establishing the nature and prevalence of deficit discourse in the Australian health and wellbeing context. This report takes the analysis of this field to the next stage: to understand best practice internationally that affects change in discourse, and to identify and synthesise scholarship that argues for the benefits of doing so. Specifically the research aims of this project are to:

1. Identify national and international methods and approaches that are effective in changing the narrative used to talk about Indigenous peoples' health and wellbeing from a discourse based on deficit and ill-health, to one of strength and resilience.
2. Summarise the characteristics of successful programs and initiatives, and build the evidence of best practice and the benefits of strengths-based discourse on Indigenous peoples' health and wellbeing.
3. Make recommendations of future actions to reframe discourse in the Australian Aboriginal and Torres Strait Islander health context.

The research was conducted over 24 weeks in two distinct phases. **Phase 1** focused on data preparation including the literature review, definitions of search terms and scope, delineation of academic and grey literature for analysis, as well as the establishment of fortnightly research team meetings. A major aspect of this involved defining key elements of what strengths-based programs and approaches actually are, and this definitional work has heavily informed the following section of this report (from p. 9). Another major aspect of this research phase involved identifying and analysing 'successful' strengths-based programs.

Phase 2 of the research concentrated on systematic review and Critical Discourse Analysis (CDA) of 82 key academic texts and 120 grey literature texts that were deemed to be within the scope of the project. Our scope encompassed a multi-disciplinary, international Indigenous health and wellbeing literature, and included texts from academic medical repositories such as *PubMed* as well as the broader social sciences research databases *Informit, World cat* and *Web of Science*. We captured grey literature from websites of organisations conducting strengths-based programs, promotional materials for Indigenous health and wellbeing programs, medical and health magazines, news media feature articles, government speeches and reports, and literature from peak body, union and non-government sectors. In addition, during Phase 2 we identified and analysed case studies of initiatives that actively sought to take a strengths-based approach.

Key method: Critical Discourse Analysis

Critical Discourse Analysis (CDA) was a key method used by the research team to analyse the data. CDA is a form of linguistic analysis that aims to reveal the interconnection between language, ideology and power (Blomeart & Bulcaen 2000:447; Liu & Guo 2016:1076). It was viewed as particularly suitable to this project as it focuses on the role of discourse in producing and challenging the relations of dominance that result in social inequality (Van Dijk 1993:249). In line with this, the researchers conducted a qualitative analysis using search terms defined during the data collection process. Such an approach enables analysis of how 'language figures within social relations of power and domination; how language works ideologically; [and] the negotiation of personal and social identities' (Fairclough 2003:230). It is predicated on the

idea that 'the lines of action that people argue in favour of or against are… strongly dependent upon the premises they argue from' (Fairclough & Fairclough 2012:83). CDA provides tools for identifying how the ideas embedded in specific communicative contexts – in this case, the academic and grey literature selected – function as part of broader shared discourses about the health of Indigenous peoples. These discourses can then be subjected to further critique and analysis, including how they may shape or limit opportunities for action and reform in the health context. The analysis involved identifying key themes that occurred in the literature with particular reference to strengths-based approaches to health.

As an explicit part of the CDA process we recognised that discourse is complex, and it is entirely possible that programs and initiatives framed as 'strengths-based' may actually utilise deficit discourse (which itself may impact on evaluations, as well as on the general understanding of what strengths-based approaches entail). As a way to further interrogate the materials above, a sample was also analysed using the software packages *Nvivo* and *Leximancer*. The latter provides a useful 'X-ray' view of the semantic field[3] and a means to illuminate narratives in the text. *Leximancer* is particularly useful for identifying themes, nodes and correlations, and the discovery of patterns and linked concepts. It helps guide further detailed analysis that will be undertaken using Nvivo. This qualitative textual analysis tool was used to code text, and thus identify narratives and discursive themes, and how they operate, in much greater detail.

Tool 1: Leximancer

Leximancer is a software tool that analyses the semantic and relational meaning of texts. It uses statistical algorithms to reveal patterns within the data in a raw, unbiased way, and allows the researcher to see a visual concept map of the texts included for analysis (Cretchley & Neal 2013). The full set of academic texts used in the literature review were uploaded to Leximancer and the resultant concept map analysed. More specific analysis was undertaken for groups of texts with particular characteristics including:

- international initiatives seeking to shift health narratives away from a deficit focus (see p. 26)
- Australian initiatives attempting to shift the Aboriginal and Torres Strait Islander health narrative (see p. 27); and
- seven case studies of Australian and international initiatives.

Tool 2: NVivo

NVivo is a qualitative data analysis software package used by researchers to organise, analyse and discover meaning in texts. It is a useful tool for managing large volumes of unstructured linguistic data.[4] As the texts for the literature review were identified using key word searches and abstracts, closer analysis revealed that some texts provided more in-depth subject matter than others. To assess and determine approaches that have been effective, through NVivo we were able to interrogate how the literature contributes to approaches that seek to shift the narrative around Indigenous health. The framework that NVivo revealed was also applied to the case studies. In addition, data from the texts was categorised through analysis of metaphors and vocabulary used as descriptors of health-related action such as focusing on:

- assets or existing resources
- family or community
- culture
- framing in terms of colonialism, racism and resistance

3 Linguist Adrienne Lehrer has defined *semantic field* as 'a set of lexemes which cover a certain conceptual domain and which bear certain specifiable relations to one another' (Lehrer 1985:283).

4 For more on this go to: http://www.qsrinternational.com/what-is-nvivo

- the word ‘strength’ used without mixing deficit vocabulary
- framing inside the medical only model
- problems to be fixed (problematisation)
- bad behaviours leading to poor outcomes (behaviourism)
- undertaking a ‘needs assessment’
- disadvantage
- using the phrase ‘closing the gap’ or just ‘gap’ – an articulation of what is ‘missing’.

The following questions were also applied uniformly to both the Australian and international peer-reviewed samples that had substantive results. These were coded in NVivo using ‘thematic nodes’.

- How do academic authors define strengths-based approaches?
- What justifications are given in advocating for strength and resilience-based approaches to Indigenous health?
- Are contrasts made between strengths-based approaches and deficit-approaches? If so, what are they?
- What do ‘best practice’ strengths-based approaches look like in academic texts?
- Are there other methods or approaches to shifting the narrative that are not necessarily rooted in strength- or resilience-based approaches?
- Are there limitations evident in the approaches being used to move away from a deficit-based discourse?

Strengths-based approaches and concepts in health

Strengths-based approaches may provide alternatives to the deficit narrative (Australian Indigenous Health InfoNet 2017; Scerra 2011; Wolf 2016), but this does not mean denying that people face health-related conditions (Resiliency Initiatives 2013). Rather, strengths-based approaches seek to move away from the traditional problem-based paradigm and offer a different language and a set of solutions to overcoming an issue (Foley & Schubert 2013; Resiliency Initiatives 2013; Wolf 2016). A review of actions addressing the social and economic determinants of Aboriginal and Torres Strait Islander health showed that a key factor influencing success was the adoption of a strengths-based perspective (AIHW 2013). In addition, there is growing evidence to suggest that employing strengths-based approaches and focusing on health assets can counter negative social and economic determinants of health (University of Victoria 2017; Scerra 2011). A focus on strength invites health practitioners to ask a set of different questions that are more conducive to the diversity of individuals and communities (Resiliency Initiatives 2013).

While the term, 'strengths-based approaches' is in common use throughout the academic and grey literature, the term has multiple and sometimes paradoxical meanings. It is, therefore, not a uniform set of policy and program protocols, nor is it a given that a 'strengths-based approach' will always be an antidote to deficit. Rather, strengths-based approaches are best viewed as a set of conceptual frameworks for Indigenous health development. To better understand the scope and composition of these frameworks, we have drawn on our literature review to construct a typology of strengths-based concepts and cross-cutting themes that scholars have identified as useful in this area.

Asset-based approaches and resilience

The international Indigenous health literature we analysed often uses the term 'assets' in conjunction with, or even as synonymous with, 'strengths'. For example, Jain and Cohen (2013) link the building of *assets and strengths* to creating protective processes in health and wellbeing. Similarly, Priest et al. (2016) argue that a deficit-based approach has resulted in overlooking the strengths and assets of Aboriginal and Torres Strait Islander children. According to the Glasgow Centre for Population Health (GCPH 2017), as public health centres increasingly focus on prevention, asset-based language is becoming more widely used. The Centre describes assets as:

> *...the collective resources which individuals and communities have at their disposal, which protect against negative health outcomes and promote health status. Although health assets are a part of every person they are not necessarily used purposefully or mindfully. (GCPH 2011)*

While asset-based approaches can work in tandem with a needs-assessment, the latter tend to start with what is explicitly missing or required. By contrast, an asset-based approach takes 'pluses' – such as knowledge, skills, networks, extended family and cultural identity – as a starting point (Brough, Bond & Hunt 2004). The idea is to encourage people to think about how these can promote, protect and maintain health and wellbeing. As such, asset-based approaches aim to redress the balance between meeting needs and nurturing and promoting the strengths and resources of people and communities.

'Resilience' is a related concept that highlights the strengths and assets of individuals or communities in facing adversity or change (Payne, Olson & Parrish 2013:7). West et al. (2016) describe identifying 'resilient attributes' as an element of a successful strengths-based approach. Yuan et al. (2015) use 'strength-based' and 'resilient' in describing their approach to Indigenous health and wellbeing, while West et al. (2016:353) describe resilience as a protective factor.

In the context of the strengths-based literature, resilience refers more to spiritual and emotional aspects – such as happiness, strength of spirit, strength of character or positive coping mechanisms (Priest et al. 2012) – than to physical attributes. It is also recognised that access to resources and the ability to navigate them can affect one's resilience (Ungar 2006 in West et al. 2016:353).

Strength as 'holistic health and cultural appropriateness'

Neumayer (2013:21) suggests that the Western biomedical approach concentrates on the treatment of disease. Other scholars have characterised this approach to Indigenous health and wellbeing as being bio-reductionist, as it focuses on health as biology and overlooks a broader set of health criteria (Mark & Lyons 2010 in Priest et al. 2016:2). Hinton and Nagel (2012:1) highlight that 'wellbeing' for Indigenous peoples is a 'whole of life' view rather than one that can be compartmentalised into physical, mental, cultural or spiritual components. Tagalik (2009:4) adds to this definition by emphasising the important contrast between Western notions of health as a personal possession and Indigenous conceptions of health as the relationships – between people, the land and environment, tribes, families and ancestors – that operate on a continuum.

Authors within our selected literature commonly summon a binary analysis of Western versus Indigenous approaches to health and wellbeing (Tagalik 2009:4; Nagel, Hinton & Griffin 2012:216), emphasising a holistic approach to considering physical health alongside mental, emotional, social and community approaches to health and wellbeing. This is juxtaposed with Western medical models that are represented as focusing on specific issues and problems. Indigenous health is often conceptualised as being more about interconnectedness, relationships and community than physical illness. This concept is often talked about in the literature as 'cultural appropriateness'.

The peer-reviewed literature uses a range of terms to draw attention to broader or more holistic cultural values, including cultural safety, cultural relevance, cultural competence, culturally adapted, culturally responsive or culturally appropriate. The lineage of this language, which is central to defining strengths-based approaches to health, comes from the concept of 'cultural safety'. Developed by New Zealanders in the field of nursing, cultural safety refers to a practitioner's ability to keep issues of colonialism, power imbalances and value differences in mind when practising health care (Taylor & Guerin 2010 in Booth & Nelson 2013:120). As this concept was developed outside Australia, some adaptation of it is required in an Aboriginal and Torres Strait Islander context (Taylor & Guerin 2010 in Booth & Nelson 2013:120).

Grothaus, McAuliffe & Craigen (2012) state that 'cultural competence' and advocacy is strengths-based, while Monchalin et al. (2016) add that strengths-based approaches are peer led and 'culturally safe'. Nagel, Hinton and Griffin (2012) support a 'culturally adapted', strengths-based approach – suggesting the two concepts are compatible or complementary. Yuan et al. (2015) use 'culturally-appropriate', 'strength-based' and 'resilient' to describe a single approach, and Prentice (2015) prefers 'culturally grounded' as a *like-term* or *adjective* to '*strength based*' in describing a corrective approach to descriptions of Indigenous health.

Culture is used alongside strength in a number of indirect ways. Payne, Olson & Parrish (2013) discuss using the 'cultural strengths' of different communities, thereby mixing strength with

culture in this conceptual approach. Some authors describe culture-based approaches and strengths-based approaches as having an interrelated effect upon each other. For example, Robson and Silburn (2002) describe the Western Australian Aboriginal and Torres Strait Islander public health program as moving toward 'culturally responsible approaches' that can facilitate a strengths-based approach. Smith, Grundy & Nelson (2010) describe the Family Model of Care as having both community control and 'cultural comfort' sustaining strength. In this way, it is difficult to extricate the two approaches from one another, but both depend on ensuring 'cultural fit' between the intervention or program and the cultural background of the individual or community involved.

Strength and social determinants of health

There is a clear argument in the literature connecting strengths-based approaches and the social determinants of health, those factors or conditions that can be measured to determine the likelihood of ill-health in a population. Various models include combinations of the following factors: work or income, poverty, nutrition, housing, education, social capital or status, gender, intergenerational trauma, social support, physical environments, personal health practices, health services, biology and genetics (Neumayer 2013:38; Di Pietro & Illes 2016; Tagalik 2009:12–13). This school of thought flows from the work of early sociologists such as Marx and Durkheim who highlighted the relationship between illness and social conditions (Carson et al. 2007:5 in Neumayer 2013:38). Social determinants of health are principles used by key international bodies, such as the United Nations and World Health Organization (Neumayer 2013) and, therefore, inform 'best practice' norms. An international language of health and human rights actively informs the programmatic work in health fields, and influences high-level principles of practice (Gruskin and Tarantola, 2001 in Neumayer 2013:10).

Social determinants of 'good' health can be positioned as a strength that exists within in a context or community. For example, access and custodianship of land, language and culture are positioned in the research base as social determinants that affect health in a positive way (HREOC 2005:26). The active positioning of strong social and cultural capital as a determinant of health can be used as a mechanism to counter deficit, as well as to support community-based development approaches. It should be noted that there are some issues as to how such determinants are measured. Generally, the research base suggests that the social determinants of health framework is useful for practitioners to identify groups at risk of disease (Di Pietro & Illes 2016:247).

However, there is a significant literature in which scholars perceive the measurement of such social determinants as unhelpful or harmful in the context of Indigenous health. They argue that such indicators are typically based on Western cultural norms and do not include concepts such as land, relationships and family support (Neumayer 2013:39, Rowley et al. 2015:2) that are fundamental to good health outcomes for Indigenous peoples. There are also concerns about the pathologising impact such 'social determinants of health' can create, as they focus on physical illness (Priest et al. 2012:181). In response to this concern, research and practitioners propose 'decolonising' such metrics (Priest et al. 2012:190), and argue that community control over the determination of preferred metrics could legitimise the social determinants framework and make it more effective for the promotion of good health (Nelson, Abbott & MacDonald 2010).

Under this broad typology we can also include 'the systems approach', which is underpinned by shared values; systems thinking; leadership; governance; learning networks; and evaluation, research and feedback loops (Durham, Shubert & Vaughan 2015:15). Similarly, ecological theory recognises the impact of physical and social environments on the health and wellbeing of

individuals, with recent programs in Australia adopting this approach in their design and evaluation. Many Aboriginal Community Controlled Organisations also prefer this concept to the social determinants of health because it encompasses more of a whole-of-community approach to wellness and wellbeing (Rowley et al. 2015:2).

Strengths-based counselling approaches

The strengths-based approach has historical roots in vocational guidance, where it was used with groups such as youth and the elderly. It emerged in the early 1990s, and shortly after was adapted to treating people with severe mental illness (Saleebey 1996:296). The approach requires moving the capabilities, talents, competencies, hope and resources of both the individual and the community to the forefront of issues, thereby shifting the focus from pathologising the circumstances of the individual to examining possibilities and options for individuals to grow and develop their already-existing strengths (Saleebey 1996:297). By the 2000s, the strengths-based counselling approach was an established alternative to deficit and medical models (Grothaus, McAuliffe & Craigen 2012:51).

Strengths-based case management has also been successful when working with those with mental health and substance abuse issues (Arnold et al. 2007 cited in Scerra 2011). It draws on individual strengths rather than pathology, diagnosis or labels, and it sees communities as resource abundant. Interventions are based on client self-determination and on the client–case manager relationship. Aggressive outreach is the model of intervention along with the belief that people can learn, grow and change (Scerra 2011).

In a similar vein, positive psychology is an approach that focuses on strengths and virtues, offering an alternative to problem-based and deficit thinking (Craven et al. 2016; Positive Psychology Institute 2012). It has been argued that many of the fundamental principles of positive psychology are in symmetry with 'Indigenous conceptualisations of human experience, especially those emphasising the wholeness and interrelatedness of human experience' (Craven et al. 2016). In developing a reciprocal research partnership mode of 'Indigenous thriving', Craven et al. (2016) discuss the controversy of defining success. Instead, they offer a model of thriving, in which they argue that, for Aboriginal and Torres Strait Islander Australians, 'a positive psychology approach is not about a preconceived notion of success, but rather to allow their autonomous perspective to be considered among the drivers of thriving' (2016).

Strength through protective factors

Protective factors are generally discussed as non-physical, non-medical elements leading to good health and wellbeing. Henson et al. (2017) propose that there are nine 'protective factors' to Indigenous health and wellbeing and that *these are leveraged by strengths-based health approaches*. The nine factors are: aspirations, personal wellness, positive self-image, self-efficacy, non-familial connectedness, family connectedness, positive opportunities, positive social norms and cultural connectedness. Tagalik (2009:5–6) claims that Canadian Aboriginal cultural strengths – in the form of Indigenous knowledge, influence of Elders, extended family and relationships to nature and spirituality – are protective factors for health. Similarly, Priest et al. (2012:184) describe pride in Aboriginality as a protective factor against racism. In a study interviewing homeless Indigenous and non-Indigenous people, the strategy of being positive and content about being homeless was found to be a key protective factor in mental, emotional and spiritual wellbeing (Thomas, Gray & McGinty 2012:792).

Strength as empowerment

The concept of empowerment is closely tied to strengths in the literature. Sweet et al. (2015) describe the strengths-based discourse in Indigenous health as having an empowering effect on social and emotional wellbeing. Nagel, Hinton and Griffin (2012:218–19) describe empowerment as a value similar to strengths, citing both as central to recovery. However, empowerment and health promotion can be devalued by a tendency to focus on 'unhealthy' behaviours among Indigenous peoples (Brough, Bond & Hunt 2004:215). Prilleltensky (2005) theorises that there is a continuum of people-centred services, with deficit obverse to empowerment and strength.

Strength, wellness and wellbeing

Wellness and wellbeing are often framed as part of the general 'strengths-based' alternative to the clinical or medical model of ill physical health. Concepts of wellbeing include subjective wellbeing (Thomas, Gray & McGinty 2012), and social and emotional wellbeing (Kilcullen, Swinbourne & Cadet-James 2017; Sweet et al. 2015). These broaden the focus from purely physical or clinical measures of health, to include other types of health gained through connectedness, community and spirituality.

Despite similar terminology between different wellness and wellbeing approaches, they are by no means homogenous. Wellbeing can be measured objectively or subjectively and can indicate material, social and human satisfaction more generally (Thomas, Gray & McGinty 2012:780). Encompassing an Aristotelian philosophical approach, subjective wellbeing is a more individualistic approach to wellbeing than the more connected focus of social and emotional wellbeing. Subjective wellbeing can be defined as measuring wellbeing as happiness – the presence of positivity and absence of negativity – but not measured against social achievements or wealth (Thomas, Gray & McGinty 2012).

Social and emotional wellbeing, on the other hand, encompasses the ability of a person to work through everyday stressors and contribute to the community, with such wellbeing requiring a certain level of social support. It is typically associated more with Indigenous than non-Indigenous health (Day and Francisco 2013:350). Gee et al. suggest that in an Aboriginal and Torres Strait Islander context, social and emotional wellbeing involves seven explicit dimensions: 'connection to body; mind and emotions; family and kinship; community; culture; country; and spirit, spirituality, and ancestors' (in Kilcullen, Swinbourne & Cadet-James 2017:2).

Wellness and wellbeing in Indigenous health is often connected to the strengths-based approach. Tang, Community Wellness Program & Jardine (2016) use 'wellness' and 'strength based' as adjectives for a single approach to Indigenous health. Wellness is also frequently mentioned alongside strength, and holistic approaches used to shift the evaluation of 'health' from a disease-orientation (Tagalik 2009; Priest et al. 2012:108). Thomas, Gray and McGinty (2012:791) found that conceiving wellbeing from a strengths-based perspective can effectively counter the deficit model of thinking in homeless people.

Strength through decolonisation

Theories and methodologies of decolonisation go far beyond the health paradigm. They nonetheless form a key component of strengths-based approaches to Indigenous health. Decolonisation proactively shifts the focus from a Western and European set of worldviews and ideologies to centre on Indigenous concerns, ways of knowing and aspirations (Smith 1999:39, cited in Monchalin et al. 2016). In so doing, it can be seen as a critical approach to disturbing the 'colonisation' base of deficit paradigms. In terms of its relationship to types of strengths-based approaches, a decolonising approach begins in 'speaking back' to, and 'speaking beyond', simple problematics of health to recognise and fully embrace Indigenous worldviews including interconnectivity.

Sweet et al. (2015) depict decolonising methodologies as fully engaging with Aboriginal and Torres Strait Islander multidimensional concepts of wellbeing, including social and emotional wellbeing. For example, this entails appreciating connection to land or 'Country', culture, spirituality, ancestry, family and community as central to Aboriginal and Torres Strait Islander Australians' ways of understanding and conceptualising a sense of self, health and wellbeing (Sweet et al. 2015). Geia and Sweet (2015) suggest that Indigenous ways of knowing and doing in the health sphere include:

- the development of Aboriginal Community Controlled Services;
- the adaption of digital technologies for Indigenous storytelling; and
- the contribution of Indigenous knowledge to land management and environmental health.

In this way, decolonisation can be seen both as a concept underpinning strengths-based approaches and as a deliberate mechanism to reframe dominant narratives in the Indigenous health space.

Strength as salutogenesis

Finally, in our analysis of the literature there is a growing and emergent interest in salutogenesis as a conceptual underpinning based in strength. First coined by Anton Antonovsky (1979, 1987), salutogenesis is a 'scholastic focus on the study of the origins and assets for health, rather than disease and risk factors' (IUHPE n.d; Mittlemark et al. 2017). It conceptualises a healthy/dis-ease continuum that is in contrast to the dichotomous classification of health or illness as pathology (Mittlemark et al. 2017). Essentially, it is concerned with positive health and asks 'what makes people healthy?' (Antonovsky 1979 cited in Mittlemark et al. 2017; IUHPE n.d). Rather than focusing on risk factors it highlights 'salutary factors that actively promote health', and when working with communities and individuals it looks holistically at a person and their life (Mittlemark et al. 2017).

Prentice (2015) suggests that a growing critique of current Indigenous health research is that it is conducted within a pathogenic paradigm that highlights the 'problems' of Indigenous communities. This involves focusing on illness-related gaps and needs, and the risks and vulnerabilities for Indigenous ill-health (Prentice 2015). For example, in relation to research with Canadian Aboriginal women living with HIV in Canada, the focus has been on risk and vulnerability, including sexual and physical violence (Prentice 2015). To counteract a deficit and pathogenic approach, and to decolonise the research process, Prentice (2015) employs a salutogenesis model. She argues a salutogenesis approach is a theoretical foundation for emerging strengths-based perspectives.

Typology

In this section we have used CDA across the range of academic and grey literature selected in this study to create a conceptual typology of 11 strengths-based approaches and related concepts. Given the relatively small scale of the sample, this typology is not all-inclusive; but it is clear from the evidence that strengths-based concepts both incorporate and feed into crucial health concepts and approaches. Similarly, we acknowledge there is a distinct interrelatedness between each of the categories in our typology. We hope, however, that the typology has potential use as a heuristic device. It provides a conceptual map of the ways in which strengths-based approaches may be defined, conceived of and used in Indigenous health. In turn, the typology may be seen to represent a conceptual framework for challenging, disturbing and rejecting discourses of deficit within the larger discursive formation and, in turn, Indigenous health development policy and programming.

	Strengths-based approaches	Key elements	Example texts
1	Asset-based	Utilises existing positive attributes, characteristics and resources of a person and/or community	Priest et al. 2012 Priest et al. 2016 Brough, Bond & Hunt 2004 Grothaus, McAuliffe & Craigen 2012 GCPH 2017
2	Resilience	The ability to withstand adverse circumstances through mental, emotional, social and spiritual strength	Jain & Cohen 2013 Payne, Olson & Parrish 2013 West et al. 2016 Thomas, Gray & McGinty 2012
3	Cultural appropriateness	The tailoring of programs, resources and health care to privilege cultural aspects of indigeneity	Grothaus, McAuliffe & Craigen 2012 Monchalin et al. 2016 Smith, Grundy & Nelson 2010
4	Social determinants of health and ecological theories	Structural factors or conditions that influence health and wellbeing	Di Pietro & Illes 2016 Rowley et al. 2015 Neumayer 2013 Nelson, Abbott & MacDonald 2010
5	Protective factors	Non-physical and non-medical elements that counteract or mitigate the effects of adversity	Henson et al. 2017 Tagalik 2009
6	Empowerment	Focuses on self-determination and abilities rather than limiting factors, such as poor physical health	Sweet et al. 2015 Nagel, Hinton & Griffin 2012 Prillentesky 2005
7	Holistic approaches	Privilege Indigenous ways of knowing and being	Priest et al. 2012 Priest et al. 2016 Rowley et al. 2015 Hinton & Nagel 2012
8	Wellness and wellbeing	Measuring health in a wider range of metrics than physical illness or disease, usually including mental, social, emotional, spiritual and communal wellness	Thomas, Gray & McGinty 2012 Day & Francisco 2012 Sweet et al. 2015 Tagalik 2009
9	Strengths-based counselling approaches and positive psychology	Prioritises capabilities, talents, competencies, hope, resources, optimism and autonomy of individuals and communities when remedying challenging circumstances	Saleeby 1996 Grothaus, McAuliffe & Craigen 2012 Craven et al. 2016
10	Decolonisation methodology	A broad methodology proactively shifting the Western and European worldview to the Indigenous	Sweet et al. 2015 Geia & Sweet 2015 Monchalin et al. 2016
11	Salutogenesis	Focuses on the assets and origins of health rather than the deficits of ill-health, to shift the pathologising paradigm	Antonovsky 1979,1989 Mittlemark et al. 2017 IUHPE n.d. Prentice 2015

Why use strengths-based approaches?

Justifications for using strengths-based approaches

The literature review revealed that arguments for the use of strengths-based approaches in Indigenous health fell into two broad categories:

- Those using 'utilitarian' justifications, which advocate for strengths-based approaches for the purposes of efficiency in resourcing or funding, or due to a similarity to existing approaches. They often include arguments pitched as value-for-money, cost saving or a good use of existing knowledge, approaches, assets or resources that could be economic or social in nature. Generally, these were texts that defined strength as family or community, with some defining strength as culture.
- Those using 'binary justifications', which argued for 'balance', 'fairness' or correcting negative stereotypes, and characterised strengths-based approaches as a counterbalance to deficit discourse. These were usually texts that defined strength as resistance, although some also viewed strength in terms of culture.

Not all justifications were as definitive, with some authors arguing along utilitarian lines and binary counter-narrative lines simultaneously. Generally, however, the arguments employed underpinned the extent to which policy and program design sought, either passively or actively, to shift deficit discourse.

Utilitarian justifications

A primary argument around the utility of strengths-based approaches is its potential compatibility with existing 'Indigenous' approaches. This is often articulated as 'strength as family or community' and 'strength as culture'. For example, Sweet et al. (2015) show that strengths-based approaches focus on empowerment, healing and self-determination, which are seen as central to Aboriginal and Torres Strait Islander conceptions of health and wellbeing. Priest et al. (2012) similarly demonstrate that using the strengths-based approach can directly correlate with Aboriginal and Torres Strait Islander ways of raising children's self-esteem and confidence. They also argue that these approaches should be used because they evaluate the existing assets on which Aboriginal and Torres Strait Islander children and families can draw to improve their wellbeing (Priest et al. 2012:181). Thomas, Gray & McGinty (2012) endorse the strengths-based approach as a unique bottom-up tool for supporting Indigenous homeless people. In their study, they found that a strengths-based approach allows for analysis and evaluation of individual agency and ability to improve health and wellbeing, starting with an Indigenous perspective. In all such cases, the use of existing social and economic capital is seen as paramount (see, for example, Priest et al. 2016; Di Pietro & Illes 2016; Jain & Cohen 2013).

Many of the authors writing in the academic and grey literature in our sample who advocate for strengths-based approaches emphasise the 'efficiency' gained by using resources that already exist. The influence of the New Public Management discourse is evident, particularly in literature on public policy issues (Marsh 2015). While perhaps effective in persuading government and other funders to endorse a strengths-based approach, there is some danger in promulgating the idea that efficiency of local resources should be a driving reason to adopt a strengths-based approach. In particular, there may be a temptation by funders to use this as a reason to provide less, and a shifting of responsibility for social development to the local, allowing systems to abnegate their critical role in tackling the structural drivers of inequality. Similarly, if a community or group 'fail' to achieve desired health outcomes, responsibility can be shifted to the local Aboriginal or Torres Strait Islander people. Such slippage is an active producer of deficit development models and policy settings.

Some arguments for adopting a strengths-based approach in health group together net positive outcomes of manifest deliverables. This also reflects the influence of 'new public management', but widens the scope to other forms of efficiency beyond existing assets. Maclean, Harney and Arabena (2015) found that strengths-based approaches reduce stigma in addressing health and wellbeing issues among Aboriginal and Torres Strait Islander groups. Smith et al. (2011) argue greater gains exist in the coordination and service delivery of aged care to Aboriginal and Torres Strait Islander people when working with the community to determine program trajectory. Neumayer (2013) argues that strengths-based approaches embrace positive cultural identity and facilitate community leadership on health issues. The logic behind these various types of advocacy is that if the strengths-based approach is leveraging attention and leadership from the local community, then it is a better approach than focusing on deficit, disadvantage or problems disempowering collective action. It should be noted, however, that this logic is not stated as explicitly against deficit discourse; rather, the focus is on utilitarian gains.

Binary justifications

Within the sample, strengths-based approaches were often justified as correctional or as being explicitly necessary to remedy the narrative of deficit, disadvantage and negative stereotypes in Indigenous health. In this way, the justification is positioned as in 'binary opposition' to deficit-based approaches. The need for change is pitched as achieving justice for the group, due to the injustices they have suffered as a result of the deficit discourse in Indigenous health. Such justifications predominantly appear in texts representing 'strength as resistance' (see p. 13). In what can be seen as the forerunner to strengths-based health, approaches such as strengths-based counselling (see p. 12) deliberately aim to shift the biomedical and deficit paradigm (Grothaus, McAuliffe & Craigen 2012:51).

A number of the texts that we analysed adopt this binary justification. For example, a common justification for focusing on the strengths, values, identities and beliefs of people is 'giving voice' to marginalised communities (Brough, Bond & Hunt 2004). This is an explicitly counter-deficit justification that sits in opposition to the assumption that marginalised communities lack strengths, values and resources. Another example appears in the work of Brough, Bond & Hunt (2004), which explicitly makes the link between negative stereotypes, hegemonic discourse and poor outcomes, citing the need to shift discourse towards strength to ensure this pathway is changed effectively.

Challenging negative stereotypes is also presented as a justification for adopting the strengths-based approach. For example, Priest et al. (2012:189) cite the need for more 'balanced' reporting on issues affecting the health and wellbeing of Aboriginal and Torres Strait Islander people, many of whom report that they are healthy, 'doing well' or feel that they possess more financial, physical and emotional resources than what is reported in the non-Indigenous community and media. Adopting strengths-based approaches is also justified as counterbalancing stereotypes of Aboriginal and Torres Strait Islander communities as weak or lacking (Brough, Bond & Hunt 2004:217). Tagalik (2009) argues for strengths-based approaches, in part, due to their focus on collaboration and consensus.

Similarly, programs such as Sexy Health Carnival are justified on the grounds that youth-aged groups need positive, focused health messages that do not stigmatise or shame the individual or group (Monchalin et al. 2016). Again the justification for such an approach is aimed specifically at challenging or moving away from negatives of the dominant deficit narratives. Sweet et al. (2015) argue that strengths need to be maximised so as to see past disadvantage, and that health policy must focus on what outcomes can be achieved through Indigenous self-determination and co-creation of health.

Although different, both the utilitarian and the binary justifications for using strengths-based approaches to Indigenous health are relevant to the policy context, and each can be used to challenge and shift dominant narratives of deficit at a broader level.

Strengths-based Indigenous health programs

Our research identified and analysed a range of case studies based on their active attempts to shift or challenge deficit discourse through strengths-based approaches. In this section we offer a selection of these case studies, mainly from Australia but also New Zealand, to show the diverse forms such initiatives take.

Whānau Ora Framework

Whānau Ora (meaning 'healthy families') is a New Zealand Government framework, established in 2010, to improve and integrate service delivery in areas such as health, education, housing and employment. Recognising that government services were typically designed on an individualistic, client-centre and single-issue basis that resulted in uncoordinated and fragmented service provision, Whānau Ora is community and family-oriented. As part of the initiative, three main government commissioning agencies devolve service delivery to community-based organisations, while 'navigators' work with families (whānau) in need to help them access a range of relevant services in coordinated ways. The community organisations are supported in providing services that are culturally and locally relevant.

There have been two phases of the project. The first focused on building the capacity of service providers in adopting and delivering the Whānau Ora model. The second focused on community organisations operationalising their whānau-centred activities (Wehipeihana et al. 2016).

Although the initiative does not describe itself as 'strengths-based' per se, it actively draws on the language of strengths by contending, for example, that 'Whānau strengths, assets and ability are the starting place for future growth' (Wehipeihana et al. 2016:54). In addition, strong and trusting relationships, shifting toward whānau capability rather than provider capability, and being responsive and flexible to positive change, are seen as key to success.

An evaluation found that the commissioning agencies were viewed as 'more networked and connected to communities, closer to whanau and better informed about their needs' (Wehipeihana et al. 2016:87). However, the commissioning model can be strengthened in a number of ways: for example, some partner organisations need more time than others to adjust to the new environment and requirements. The evaluation also identified that measuring outcomes can be difficult and recommended strengthening data capture, analysis and reporting systems.

Working with culturally relevant worldviews and perspectives has been associated with a strengths-based approach (Neumayer 2013). The Whānau Ora framework is consciously imbued with Māori values and ways of working, even while the services are open to all New Zealanders. Applying a family-centred framework is a structural shift from the dominant client-centred approach that has been fundamental to social service delivery.

Deadly Kids Deadly Futures Framework

Deadly Kids, Deadly Futures is Queensland's Aboriginal and Torres Strait Islander Child Ear and Hearing Health framework for 2016 to 2026. Although still in the early stages of implementation, the framework commits the Queensland Government to improving the hearing health of Aboriginal and Torres Strait Islander children. Jointly implemented by Queensland Health and the Commonwealth Department of Education, it builds on the successes and learnings from the Deadly Ears Deadly Kids Deadly Communities 2009–2013 framework that aimed to reduce the rates of otitis media (OM) (aka 'middle ear infection') by preventing, identifying and treating the condition. The framework ensures partnerships with communities and non-government stakeholders are in place to implement three priority areas: health, early childhood development and schooling.

In addition to working in schools, the framework employs a multi-disciplinary health team to provide outreach, clinical support, health promotion, education and training. It draws on a socio-ecological model that proposes a 'systems approach' (Durham, Shubert & Vaughan 2015) to working with children and families in 11 Queensland Aboriginal and Torres Strait Islander communities to raise awareness and understanding of the impact in children of ear disease and when to treat it. A strengths-based approach to stakeholder engagement underpins the systems approach that is value-driven and built on the principle that those directly affected are best placed to determine the design of treatments (Durham, Shubert & Vaughan 2015).

An evaluation of the earlier Deadly Ears Deadly Kids Deadly Communities framework 2009–2013 (Durham, Shubert & Vaughan 2015) incorporated quantitative and qualitative measures, including a utilisation-focused approach involving Deadly Ears program staff assisting in evaluation design. While mainly operating within a pathologising paradigm, the Deadly Ears program employed a socio-ecological model to public health to reduce the rates of OM. It encompassed a systems approach that included a coordinated multi-sector, multi-level and multi-strategy response, and took in the broader social determinants influencing health outcomes. It also valued the partnerships with key stakeholder engagement – the cornerstone of the framework.

Due to its success in improving ear and hearing health outcomes, the Deadly Ears program won several awards and received recurrent funding. Its successes include substantial progress in preventing OM and a significant reduction in the presentations of chronic suppurative OM (CSOM), which is attributed to the program's education activities, partnerships, training, and health promotion activities such as physical activity.

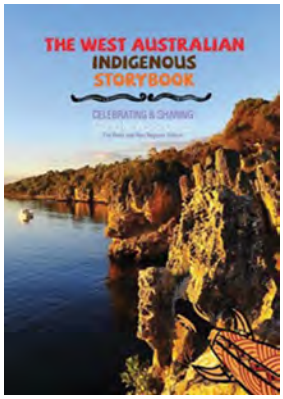
#IHMayDay

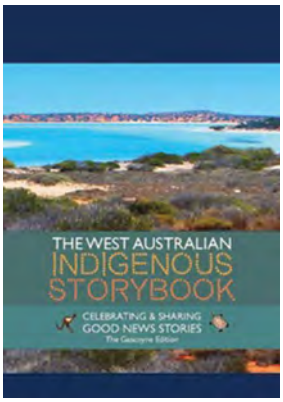
#IHMayDay (Indigenous Health May Day) is an annual, day-long Twitter event (aka Twitterfest), led by Aboriginal and Torres Strait Islander people, to discuss issues relating to health and wellbeing. Starting in 2014 in response to a suggestion made on Twitter, it is a platform for Aboriginal and Torres Strait Islander Australians to share views and knowledge about wide-ranging issues affecting their health. Non-Indigenous people are encouraged to participate by listening and/or re-tweeting. Cultural protocols are followed, such as tweeting one's Country or nation along with one's comment. Each year's event is themed and guest moderators have around two hours to tweet and facilitate discussions on topics ranging from 'Celebrating Aboriginality' to 'Healing and Youth', 'Sexy Health', and 'Positive Male Perspectives'. #IHMayDay is informed by a decolonising methodology, which shows existing counter-discourses in the Australian Aboriginal and Torres Strait Islander health space. #IHMayDay also explicitly advocates for the power of strengths-based approaches to health by highlighting the strengths of Aboriginal and Torres Strait Islander people, communities and organisations. It also provides a unique platform for rejecting constructs of deficit. For example, in 2017 Dr Chelsea Bond used #IHMayDay to critique the discourse of mainstream public health, arguing that it equates Aboriginality with sickness. As an alternative she proposed a position acknowledging the ways in which Aboriginality is conducive to better health (Geia & Sweet 2015:4).

Sweet et al. (2015) thematically coded the 1299 tweets made with the #IHMayDay hashtag using the analytical tool Symplur. The primary themes of the event were issues relating to social and emotional wellbeing, which occupied 20 per cent of the content, and empowerment at 12 per cent (Sweet et al. 2015:693).

One of the coded themes in the discourse analysis was 'Counter narratives', of which Sweet et al. provided the following example tweet: 'I'm over the negative stereotype that social marketing campaigns portray Indigenous health' (2015:637). This reveals some flipping of the negative stereotype narrative when trying to reframe Aboriginal and Torres Strait Islander health. The #IHMayDay initiative is an innovative example of the use of social media to advocate for strengths-based approaches, while demonstrating them at the same time. It also provides a model for challenging the dominant discourses in Aboriginal and Torres Strait Islander health.

Indigenous Storybook WA





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Indigenous Storybook is a project run by the Public Health Advocacy Institute of Western Australia (PHAIWA), which collects and publishes community news stories in relation to social, economic, health and environmental outcomes. It involves Aboriginal and Torres Strait Islander practitioners sharing successes and challenges in achieving positive outcomes within their community. So far, seven (an eighth is in production) storybooks have been published from regions across WA. Each edition has approximately 14 stories and follows a particular story-telling format.

Evaluation coordinator Melissa Stoneham described the Storybook as 'highlighting distinctive and successful social initiatives in Aboriginal communities' (PHAIWA 2016). Stories are wide ranging, reflecting a multidimensional conception of health and wellbeing. In addition to facilitating the circulation of positive health stories from Aboriginal and Torres Strait Islander people in WA, PHAIWA also provides media training.

The project was created in response to the Public Health Advocacy Institute of Western Australia (PHAIWA) 2014 research that examined the media portrayal of Aboriginal and Torres Strait Islander health over a 12-month period. Stoneham, Goodman & Daube (2014) found that '74 percent of media coverage of Indigenous related articles were negative, 15 percent were positive and 11 percent were neutral and the most common negative themes related to alcohol, child abuse, petrol sniffing, violence, suicide, deaths in custody, and crime.' To help change the negative narrative, the project focuses on 'positive models of change and commitment in Aboriginal communities' (PHAIWA 2016).

The program is specifically targeted at providing a counter-narrative to the dominant, negative media messaging pertaining to Aboriginal and Torres Strait Islander peoples. Storytellers self-determine their storytelling style and topic. For example, some stories are in the first person while others are in third person; some authors write of their own experiences while some reflect on the work of others (PHAIWA 2011). The focus is on what has been accomplished and the way it was achieved. Although some stories point out challenges, these are not framed in terms of deficiency as similar stories often are in the mainstream media. The Storybooks provide a different lens onto the community – one defined by members themselves. As Stoneham, Goodman & Daube (2014) point out, the stories are less sensationalist and portray more positive descriptions of achievements of health and wellbeing of the community.

While asset- and strengths-based approaches are not explicitly discussed in the stories, they nonetheless emphasise personal and community assets. Positive, asset-based language is evident in the messaging and promotion of the initiative, and moving away from deficit language is a primary aim of the project. For example, PHAIWA emphasises 'excellence' and 'success' over 'disadvantage' and 'closing the gap' (PHAIWA 2016:21). Other positive language demonstrated includes:

'This Storybook is the first in a series of Indigenous Storybooks showcasing the achievements of Indigenous people and communities across Western Australia.'

'Each Storybook will be a celebration of Indigenous people who have contributed to social, economic, health and environmental outcomes for their communities.'

In a recent evaluation, PHAIWA used a happiness-level indicator to measure the storytellers' satisfaction with the process and end product (*The WA Indigenous Storybook Evaluation Report*, Nov. 2011 – Nov. 2016). They also collected stakeholder and community feedback about the Storybooks. Crucially, the Storybook provides a platform for individuals and communities to come to their own definitions of progress and success.

Ngangkari Program

The Ngangkari Program commenced in 1998 and is run by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council located in central Australia's Arrente country. It employs ngangkari – Anangu traditional healers – to provide treatments to Anangu across 25 communities in the Northern Territory, South Australia and Western Australia. In addition to facilitating traditional healing, the program aims to promote and mainstream ngangkari healing by working with public health systems and providing education. Furthermore, it provides direction for the development of culturally appropriate mental health services (NPY Women's Council Aboriginal Corporation 2012). The ngangkaris' work with mainstream health services and hospitals involves preparing patients and working directly with doctors and medical staff. While ngangkari draw on practices that are passed down orally across generations, they 'value collaboration and mutual respect between Western health and human services and ngangkari for better health outcomes' (NPY Women's Council Aboriginal Corporation 2012).

Often synonymous with a strengths-based approach, cultural-based programs and methods draw on Indigenous frameworks and ways of understanding to underpin a program or initiative. The Ngangkari Program is a traditional Anangu healing program that fits outside biomedical conceptions of healing, health and wellbeing. Although it remains within a pathologising paradigm of treating ill health, the Ngangkari Program is a subtle example of changing the narrative. The program values working in partnership with Western mainstream medicine and practitioners, and for approximately 10 years has been attempting to mainstream ngangkari healers alongside biomedical practitioners. As a result, their significance is becoming widely accepted, and both doctors and Anangu treat ngangkari as precious and accord them a place within hospital and clinical service provision (Lynch cited

in Vibe 2013). Across central Australia and NPY lands, ngangkari healers work collaboratively alongside medical practitioners in addition to working independently with communities and individuals. They will often work at the clinic preparing those patients who need to travel into Alice Springs Hospital (Burton cited in Vibe 2013). Essentially the adoption of ngangkari traditional healers alongside Western science-based medicine is offering a two-way health care model (Panzironi 2013).

The Ngangkari Program has now branched into related programs. For example, the Uti Kulintjaku Project is a mental health literacy project, initiated by ngangkari (Togni 2015), with the aim of strengthening bi-cultural mental health literacy for Anangu and non-Anangu practitioners (NPY Women's Council Aboriginal Corporation 2012).

L–R: Josephine Mick, Ilawanti ken, Mary Pan and Maringka Burton. Photo by Rhett Hammerton.
© NPY Women's Council

Talking Up Our Strengths

Talking Up Our Strengths utilises 22 picture cards to generate conversations about 'what Aboriginal people have done to remain proud, resilient and strong' (SNAICC & Innovative Resources 2011). The themes of the cards centre on children, identity, knowledge, Elders, connection, celebrations, heroes, our land, colours, language, stories, humour, men, women, 'our mob', music, sport, health, tucker, pride, struggles, and our past, present and future. They are visual aides to start conversations and share stories, to name and celebrate the strengths of the world's most enduring cultures.

First published in 2009 then again in 2011, Talking Up Our Strengths was created by the Secretariat of National Aboriginal and Torres Strait Islander Child Care or SNAICC in partnership with St Luke's Anglicare's Innovative Resources (St Luke's), with the help of

community organisations and individuals. SNAICC is a peak membership body advocating for the rights for the child, made up of childhood organisations, practitioners, community groups and individuals. Innovative Resources – the publishing arm of St Luke's Anglicare (Bendigo, Victoria) – advocates for community and social justice concerns. The work of both organisations is underpinned by strengths-based practice and constructive social practice.

The cards are centred on positive themes, such as celebrations, heroes, our land and pride. The only theme that could be seen as focusing on deficit is 'struggles'. Arguably, however, as the resource instructs, the interpretation of each card remains with the participant. Thus, by talking about or reflecting on struggles one could potentially generate a story of resilience, '…to help focus on what we, as Aboriginal people, have done to remain proud, resilient and strong'.

The overall aim of the cards is to effect schematic change through conversation and imagery. According to Piaget and Cook (1952), schemas are the architecture through which we organise knowledge. Eysenck and Keane (2005) argue 'schemas are integral in language processing, because they contain much of the knowledge used to facilitate understanding of what we hear and read'. If a negative schema or stereotype dominates the discourse in narratives associated with Aboriginal and Torres Strait Islander health and wellbeing, then combining positive imagery with positive themes and language could be a powerful tool for changing these narratives.

However, it remains unclear how people actually engage in conversation as a result of the cards. Are positive, strengths-based conversations generated, or do people continue to use dominant deficit narratives?

AIMhi Stay Strong App

The AIMhi Stay Strong App is a tablet-based application developed for health care practitioners to engage more effectively with their Aboriginal and Torres Strait Islander clients to bring about positive behaviour change (Dingwall et al. 2015; Menzies School of Health Research 2013). It was designed, in collaboration with Aboriginal and Torres Strait Islander people, by researchers at the Menzies School of Health Research and Queensland University of Technology (Menzies School of Health Research 2013).

The app provides interactive visual representations of life areas, which allows practitioners and clients to work together to identify strengths and worries, and to set specific and achievable goals (Dingwall et al. 2015). It first looks at facets of a person's life and what keeps them strong, and then at their worries and fears. Goal setting is then explored, and an overall summary provided to the client, followed by a goal planning review and visits from the practitioner.

The Stay Strong App is described as a strengths-based approach because it draws on the positive factors of a person's life that keeps them strong. Some of these include (but are not limited to): people in the person's life, going to Country, spirituality, music and physical activity (Menzies School of Health Research 2013). According to Tagalik (2009), such attributes are considered protective factors for health. Henson et al. (2017) note that

protective factors like these are often used in strengths-based health approaches because they are associated with good health outcomes. The Stay Strong App facilitates a process for identifying both protective factors (strengths) and worries so clients can then move forward to set specific goals and ways to achieve them. In identifying a full picture of both strengths and worries, the Stay Strong App exemplifies how a strengths-based approach can be utilised without the problem deflation of health issues.

Dingwell et al. (2015) used semi-structured interviews to investigate the feasibility, acceptability and appropriateness of the AIMhi Stay Strong App. People interviewed by Dingwell et al. undertook a month-long trial with the App and reported on their findings. These findings only represent the perspectives of service providers, and the research identified room to further explore the perspectives of Aboriginal and Torres Strait Islander practitioners.

As is apparent from the above case studies, a diverse range of initiatives draws on strengths-based approaches to varying degrees. In some cases countering the negative discourses around Indigenous health is an explicit and principal goal of the initiative, in others it is subsidiary to another goal.

Due to a paucity of evidence, it remains difficult to judge how successful strengths-based initiatives actually are in shifting discourse, or what kinds of initiatives work best. Many lack evaluations, or their evaluations do not measure the extent to which discourses have altered. This is most likely due to a range of factors such as:

- limited funding both for innovative strengths-based programs and for their evaluation
- a focus on (and incentives for) quantitatively measuring health outcomes rather than examining shifts in discourse, even when assessments occur; and
- the logistical challenges of measuring real-world changes in discourse.

Indeed, given its intangible and fluid nature, success in shifting discourse is not easily measured through the kinds of quantitative analyses that are conventional in health sector evaluations. Qualitative and mixed-methods approaches are necessary to capture how language, and the concepts that underlie it, circulate in real-world settings and with what effects. Here social science can play a special role in better understanding the interrelationships between, on one hand, how health and its determinants are conceptualised and framed, and on the other, the achievement of culturally valued health outcomes.

Differences in discourse between Australian and international literature

While the case studies provide some small examples of strengths-based approaches, at a larger level we were also interested to examine if there was a difference in the way international and Australian literature used, conceived of and implemented strengths-based approaches to disturb deficit discourse. To do this, we were able to use CDA to undertake some comparative analysis between two key sets of text. The literature sample for this project was selected using key words to yield texts specifically discussing strengths-based approaches to Indigenous health.

Figures 1 and 2 provide a useful X-ray of the literature's semantic field, broadly evidencing very different thematic landscapes between the Australian and international literatures. This is another way of analysing how 'strengths-based' approaches to Indigenous health overlap one another, but also demonstrates the different thematic emphasis in different contexts. The key finding of this visual mapping is a divergence in the dominant discursive themes between the Australian and international literature.

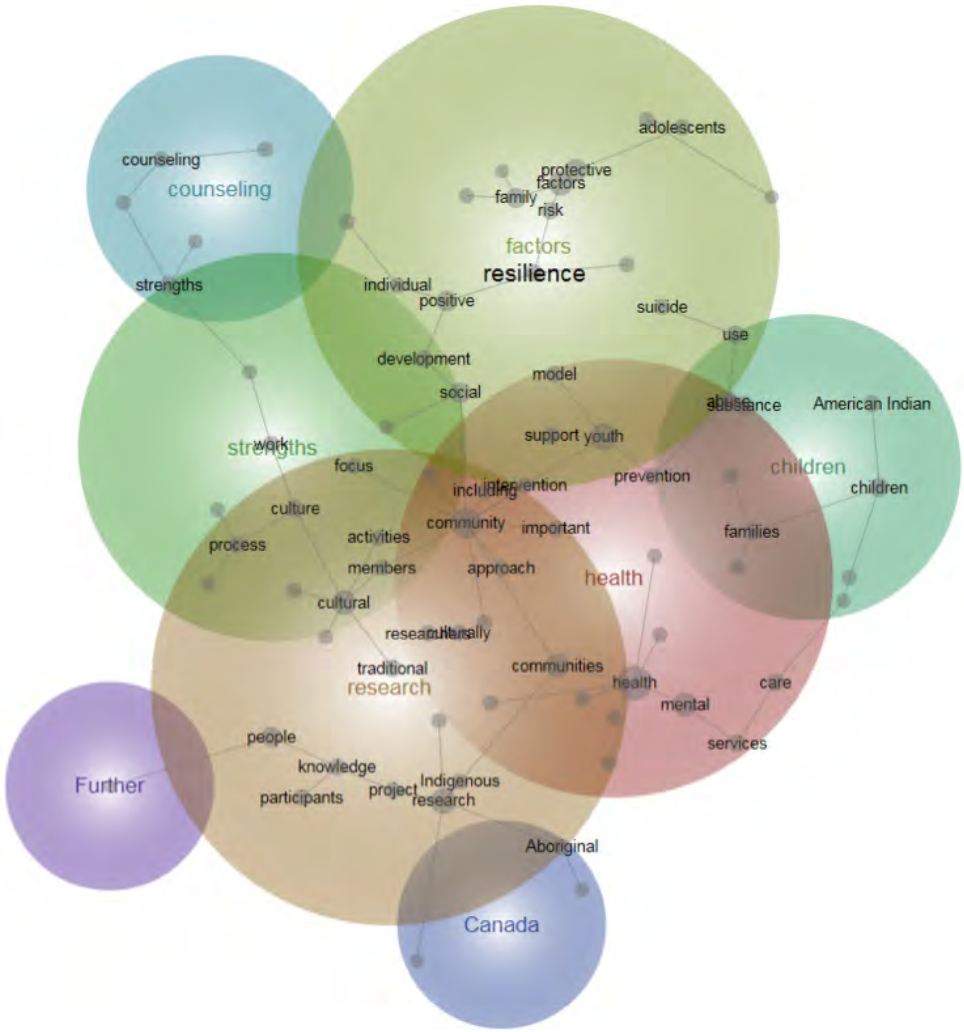

Figure 1: International thematic landscape of selected strengths-based literature

In the international sample, the main linguistic themes speak to the epistemology of the strengths-based discourse, with origins in 'counselling' and building on key concepts such as 'resilience' and 'protective factors'. In the visual representation of this sample, three of the largest themes are: 'counselling', 'strength' and 'resilience'. The overall tone of the international literature is also noteworthy. In the linguistic mapping, Leximancer located 'positive' as most closely related to 'individual', 'development' and 'resilience', with the word 'negative' not even occurring on the substantive mapping. Conversely, in the Australian sample the word 'negative' is its own major theme, although tied to 'positive' and also 'health'.

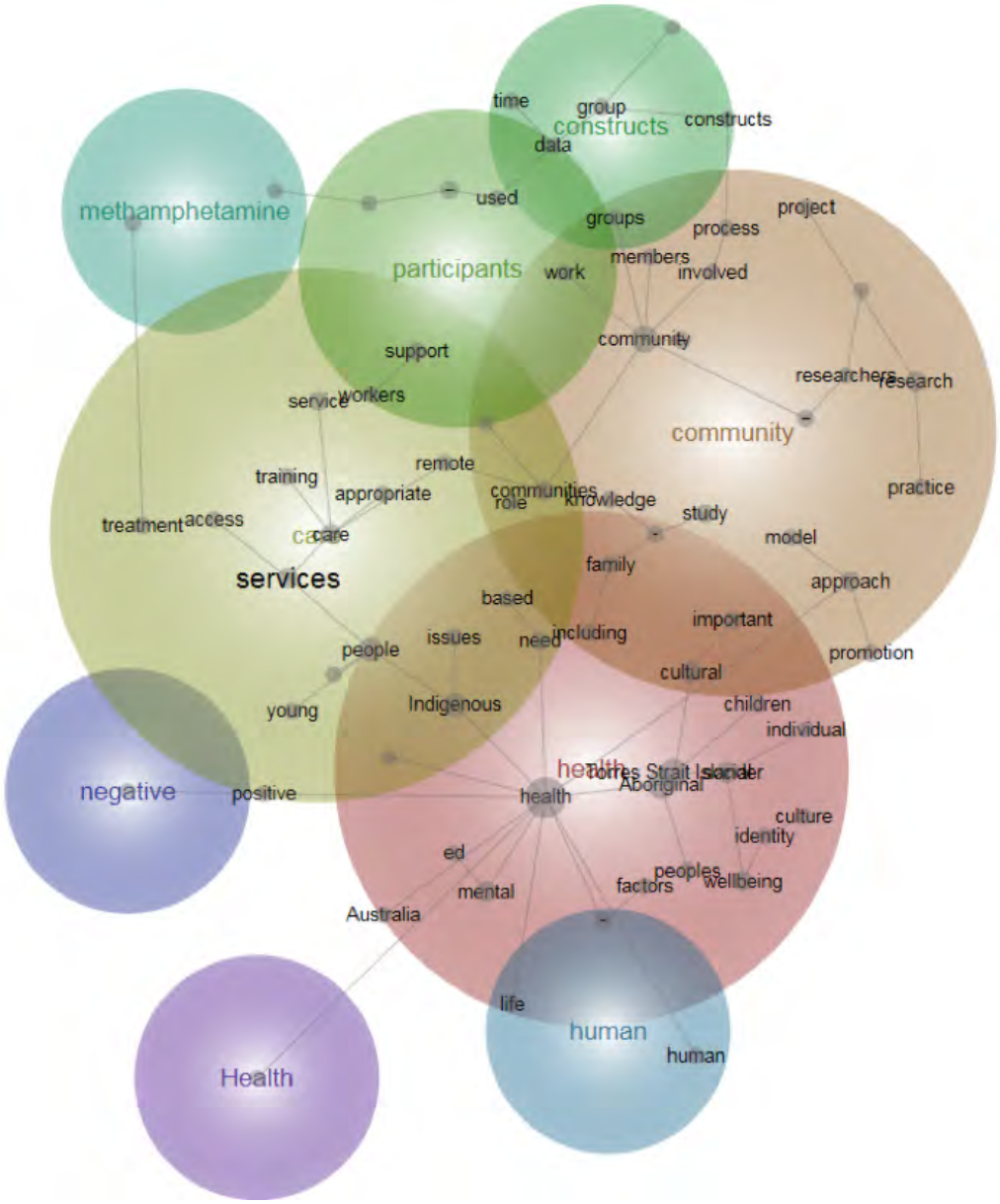

Figure 2: Australian thematic landscape of selected strengths-based literature

In contrast to Figure 1, a key theme in the Australian sample is 'methamphetamine', a recreational drug commonly associated with harm and bad behaviour. This thematic focus could suggest that drug taking, or a focus on behaviour change, is actually a key theme in the Australian sample. The international sample, however, features 'use' as a word relating to 'substance' and 'suicide', neither of which are connected to any other language or key theme, suggesting this body of literature may more effectively avoid linguistic blame without minimising the problem.

Of interest to this research is the location of the key words 'community' and 'communities', 'family', 'member', 'groups' and 'culture' in the Australian sample. All of these words semantically relate to one another, and reinforce the finding that strengths-based approaches to Aboriginal and Torres Strait Islander health are often conceived along these lines. Other notable linkages include the appearance of 'need' being most closely related to 'health', suggesting that Australian health literature often constructs a needs assessment (and/or deficit assessment). Also of note is the prominent position of the theme 'services', as this relates to the key role that government and community services play in the health and wellbeing of Aboriginal and Torres Strait Islander people. A similar theme is notably absent in the international sample.

Our typology and analysis of strengths-based approaches suggested both utilitarian and binary justifications for their use (see p. 16). However, it would seem that Australia relies far more heavily on utilitarian arguments or justifications for using strengths-based approaches. We can see this in the linkages between themes built around the key terms of 'services' and 'health'. This may suggest that there is an underuse, or potential for more use, of binary justifications. In particular, it would seem that international contexts are far more comfortable in promulgating strengths-based approaches aimed specifically at alleviating or challenging deficit discourse. Given that we note both utilitarian and binary justifications are recognised as influencing policy, and are noted as 'successful' in garnering change, perhaps the Australian Aboriginal and Torres Strait Islander health field can be seen as being reticent to use binary approaches. Although it would take a broader research project to say this definitively, it does suggest that there is potential for far more explicit advocacy (binary justification) to use strengths-based approaches to shift deficit narrative.

Conclusion

As the culmination of findings from a six-month research project, much of the work in this report can be seen as building blocks helping us to find ways to shift dominant narratives of deficit in Aboriginal and Torres Strait Islander health development. There are, however, a number of key findings of importance in trying to reframe the narrative of Aboriginal and Torres Strait Islander health, to challenge or eliminate the effects of a discourse of deficit. With this in mind, we finish this report with the following observations and conclusions:

- There is an emerging evidence base that deficit discourse has an impact on the health and wellbeing of Aboriginal and Torres Strait Islander people.
- The analysis found that 'strengths-based approaches' to health were the most common concept used and accepted as successful to counter deficit either explicitly or implicitly.
- A strengths-based approach is not a set of policies or programs; rather it is a conceptual framework for approaching Indigenous health development and intervention.
- Strengths-based approaches are not a simple corollary or antidote to deficit, and can be seen to grow out of the same discursive field. At the same time, by explicitly acknowledging a want to overcome deficit-based models, the research suggests a strengths-based approach can be a highly effective method for shifting or changing narratives of Indigenous health, and to illuminate and provide alternative ways to deal with health issues effecting Indigenous peoples.
- There are some serious barriers to implementing strengths-based models of development for Indigenous health. These include: (a) an often broad, weak or ill-defined conceptual base for research, policy and program design; (b) a tendency, particularly in the grey literature, to use platitudes or to 'pay lip service' to strengths-based ideation; and (c) a paucity of strong qualitative evaluation including a lack of formative evaluation design. In addition, there is almost no evaluation of actual impact on the discourse itself and, in turn, health outcomes for First Peoples. Similarly, we found no evaluation techniques specifically designed to measure or demonstrate shifts in Indigenous health discourse, which in part may be due to the difficulty of measuring change.
- Through the sample of text we analysed using CDA, we were able to identify and create an emerging typology of concepts (and associated literature) that can be used to underpin strengths-based approaches to Indigenous health development. This typology may, in conjunction with other and further research, be used as a heuristic device to assist in the design of research, programs and policy aimed explicitly at shifting dominant narratives of Indigenous health development.
- We have identified two 'successful' justifications for using strengths-based approaches to influence a change in the narrative of Indigenous health – the utilitarian approach and the binary approach.
- On the sample analysed, the international semantic field of Indigenous health seems to demonstrate a far greater congruence with the epistemology of the strengths-based discourse than the Australian semantic field, which may be significantly underutilising 'binary justifications' (see p. 17) as a way to shift, change or challenge current framings of the Aboriginal and Torres Strait Islander health narrative at a national level.
- In certain circles there is an increasing awareness of strengths-based approaches, which we are hopeful will continue to be critically explored, developed and implemented, and that recognising the rights, culture, diversity and strengths of First Peoples will become the norm.

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