FLAOHT
Frontenac Lennox & Addington
Ontario Health Team

Queen's UNIVERSITY

Toolkit of Indigenous-focused approaches and evaluation indicators for health systems

A series of rapid literature reviews for use by the Frontenac, Lennox, and Addington Ontario Health Team (FLA OHT)

November 2023

ABOUT THIS TOOLKIT

This toolkit was produced for use by working groups and support structures of the Frontenac, Lennox, and Addington Ontario Health Team (FLA OHT). However, it may be useful for other mainstream and Indigenous organizations, as well. This document is thus being made publicly available. Please cite appropriately if using it as a reference.

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ABSTRACT

Background: Ontario Health Teams (OHTs) seek to address the health needs of equity-deserving populations. The Frontenac, Lennox, and Addington Ontario Health Team (FLA OHT) is comprised of the city of Kingston and surrounding regions, and aims to address such issues. Indigenous communities continue to face health inequities as a result of systemic racism and colonialism. This series of rapid reviews will help to ensure that FLA OHT projects are meeting the unique needs of surrounding Indigenous communities.

Study Methods and Objectives: This report aims to provide an overview of seven rapid literature reviews on the topics of 1) Indigenous Peoples and Overall Wellbeing, 2) Indigenous Peoples and Health Governance, 3) Indigenous Peoples and Patient Intake, 4) Indigenous Peoples and Coordinated Discharge, 5) Indigenous Peoples and Mental Health, 6) Indigenous Peoples and Aging Well, and 7) Indigenous Peoples and Palliative Care. For each topic, Indigenous perspectives and conceptualizations are summarized, and Indigenous-specific indicators and approaches relevant to health services and systems are outlined.

Key Results: Indigenous conceptualizations of health are multi-faceted and often incorporate physical, mental, emotional, spiritual, social, ecological, and economic wellbeing; indicators in applied research and evaluation activities should reflect this holism. Indigenous health and overall wellness is a significant concern due to inequitable healthcare access and gaps in service delivery. Current health decision-making surrounding Indigenous communities is not always in the hands of Indigenous communities and leadership. Additionally, existing interventions are not always tailored to Indigenous peoples or their unique communities, further exacerbating this issue. These contribute to poor overall health, as there is a lack of autonomy and incorporation of Indigenous beliefs and values in existing health systems.

Key Recommendations: The inclusion of Indigenous leadership in decision-making processes, in partnership with varying levels of mainstream government, is necessary for improving the overall wellbeing of Indigenous communities. Culturally-grounded community development and capacity-strengthening to improve Indigenous governance must begin with the family and community. In order to create sustainable change, long-term commitment and collaboration are required between stakeholders such as federal, provincial, territorial, and municipal governments alongside Indigenous leaders and Elders. Equitable funding must be available to support these initiatives. Upon the implementation of novel policies and programs formed with Indigenous input, monitoring measures must be put in place to identify persisting health inequities; evaluation indicators should be holistic to capture comprehensive data.

INTRODUCTION

The Ontario healthcare system is being restructured into Ontario Health Teams (OHTs), which seek to deliver more connected care and facilitate access for patients and caregivers. The goal of the OHTs is to improve the healthcare system and patient care. Initially, four primary areas for improvement were identified, titled the “Quadruple Aims”: 1) improving patient experience, 2) improving population health outcomes, 3) improving care team wellbeing, and 4) reducing costs (1). More recently, a fifth area (“Quintuple Aims”) has been added – namely, health equity (2). OHTs seek to address the needs of equity-deserving populations, including (but not limited to) Francophone communities and Indigenous communities.

Kingston and the surrounding region form the Frontenac, Lennox, and Addington Ontario Health Team (FLA OHT). The successful creation of the FLA OHT brought together numerous partners, including local Indigenous health groups (1). FLA OHT has identified four introductory projects: 1) Aging well at home, 2) Palliative care collaborative, 3) Mental health support integration, and 4) Coordinated hospital discharge and attachment to primary care. Each project has a dedicated working group, and each working group is comprised of members from key stakeholder groups (such as patients/clients with lived experience, primary care and other service providers, Indigenous community representatives, Francophone community members, and key service organizations) (1).

Indigenous peoples face health inequities driven by colonialism and systematic racism. Improving accessibility, cultural appropriateness, and cultural safety of health services and health systems are thus essential. Culturally competent care refers to the personal development of healthcare professionals, in which they learn about the culture and apply their findings within their practice to improve health outcomes for patients. Culturally safe care refers to the organizational development of the healthcare system, in which policies and practices are implemented to increase access and remove perceived barriers to health services. Culturally safe care also requires that the individuals supporting the community are culturally competent in their knowledge of Indigenous health. Forming respectful partnerships with Indigenous communities is integral to reorienting health services and systems to be more culturally safe (3).

This series of rapid literature reviews arose due to the need to ensure that FLA OHT projects are meeting the unique needs of Indigenous peoples. In Canada, striking disparities continue to persist across all health outcomes for equity-deserving groups, especially within Indigenous communities (4). These disparities between Indigenous communities and the rest of the population evidence a need to prioritize responsive and evidence-based practice in healthcare. In order to monitor and analyze healthcare system performance with respect to Indigenous communities, a thoughtful approach should be taken to identify Indigenous-specific indicators, which align with Indigenous approaches to evaluation. How health and wellbeing are defined and assessed is a priority area for Indigenous health groups,

due to continuing health risks and inequities faced by Indigenous communities. Additionally, it is necessary to prioritize identifying and defining Indigenous-specific indicators because what is “at risk” and what counts as an indicator is often determined without input or approval directly from Indigenous groups (5). Indigenous perceptions and understanding of wellbeing and healthcare priorities may differ, extend, or conflict with conventional reporting frameworks. Healthcare reporting frameworks should be assessed and modified to reflect and incorporate greater recognition of Indigenous perspectives, concerns and interpretations of healthcare and wellbeing (6).

Although these reviews were conducted for use by FLA OHT working groups and support structures, they may be useful for other mainstream and Indigenous organizations, as well. This report is thus being made publicly available.

METHODS & OBJECTIVES

Papers were searched from Canada, the United States of America, New Zealand, and Australia. The Indigenous peoples of these nations share similar colonial histories, which have translated into similar societal and health issues due to ongoing mistreatment and marginalization (7). Valuable insight can be gained by studying population groups with similar experiences, which informed the rapid review's search strategies and led to the search focussing on these four countries.

Rapid literature reviews consist of a similar methodological approach to knowledge synthesis as systematic literature reviews, with certain components being simplified or excluded to ensure completion in a timely manner (8). Based on FLA OHT priorities, rapid literature reviews were conducted on the following topics:

1. Indigenous Peoples and Overall Wellbeing
2. Indigenous Peoples and Health Governance
3. Indigenous Peoples and Patient Intake
4. Indigenous Peoples and Coordinated Discharge
5. Indigenous Peoples and Mental Health
6. Indigenous Peoples and Aging Well
7. Indigenous Peoples and Palliative Care

These reviews sought to provide an overview of each topic from Indigenous perspectives and lenses, with focus on Indigenous-specific indicators and approaches relevant to health services and systems. Specific search protocols for each of the individual rapid literature reviews are outlined in each full-length review found in Appendix I, including search terms used and the databases included. Key terms and definitions are also included in Appendix I. An overview of the included papers for each review can be found in Appendix II. Brief take-home points and summaries of each rapid literature review can be found in the Key Results and Recommendations portion of this report.

Members of FLA OHT working groups and support structures, including Indigenous members, were consulted for feedback both regarding the search protocol for each review and regarding preliminary results of each review. Research librarians from Queen's University assisted with the development of search protocols.

KEY RESULTS & RECOMMENDATIONS

Indigenous communities conceptualize health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. Indicators of Indigenous health should therefore reflect this complexity through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing (9).

Indigenous Peoples and Overall Wellbeing:

Take-Home Points:

	Key Findings
Indigenous Conceptualization of Health and Overall Wellbeing	The Indigenous conceptualization of health is multifaceted, incorporating physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. Indigenous peoples and communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience.
Indicators Identified from the Literature	• Physical Health (e.g., food and water security) • Mental Health (e.g., fostering community cohesion) • Natural Environment (e.g., maintaining connection with the land) • Community Vitality (e.g., use of traditional knowledge and wisdom) • Community Infrastructure (e.g., access to essential services) • Connection to Culture (e.g., practice of Indigenous ceremonies)
Conclusion	Healthcare improvement initiatives must be multifaceted, with a focus on community development, ownership, and capacity strengthening as well as culturally responsive and safe care and competency service delivery. Collaboration must also be effective, between partners and organizations at the community, provincial, territorial, and national level. As each community is unique Indigenous community members must also be involved in this process and must decide which indicators are relevant to them. Efforts must continue to address the interrelated and broad structural factors - including historical, political, financial, social, and cultural - that affect Indigenous health and wellbeing.

Health and wellness is an area of significant concern for Indigenous communities. Federal, provincial, and territorial health services have sought to address factors related to healthcare provision and access in Indigenous communities; however, there are significant challenges and gaps associated with service delivery and accessibility. Indigenous communities conceptualize health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. Indicators of Indigenous health should therefore reflect this complexity through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing. Despite the impacts of historical and present-day colonialism, Indigenous peoples and communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience.

Several indicators of overall wellbeing were identified from the literature, including:

- Physical Health: balance in diet and nutrition; food and water security; access and space for physical activity; access to Indigenous healing practices; timely access to healthcare facilities
- Mental health: social, spiritual, and emotional wellbeing; fostering community cohesion; access to mental health support and services
- Natural environment: environmental protection; maintaining connection with, and stewardship of, natural environment and the land, animals, plants
- Community vitality: connection to the community; facilities for education, community, and culture; economic resources and employment; usage of traditional resources, knowledge, wisdom, arts, and language
- Community infrastructure: access to essential services; facilities for healthcare, community services, safety; sports and recreational facilities.
- Connection to culture: connection to cultural and spiritual practices; practice of Indigenous ceremonies and embodiment of Indigenous cultural values; Indigenous leadership at centre of initiatives

In order for healthcare improvement and health policy initiatives to be meaningful, the following points must be kept in mind:

- There must be a focus on community development, ownership, and capacity building
- There must be a focus on culturally responsive and safe care and culturally competent service delivery
- There must be effective collaboration with partners and organizations at the community, provincial, territorial, and national level
- It is important that leadership from Indigenous youth, community leaders, and Elders be at the forefront of planning and development strategies for Indigenous healthcare services.

- Each Indigenous community is unique and cannot be generalized under one model; therefore, it is imperative that healthcare indicators are determined by the community themselves and that interventions are personally tailored to fit the community that they aim to serve.
- Continued work and efforts are required to address the interrelated and broad structural factors - including historical, political, financial, social, and cultural - that affect Indigenous health and wellbeing.

Indigenous Peoples and Health Governance:

Take-Home Points:

	Key Findings
Defining Governance and its Importance	Governance is the right for expression of Indigenous peoples' autonomy and the right to take responsibility for the decisions that affect their lives. The involvement of Indigenous leadership in decision-making processes is essential for the improvement of the wellbeing of Indigenous communities.
Facilitators for Improving Indigenous Community Governance	• Positioning of Indigenous leadership and building trusting partnerships between Indigenous leadership and mainstream government officials • Approaches tailored based on particular issues, taking the complexities of Indigenous opinions and governance across communities into account • ·Sustainable capacity-strengthening programs and recruitment of Indigenous leadership • Thorough assessment of the current status of Indigenous governance • Training for Indigenous-centred governance within all levels of government
Barriers to Improving Indigenous Community Governance	• Programs that are not reflective of Indigenous community values • Amalgamation of changes with existing policies • Rapid changes and overloading communities with new policies • Poor coordination during policy implementation • Poor monitoring of policy initiatives

Key Findings (contd.)	
Steps for Advancing Indigenous Community Governance	• Strengthening intercultural process • Considering how to implement capacity-strengthening programs with limited resources • Considering how to implement leadership succession and handover • Considering how to implement informal processes and cultural values in organizations
Defining Capacity Strengthening	• This term is preferred to “capacity building” which holds patronizing connotations, suggesting that there are innate deficiencies in Indigenous communities. Capacity strengthening, on the other hand, acknowledges that people have knowledge and skills, but simply must engage in different activities to contribute to community wellbeing.
Conclusion	An approach that focuses on strengthening Indigenous decision-making is needed, as opposed to one that utilizes disjointed government consultation which does not contribute to the creation of a coordinated plan. It must also be recognized that Western approaches cannot be applied directly to Indigenous contexts. Furthermore, each community is different and decisions regarding these principles can differ between areas. Principles central to Indigenous governance include: • Respect at the centre of all initiatives • Recognizing the interconnectedness between humans, land, water, and the development of life • Belief in spirit beings/realm and ancestors as central aspects of daily life and discussion • Retain team dynamics, emotions, culture, values, and beliefs through reflection on relationships • Ensure an accurate reflection of Indigenous community • Leaders may be connected to the community through informal and formal networks, which are equally important • Equal involvement from youth, Elders, and community leaders • Centring unique community beliefs through input directly from the community • De-centring approaches with ‘law-makers’ and ‘rulers’, and instead placing focus on living harmoniously with the natural world.

Governance encapsulates the right to expression of Indigenous peoples' autonomy and the right to take control over decisions that affect their lives. Federal, provincial, territorial, and municipal governments must recognize and develop initiatives to facilitate Indigenous governance, in order to enable autonomy and improve outcomes for Indigenous populations. It is important that the inclusion of Indigenous perspectives be instituted from the community-level, to begin with; without the foundation of effective and stable leadership at the local level within Indigenous communities, governance and capacity strengthening cannot be sustained and developed at the provincial and federal levels (10-12). Strengthening and fostering Indigenous leadership and governance is critical for improving the healthcare system and the wellbeing of Indigenous communities. Improving governance processes related to Indigenous healthcare will require strengthening Indigenous and mainstream government organizational values, goals, structures, and culture. Critical to this aim is the involvement and centering of Indigenous leadership in decision-making processes.

Several principles were identified from the literature, to be followed in the process of improving Indigenous community governance effectively (13-19). The positioning of Indigenous leadership is of great importance to establish and foster community ownership of governance improvement, with organizational change led by Indigenous people using existing community capacity. It is also critical to establish long-term partnerships with mainstream governments and Indigenous leadership, with a focus on strengthening capacity and resources, and on developing shared goals and approaches between these two parties. Trust and rapport are required within these partnerships. There are also complexities within Indigenous governance, so it is necessary that tailored approaches are adapted for each issue or situation that arises. Sustainable capacity-strengthening programs must also be developed, implemented and later evaluated, along with the recruitment of Indigenous leadership. A thorough assessment of current systemic policies and processes, as well as barriers, constraints, and resources, must be conducted to understand and improve Indigenous community governance. Finally, it is necessary to introduce training throughout all levels of mainstream governments in Indigenous-centered governance, with a focus on shared responsibility and accountability and on creating locally responsive solutions.

Other approaches were identified from the literature as being ineffective in establishing Indigenous community governance (14, 19-23). These include establishing programs that do not reflect community values and priorities, efforts to change governance structures through amalgamation with existing structures, fragmentation or rapidly changing governance policies that overload communities with sudden changes, and program initiatives that are poorly coordinated and monitored without systems in place for measurement of accountability and effectiveness.

Further research is required into how to reach agreed understandings of community governance, taking into consideration the diversity within and across Indigenous governance levels, sectors and institutions. Further efforts are also needed to elucidate best practices for strengthening intercultural processes in both Indigenous organizations and mainstream governance systems; how capacity-strengthening programs can best be implemented across resource-limited settings; how to best implement leadership succession and handover between leadership committees; and how to best establish informal processes and cultural values linked with Indigenous governance in developing organizations (19-28).

Overall, in the literature, there is a paucity of studies on well-designed and standardized evaluations of Indigenous governance capacity-strengthening programs. The term itself emerged in the 1990s in international development discourse due to a general shift in initiatives towards focusing on sustainable development and intercultural engagement between Indigenous communities and national governments (12-17). Currently, one of the main concerns of Indigenous leaders is the piece-meal nature of development initiatives between mainstream governments and Indigenous communities. Areas requiring change are each addressed by different segments of mainstream government - each with different teams, internal systems and policies - which makes it very difficult to organize a sustainable and coordinated plan for development in the long-term for Indigenous communities. In Indigenous community settings, community governance needs to focus on strengthening Indigenous decision-making processes rather than more disjointed consulting from different Indigenous leadership groups that do not amount to a coordinated plan with sufficient logistical, financial, and systemic resources for long-term change (10, 12 ,17).

Indigenous Peoples and Patient Intake and Navigation:

Take-Home Points:

	Key Findings
Indigenous Healthcare Needs for Patient Intake	The healthcare system is complex and difficult to navigate, especially for Indigenous people due to systemic racism and discrimination. Culturally safe patient intake processes can assist in reducing these disparities.
Indigenous Patient Navigator Programs	These programs have proven helpful in addressing systemic problems within the care system. They inform patients about their health conditions, availability of services, and address barriers to screening and treatment (e.g.. culture, education, language).
Successful Program Examples	1. Native Sisters Program 2. Walking Forward Program
Barriers and Facilitators to Accessing Navigator Programs	Barriers: • Costs (transport, food, lodging) • Difficulty accessing care and screening • Lack of satisfaction in interactions with care providers • Lack of confidence in own knowledge and abilities Facilitators: • Involvement of Indigenous input during program planning = increased trust of community in program • Culturally relevant, use of local language, and/or interpreters
Importance of Cultural Safety, Cultural Competence, and Role of Community	It is essential that Indigenous communities are able to access: • Early identification and intervention services • Crisis response services • Trauma informed emergency care • Coordinated care Health services should be tailored to each community in order to be effective, relevant, and meet their diverse needs.

Key Findings (contd.)	
Conclusion	Several steps are necessary to ensure improved patient intake in Indigenous communities, including: • Long-term commitment and collaboration between stakeholders (levels of government, Indigenous leaders, etc.) • Tracking and measuring of Indigenous indicators to monitor progress and identify persistent patient intake issues • Culturally-grounded community development and capacity building, as physical health support begins with the family and community • Equitable funding

The healthcare system is complex and difficult to navigate, especially for Indigenous people due to systemic racism and discrimination. Culturally safe patient intake processes can assist in reducing these disparities (29). It is essential that Indigenous communities are able to access early identification and intervention services, crisis response services, trauma-informed emergency care, and coordinated care. Health services should be tailored to each community in order to be effective, relevant, and meet their diverse needs (30, 31). Several steps are necessary to ensure improved patient intake processes in Indigenous communities, including:

- Long-term commitment and collaboration between stakeholders (levels of government, Indigenous leaders, etc.) (32)
- Tracking and measuring of Indigenous indicators to monitor progress and identify persistent patient intake issues (33)
- Culturally-grounded community development and capacity-strengthening, as health support begins with the family and community (33-34)
- Equitable funding (32)

Indigenous patient navigator programs have proven helpful in addressing systemic problems within the care system. They inform patients about their health conditions, availability of services, and address barriers to screening and treatment such as culture, education, and language (29, 35). Some examples of Indigenous patient navigation programs were found in the literature:

- The “Native Sisters” Program: This program focused on increasing the recruitment of Indigenous women into mammography screening (36). It did this by hiring Indigenous women to act as patient navigators; in this role, they recruited women for breast cancer screening, supported them by attending screening appointments with them, assisted in preparing questions to ask healthcare professionals, and offered support as needed to the patient’s family.

- The Native Sisters program also assisted women and their families to navigate their way through the system if a cancer diagnosis was made (36).
- The “Walking Forward” Program: The main purpose of the program was to reduce cancer mortality rates for Indigenous peoples from three Lakota tribes in western South Dakota (37). The program employed community-based patient navigators to deliver culturally appropriate education about the value of screening and early detection. They played an important role in developing a relationship with the community and reducing resistance to engagement in clinical care from the community. Additionally, hospital-based patient navigators were used to assist participants who developed cancer. These navigators aimed to assist them with navigating the hospital system, assist with intake processes, and help overcome financial, social, and emotional barriers to receiving cancer-related care, including treatment, follow-up, and palliative care (37).

The literature also identified key barriers and facilitators to accessing these patient navigator programs. The identified barriers largely exist at the individual level and include: costs arising from transport, food, and lodging to name a few; difficulty accessing care and screening; lack of satisfaction in interactions with care providers; and lack of confidence in one’s own knowledge and abilities (38). Several facilitators were identified at the program level, including: the involvement of Indigenous input during program planning leading to the increased trust of the community in the program; and the programs being culturally relevant, such as through use of local language and/or interpreters (29).

Indigenous Peoples and Coordinated Discharge:

Take-Home Points:

	Key Findings
Indigenous Conceptualization of Health	The Indigenous conceptualization of health is multifaceted, incorporating physical, mental, emotional, spiritual, social, ecological, and economic wellbeing.

Key Findings (contd.)	
Indigenous Health Risks and Inequities Surrounding Hospital Discharge	Disruption of traditional Indigenous activities, mainly due to colonialism and the dispossession of land, have resulted in higher levels of sedentary behaviour. This contributes to poorer health outcomes, greater comorbidities, and lower life expectancy. Discriminatory healthcare practices and systemic racism have resulted in Indigenous communities displaying the highest rate of self-discharge. Inequitable access to timely and safe healthcare services contributes to poorer health outcomes.
Evidence-based Interventions to Improve Hospital Discharge	1. Project Re-Engineered Discharge (RED) 2. After Hospital Care Plan
Conclusion	A tailored coordinated discharge plan can: • Reduce length of hospital stay • Prevent avoidable readmission The need for this is greater for Indigenous patients, who already faced limited access to healthcare services.

Disruption of traditional Indigenous activities, mainly due to colonialism and the dispossession of land, have resulted in higher levels of sedentary behaviour and other risk factors for chronic diseases. These risk factors in turn contribute to poorer health outcomes, greater comorbidities, and lower life expectancy (39-42) for Indigenous peoples relative to other groups. Discriminatory healthcare practices and systemic racism have resulted in Indigenous patients displaying the highest rate of self-discharge. Inequitable access to timely and safe healthcare services contributes to poorer health outcomes (43, 44).

Certain interventions have been shown to improve the hospital discharge process. One example of a successful care transition model is Project Re-Engineered Discharge (RED), created by researchers at Boston Medical Center to reduce readmissions by preparing patients for the transition from hospital to home (45). Another material used for a similar purpose is the After Hospital Care Plan, which aims to teach patients and their support networks what to do and what to expect once they go home (45).

The following factors to help improve coordinated discharge were identified from the literature (45-52):

Administrative Tasks

- Designate a central person or team in charge of discharge planning (e.g.. discharge educator) who can lead the discharge planning process
- Develop an individualized discharge plan for patient prior to leaving hospital, and review the discharge plan with the patient directly
- Find out about preferred languages for all forms of communication and arrange for language assistance as needed
- With regards to the results of tests or labs that are still pending, discuss and determine who will review the results and when and how the patient will receive this information
- Document all contact information for medical equipment companies and at-home services for the patient in their discharge plan
- Collaborate with the medical team and case managers to arrange necessary at-home services
- Review all medication lists with the patient and pharmacy, including, inpatient medication list, the outpatient medication list, and the outpatient pharmacy list, as well as what the patient reports taking. Ensure a realistic plan for obtaining medications is in place for after the patient leaves the hospital.
- Sending out the discharge summary and care plan to clinicians accepting care of the patient within 24 hours of discharge

Barriers and Facilitators

- Identify any service gaps and address gaps by arranging for appropriate services (e.g., diabetic education, outpatient physiotherapy)
- Identify barriers to the discharge plan and strategies to overcome these barriers (e.g., transportation issues, cost of medications, anticipated medication side effects)

Patient Preferences and Education

- Determine primary care, sub-specialty, social support, and other follow-up needs in order to make appointments based on patient preferences, and confirm that the patient knows where to go and has a plan about how to get to appointments
- Inquire about traditional healers and healing practices, and arrange for these services according to patient preferences
- Educate the patient and their family or support network on all aspects of the discharge plan and their medical needs, including the primary diagnosis, comorbidities, medications, follow-up care, what to watch out for (i.e. red flags), as well as any questions or concerns that the patient may have.

- Calling the patient within 3 days of discharge to reinforce the discharge plan and help with problem solving and any issues that may have come up
- Ensuring that there is a discharge help-line that is available for patients and family to call if they have any questions about the care plan, hospitalization, or follow-up plan in order to help patients transition from hospital care to outpatient care setting smoothly
- Provision of a personalized guide or booklet known as the “After Hospital Care Plan” for patients to take with them when they leave the hospital. It is important to go through this plan before discharge and teach it in a way that enables patients and their support networks to understand what to do and what to expect once they go home.

The literature suggests that a coordinated discharge plan tailored to the individual patient brings about a reduction in the length of hospital stay and helps to prevent avoidable readmission. Having a dedicated discharge team or staff member to coordinate and lead this process has been highlighted as an important contributor to the success of such programs (45, 50, 51). While such services are variably available to all patients, the need is even greater for Indigenous patients, who already face limited access to healthcare, and are more likely to face issues relating to a greater burden of comorbidity, sociocultural barriers, and economic and environmental limitations (52).

Indigenous Peoples and Mental Health:

Take-Home Points:

	Key Findings
Indigenous Conceptualization of Health and Mental Healthcare Needs	The Indigenous conceptualization of health is multifaceted, incorporating physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. In order to support this balance, it is necessary for mental healthcare to be accessible. Early identification and intervention services, crisis response services, trauma informed emergency care, and coordinated care may not all be available to all Indigenous communities, but they are essential.
Indigenous Priorities for Mental Health	The centering of Indigenous cultures, beliefs, and practices should be prioritized. This includes knowledge, language, culture, and community.
Mental Health Indicators	Potential indicators of mental wellness in Indigenous communities include: · overall life expectancy · level of Indigenous participation within community and health sector services · overall population growth, percentage of population under age 22 · number of community support organizations · number of speakers of traditional languages · number of networks of traditional healers · high school graduation rates · level of adequate housing · food insecurity rates · unemployment and poverty rates · arrest, accident or substance abuse rates · rates of suicide and related behaviors · juvenile delinquency rates · rates of domestic violence · child abuse/neglect · foster care placements · teenage pregnancy · infant mortality · alcohol abuse · depression · domestic violence · number of single parent families

Key Findings (contd.)	
Government Supports and Frameworks	For quality, culturally competent care as well as Indigenous centered governance, collaboration is required between provincial, territorial, and federal governments. Examples of frameworks: 1. First Nations Mental Wellness Continuum 2. Model by First Nations Health Authority in BC
Conclusion	Several steps are necessary to ensure improved mental health outcomes in Indigenous communities, including: • Long-term commitment and collaboration between stakeholders (levels of government, Indigenous leaders, etc.) • Tracking and measuring of Indigenous indicators to monitor progress and identify persistent mental healthcare issues • Culturally-grounded community development and capacity strengthening, as mental health support begins with the family and community • Equitable funding

In order to support the balance between the many facets of Indigenous conceptualizations of health, it is necessary for mental healthcare to be accessible. Early identification and intervention services, crisis response services, trauma-informed emergency care, and coordinated care may not all be available to all Indigenous peoples; however, they are essential (53-55). Additionally, the centering of Indigenous cultures, beliefs, and practices should be prioritized within mental
healthcare. This includes centering Indigenous knowledge, language, culture, and community (56).

Potential indicators of mental wellness in Indigenous communities were identified from the literature (54, 30, 57-58):

- overall life expectancy
- level of Indigenous participation within community and health sector services
- overall population growth, percentage of population under age 22
- the number of community support organizations
- the number of speakers of traditional languages
- the number of networks of traditional healers
- high school graduation rates
- level of adequate housing
- food insecurity rates

Potential indicators of mental wellness (contd.) (54, 30, 57-58):

- unemployment and poverty rates
- arrest, accident or substance abuse rates
- rates of suicide and related behaviours
- juvenile delinquency rates
- rates of domestic violence
- child abuse/neglect
- foster care placements
- teenage pregnancy
- infant mortality
- alcohol abuse
- depression
- domestic violence
- the number of single parent families

It is important to note that these factors cannot be generalized to all Indigenous communities. Several included papers noted that the mental health of Indigenous communities is poorly studied and described, and the priorities, culture, and perspectives of one community cannot be applied to all (58-60). Several holistic models have been developed to convey the complexities of the Indigenous conceptualizations of mental health and showcase that Indigenous mental wellness is a balance of the mental, physical, spiritual, and emotional. This includes the First Nations Mental Wellness Continuum, created by Health Canada and the Assembly of First Nations in 2015 (61), the Holistic Wellness Model created by the First Nations Health Authority of BC in 2015 (62), and the Model of Indigenous Mental Health and Healing (30). Each framework is only a snapshot of a fluid concept of wellness, and each can and should be adapted and customized freely to fit the needs of the specific population. These frameworks can be found in Appendix 1, within the Indigenous Peoples and Mental Health rapid literature review.

Collaboration between mainstream provincial, territorial, and federal governments, supported by strong Indigenous-centered leadership (53, 61), is required for quality, culturally competent care, as well as for Indigenous-centered governance. Enhancing and supporting Indigenous mental health and wellness will require strategic action and planning within government services, Indigenous communities, and services across health, justice, employment, and social service sectors (56). Steps necessary to ensure improved mental health outcomes in Indigenous communities include:

- Long-term commitment and collaboration between stakeholders (levels of government, Indigenous leaders, etc.) (32)
- Tracking and measuring of Indigenous indicators to monitor progress and identify persistent mental healthcare issues (33)
- Culturally-grounded community development and capacity strengthening, as mental health support begins with the family and community (33-34)
- Equitable funding (32)

Indigenous Peoples and Aging Well:

Take-Home Points:

	Key Findings
Indigenous Conceptualization of Health and Care Needs for Aging Well	The Indigenous conceptualization of health is multifaceted, incorporating physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. Deep connections to community and culture are necessary for healthy aging. Indigenous seniors' voices must be included in dominant models for aging well in Canada.
Health Risks of Aging in Indigenous Communities	Trauma and other ongoing impacts from colonialism and systemic racism, on all generations within the Indigenous community have contributed to poorer health outcomes and lower life expectancy for Indigenous patients as compared to non-Indigenous patients.
Successful Aging in Indigenous Communities	Although there is no universal successful aging experience for Indigenous peoples, due to the large diversity of beliefs across many different communities, the literature suggests that aging well requires: • A positive attitude towards aging challenges • Social connectedness to family • Social connectedness to community • Social connectedness to culture

Key Findings (contd.)	
Identified Categories of Contributors to Successful Aging	Cultural and community supports and the maintenance of autonomy contribute to aging well.
Conclsuion	An updated, inclusive model of care for successful aging, containing the perspectives of older people from Indigenous communities, is necessary for the development of research, policy, and practice in the field of Indigenous health. This model should focus on the different facets of wellbeing within the Indigenous conceptualization of health and the importance of family, community, and the surrounding environment in aging.

Deep connections to community, culture, language, Elders, and Earth, are necessary for healthy aging (63). Indigenous seniors' voices must be included in dominant models for aging well in Canada. The intergenerational trauma from colonialism and systemic racism continues to negatively impact Indigenous peoples' wellbeing and has contributed to poorer health outcomes and lower life expectancy for Indigenous patients as compared to non-Indigenous patients (39-40). Although there is no universal successful aging experience for Indigenous peoples, due to the large diversity of beliefs across many different communities, the literature suggests that aging well requires a positive attitude towards aging challenges, social connectedness to family, social connectedness to community, and social connectedness to culture (41-42, 64-65).

Cultural and community supports, and the maintenance of autonomy, contribute to aging well (41-42, 64-72). An updated, inclusive model of care for successful aging, containing the perspectives of older people from Indigenous communities, is necessary for the development of research, policy, and practice in the field of Indigenous health (41, 67). This model should focus on the different facets of wellbeing within the Indigenous conceptualization of health and the importance of family, community, and the surrounding environment in aging.

Indigenous Peoples and Palliative Care:

Take-Home Points:

	Key Findings
Indigenous Conceptualization of Health and Palliative Care Needs	The Indigenous conceptualization of health is multifaceted, incorporating physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. The Indigenous conceptualization of death also varies largely from the non-Indigenous perspective, considering death to be a sacred part of the life cycle and not the end of it. Early identification and palliative care services, crisis response services, and coordinated care may not all be available to all Indigenous communities; however, they are essential.
Indigenous Priorities for Palliative Care	It is important that care and support is provided primarily by the family and community. Furthermore, the established traditions for grieving must be respected. Aspects of care identified as critical include: • feeling safe in the system • importance of Indigenous staff being involved and present in their care • addressing geographical, financial, social, and other barriers to care • the role of family and friends • effective communication and education between healthcare team members and the patient's family • the streamlined coordination of care and transition between services
Family, Community, and Autonomy	The patient and patient's family (and community, at times) must be at the centre of the palliative care process. This includes for decision making and end-of-life care. Key priorities for palliative care in Indigenous communities include: • Ability to maintain and involve family connections throughout the dying process • Building local capacity for palliative care to provide more relevant and culturally appropriate care • Flexibility and multi-sectoral partnerships to address the complexity of day-to-day needs for patients/families In contrast with Western healthcare, Indigenous care often favours collective decision-making in order to provide culturally competent and safe palliative care.

Key Findings (contd.)	
Indigenous Community-based Palliative Care Program Example	1. Wiisokotaatiwin, based in Naotkamegwanning First Nations
Barriers and Facilitators to Accessing Culturally Appropriate Palliative Care	Barriers • existing care is not culturally sensitive • geographic isolation (e.g.. living in rural areas) Facilitators • care practices ascertained with family members on a regular basis
Conclusion	Several steps are necessary to ensure improved palliative care in Indigenous communities, including: • Long-term commitment and collaboration between stakeholders (levels of government, Indigenous leaders, social service sectors, etc.) • Tracking and measuring of Indigenous indicators to monitor progress and identify persistent palliative care issues • Culturally-grounded community development and capacity building, as overall health and wellbeing support begins with the family and community • Equitable funding

As mentioned previously, the Indigenous conceptualization of health is multifaceted. Indigenous conceptualizations of death also vary largely from non-Indigenous perspectives and consider death to be a sacred part of the life cycle and not the end of it (63, 73). Early identification and palliative care services, crisis response services, and coordinated care may not all be available to all Indigenous communities; however, they are essential (63, 73). Indigenous priorities for palliative care, identified from the literature, emphasize the importance of care and support being provided primarily by the family and community. Furthermore, it is important that the established traditions for grieving are respected. The patient and the patient's family, as well as the community at times, must be at the centre of the palliative care process – including in decision-making and end-of-life care.

In contrast with Western healthcare, Indigenous care often favours collective decision-making in order to provide culturally competent and safe palliative care (74). Key priorities for palliative care in Indigenous communities include the ability to maintain and involve family connections throughout the dying process, building local capacity for palliative care to provide more relevant and culturally appropriate care, and flexibility as well as multi-sectoral partnerships to address the complexity of day-to-day needs for patients and families (75).

The literature surrounding palliative care for cancer patients found that certain aspects of care were identified as critical, including:

- feeling safe in the system
- the importance of Indigenous staff being involved and present in their care
- addressing geographical, financial, social, and other barriers to care
- the role of family and friends
- effective communication and education between healthcare team members and the patient's family
- the streamlined coordination of care and transition between services (76-77)

An example of an Indigenous community-based palliative care program is one titled Wiisokotaatiwin, based in Naotkamegwanning First Nations. An evaluation of this program found that several essential activities were vital for the delivery of culturally competent and high-quality palliative care for Indigenous patients, which include:

- comprehensive education of community members and healthcare providers
- effective coordination of palliative care services and providers
- development and implementation of partnerships and service agreements with provincial and territorial health services
- evidence-based development of program guidelines with input and direction from Indigenous leadership (78)

The barriers surrounding palliative care provision in remote Indigenous communities are cultural and geographic. Culturally sensitive care requires that patients have access to family support and traditional services if requested. Geographic isolation requires that:

- patient-specific care plans be created for use in the remote community
- effective lines of communication are established between remote healthcare providers and urban specialists
- healthcare providers and family caregivers be properly trained to fill their respective roles;
- appropriate guidelines and resources are available in the community to support this type of care (74)

Several steps are necessary to ensure improved palliative care in Indigenous communities, including:

- Long-term commitment and collaboration between stakeholders (levels of government, Indigenous leaders, social service sectors, etc.) (32)
- Tracking and measuring of Indigenous indicators to monitor progress and identify persistent palliative care issues (33)
- Culturally-grounded community development and capacity building, as overall health and wellbeing support begins with the family and community (33-34)
- Equitable funding (32)

REFERENCES

1.Frontenac, Lennox & Addington Ontario Health Team. (2021). FLA-OHT: Frontenac, Lennox & Addington Ontario Health Team. Retrieved March 18, 2021, from https://www.flaoht.ca/v

2.Nundy, S., Cooper, L. A., & Mate, K. S. (2022). The Quintuple Aim for Health Care Improvement A New Imperative to Advance Health Equity. JAMA, 327(6), 521-522. 10.1001/jama.2021.25181

3.Indigenous Primary Health Care Council. (2022). Indigenous Health Systems Transformation: Foundations of IPHCC's OHT Provincial Framework. https://iphcc.ca/post_resources/indigenous-health-systems-transformation-booklet/

4.Ring, I., & Brown, N. (2003). The health status of indigenous peoples and others. BMJ (Clinical research ed.), 327(7412), 404–405. https://doi.org/10.1136/bmj.327.7412.404

5.Donatuto, J., Campbell, L., & Gregory, R. (2016). Developing responsive indicators of indigenous community health. International journal of environmental research and public health, 13(9), 899.

6.Taylor, J. (2008). Indigenous peoples and indicators of wellbeing: Australian perspectives on United Nations global frameworks. Social Indicators Research, 87(1), 111-126.

7.Cooke, M., Mitrou, F., Lawrence, D., Guimond, E., & Beavon, D. (2007). Indigenous wellbeing in four countries: an application of the UNDP'S human development index to indigenous peoples in Australia, Canada, New Zealand, and the United States. BMC international health and human rights, 7, 9. https://doi.org/10.1186/1472-698X-7-9

8.Tricco, A. C., Antony, J., Zarin, W., Strifler, L., Ghassemi, M., Ivory, J., Perrier, L., Hutton, B., Moher, D., & Straus, S. E. (2015). A scoping review of rapid review methods. BMC medicine, 13, 224. https://doi.org/10.1186/s12916-015-0465-6

9.Prince, H., Nadin, S., Crow, M., Maki, L., Monture, L., Smith, J., & Kelley, M. L. (2019). "If you understand you cope better with it": the role of education in building palliative care capacity in four First Nations communities in Canada. BMC public health, 19(1), 1-18.

10.Ladner, K. L. (2006). Indigenous governance: questioning the status and the possibilities for reconciliation with Canada's commitment to Aboriginal and Treaty Rights. National Centre for First Nations Governance.

11.Tsey, K., McCalman, J., Bainbridge, R., & Brown, C. (2012). Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 9. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies.

12.Von Der Porten, S. (2012). Canadian indigenous governance literature: A review. AlterNative: An International Journal of Indigenous Peoples, 8(1), 1-14.

13.Rice, R. (2016). How to decolonize democracy: indigenous governance innovation in Bolivia and Nunavut, Canada. Bolivian Studies Journal, 22, 220-242.

14.Acquaye-Baddoo, N-A., Ekong, J., Mwesige, D., Nass, L., Neefjes, R., Ubels, J. et al. (2010). Multi-actor systems as entry points to capacity development. Retrieved from Capacity.org 41:4–7.
15.Hunt, J., & Smith, D.E. (2005). Strengthening Indigenous community governance: a step towards advancing reconciliation in Australia. Paper presented at the Peace, Justice and Reconciliation in the Asia-Pacific Region conference, Queesland University, Brisbane, 1–3 April. Topical issue no. 4/2005. Canberra: Centre for Aboriginal Economic Policy Research, The Australian National University.
16.Abdullah, J., & Young, S. (2010). Emergent drivers for building and sustaining capacity in Australian Indigenous communities. In: Kenny S & Clarke M (eds). Challenging capacity building: comparative perspectives. Rethinking international development series. Basingstoke: Palgrave Macmillan, 87–111.
17.Von der Porten, S., & de Loë, R. C. (2013). Collaborative approaches to governance for water and Indigenous peoples: A case study from British Columbia, Canada. Geoforum, 50, 149-160.
18.Verity, F. (2007). Community capacity building – a review of the literature. Adelaide: South Australian Department of Health.
19.Phillips, G., (2010). Cultural and personal principles for Indigenous governance. The Journal of Indigenous Policy 10:86–92.
20.Dodson, M., & Smith, D.E. (2003). Governance for sustainable development: strategic issues and principles for Indigenous Australian communities. Discussion paper no. 250/2003. Canberra: Centre for Aboriginal Economic Policy Research, The Australian National University.
21.Martin, D.F. (2005). Governance, cultural appropriateness and accountability within the context of Indigenous self-determination. In: Austin-Broos D & Macdonald G (eds). Culture, economy and governance in Aboriginal Australia. Proceedings of a Workshop of the Social Sciences in Australia, 30 November–1 December 2004. Sydney: University of Sydney Press
22.Dodson, M. (2002). Leadership and capacity building for community and regional governance. Paper presented at the Indigenous Governance Conference, Canberra, 3–5 April.
23.Jarvie, W. (2008). Working differently to make a difference in Indigenous communities. Public Administration Today 14:5–13
24.Laverack, G., Hill, K., Akenson, L., & Corrie, R. (2009). Building capacity towards health leadership in remote Indigenous communities in Cape York. Australian Indigenous Health Bulletin 9(1):1–11.

25.Martin, D.F. (2003). Rethinking the design of indigenous organisations: the need for strategic engagement. Discussion paper no. 248/2003. Canberra: Centre for 13 Improving Indigenous community governance through strengthening Indigenous and government organisational capacity Aboriginal Economic Policy Research, The Australian National University.
26.Mawson, F., Madgwick, M., Judd, J., & Fergie, D. (2007). Transition to governance: building capacity in an Indigenous community. Paper presented at the Australian Social Policy Conference, Social Policy through the Life Course: Building Community Capacity and Social Resilience, Sydney, 11–13 July.
27.McEwan, A.B., Tsey, K., McCalman, J., & Travers, H.J. (2010). Empowerment and change management in Aboriginal organisations: a case study. Australian Health Review 34(3):360–7
28.First Nations Financial Management Board & Institute of Governance. (2018). First Nations Governance Project's Phase I Governance Report. Available at https://iog.ca/projects-initiatives/indigenous-governance/.
29.Whop, L. J., Valery, P. C., Beesley, V. L., Moore, S. P., Lokuge, K., Jacka, C., & Garvey, G. (2012). Navigating the cancer journey: a review of patient navigator programs for Indigenous cancer patients. Asia Pacific Journal of Clinical Oncology, 8(4), e89-e96.
30.Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. International Journal of Health Promotion and Education, 46(2), 49-56.
31.O'Brien, A. P., Boddy, J. M., Hardy, D. J., & O'Brien, A. J. (2004). Clinical indicators as measures of mental health nursing standards of practice in New Zealand. International Journal of Mental Health Nursing, 13(2), 78-88.
32.Health Canada. (2015). First nations mental wellness continuum framework.
33.Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for First Nations youth. The journal of primary prevention, 38(1-2), 67-86.
34.Day, A., & Francisco, A. (2013). Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. Australian and New Zealand journal of public health, 37(4), 350-355
35.Freeman, H.P., (2006) Patient navigation: a community based strategy to reduce cancer disparities. J Urban Health; 83: 139–41.
36.Burhansstipanov L, Wound DB, Capelouto N et al. (1998). Culturally relevant "navigator" patient support. the Native Sisters. Cancer Pract; 6: 191– 4.
37.Kanekar, S., & Petereit, D. (2009). Walking forward: a program designed to lower cancer mortality rates among American Indians in western South Dakota. South Dakota Medicine: The Journal of the South Dakota State Medical Association, 62(4), 151.

38.Grimes, C., Dankovchik, J., Cahn, M., & Warren-mears, V. (2017). American Indian and Alaska Native Cancer Patients' Perceptions of a Culturally Specific Patient Navigator Program. Journal of Primary Prevention, 38(1-2), 121.
39.Wilson K. Rosenberg M. W. Abonyi S. , & Lovelace R . (2010). Aging and health: An examination of differences between older Aboriginal and non-Aboriginal people. Canadian Journal on Aging, 29, 369–382. doi:10.1017/S0714980810000309
40.Statistics Canada . (2015). Projected life expectancy at birth by sex and Indigenous Identity, Canada, 2017. Retrieved from http://www.statcan.gc.ca/pub/89-645-x/2010001/c-g/c-g013-eng.htm
41.Pace, J. E., & Grenier, A. (2017). Expanding the circle of knowledge: Reconceptualizing successful aging among North American older Indigenous peoples. Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 72(2), 248-258.
42.Pace J . (2013). Meanings of memory: Understanding aging and dementia in First Nations communities on Manitoulin Island, Ontario (Unpublished doctoral dissertation). McMaster University, Hamilton, Canada.
43.Mitchell, W. G., Deane, A., Brown, A., Bihari, S., Wong, H., Ramadoss, R., & Finnis, M. (2020). Long term outcomes for Aboriginal and Torres Strait Islander Australians after hospital intensive care. Medical Journal of Australia, 213(1), 16-21.
44.Wilson, D., & Barton, P. (2012). Indigenous hospital experiences: A New Zealand case study. Journal of clinical nursing, 21(15-16), 2316-2326.
45.Re-Engineered Discharge (RED) Toolkit. Content last reviewed February 2020. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
46.Leppin, A. L., Gionfriddo, M. R., Kessler, M., Brito, J. P., Mair, F. S., Gallacher, K., ... & Montori, V. M. (2014). Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. JAMA internal medicine, 174(7), 1095-1107.
47.Mitchell, S. E., Weigel, G. M., Laurens, V., Martin, J., & Jack, B. W. (2017). Implementation and adaptation of the re-engineered discharge (RED) in five California hospitals: a qualitative research study. BMC health services research, 17(1), 1-14.
48.Adams, C. J., Stephens, K., Whiteman, K., Kersteen, H., & Katruska, J. (2014). Implementation of the Re-Engineered Discharge (RED) toolkit to decrease all-cause readmission rates at a rural community hospital. Quality Management in Healthcare, 23(3), 169-177.
49.Mitchell, S. E., Martin, J., Holmes, S., van Deusen Lukas, C., Cancino, R., Paasche-Orlow, M., ... & Jack, B. (2016). How hospitals reengineer their discharge processes to reduce readmissions. Journal for healthcare quality: official publication of the National Association for Healthcare Quality, 38(2), 116.

50.Jenq, G. Y., Doyle, M. M., Belton, B. M., Herrin, J., & Horwitz, L. I. (2016). Quasi-experimental evaluation of the effectiveness of a large-scale readmission reduction program. JAMA internal medicine, 176(5), 681-690.
51.Kash, B. A., Baek, J., Davis, E., Champagne-Langabeer, T., & Langabeer II, J. R. (2017). Review of successful hospital readmission reduction strategies and the role of health information exchange. International journal of medical informatics, 104, 97-104.
52.Diplock, G., Ward, J., Stewart, S., Scuffham, P., Stewart, P., Reeve, C., ... & Maguire, G. (2017). The alice springs hospital readmission prevention project (ashrapp): a randomised control trial. BMC health services research, 17(1), 1-11.
53.Canadian Institute for Health Information, ed., Mentally Healthy Communities: Aboriginal
54.Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for First Nations youth. The journal of primary prevention, 38(1-2), 67-86.
55.Day, A., & Francisco, A. (2013). Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. Australian and New Zealand journal of public health, 37(4), 350-355
56.Durie, M. (2011). Indigenous mental health 2035: Future takers, future makers and transformational potential. Australasian Psychiatry, 19(1_suppl), S8-S11.
57.Novins, D., LeMaster, P., Thurman, P. J., & Plested, B. (2004). Describing Community Needs: Examples From the Circles of Care Initiaive. American Indian and Alaska Native Mental Health Research: The Journal of the National Center, 11(2), 42-58.
58.Scott, K. M., Sarfati, D., Tobias, M. I., & Haslett, S. J. (2000). A challenge to the cross-cultural validity of the SF-36 health survey: Factor structure in Māori, Pacific and New Zealand European ethnic groups. Social Science & Medicine, 51(11), 1655-1664.
59.Rountree, J., & Smith, A. (2016). Strength-Based Wellbeing Indicators For Indigenous Children And Families: A Literature Review Of Indigenous Communities' identified Wellbeing Indicators. American Indian & Alaska Native Mental Health Research: The Journal of the National Center, 23(3).
60.Cianconi, P., Lesmana, C. B. J., Ventriglio, A., & Janiri, L. (2019). Mental health issues among indigenous communities and the role of traditional medicine. International Journal of Social Psychiatry, 65(4), 289-299.
61.Health Canada. (2015). First nations mental wellness continuum framework.
62.First Nations Health Authority. (2015). First Nations Perspective on Health and Wellness. https://www.fnha.ca/wellness/wellness-for-first-nations/first-nations-perspective-on-health-and-wellness

63.Shahid, S., Taylor, E. V., Cheetham, S., Woods, J. A., Aoun, S. M., & Thompson, S. C. (2018). Key features of palliative care service delivery to Indigenous peoples in Australia, New Zealand, Canada and the United States: a comprehensive review. BMC palliative care, 17(1), 1-20.
64.Baskin C. , & Davey C. J . (2015). Grannies, elders, and friends: Aging Aboriginal women in Toronto. Journal of Gerontological Social Work, 58, 46–65. doi:10.1080/01634372.2014.912997
65.Lewis J. (2013a). The importance of optimism in maintaining healthy aging in rural Alaska. Qualitative Health Research, 23, 1521–1527. doi:10.1177/1049732313508013
66.Abonyi S. , & Favel M . (2012). Marie's story of aging well: Toward new perspectives on the experience of aging for Aboriginal seniors in Canada. Anthropology and Aging Quarterly, 33, 11–20. doi:10.1037/e682002011-001
67.Brass E. R . (2004). Empowerment and wellness of Aboriginal Elders (Unpublished master's thesis). University of Regina, Regina, Canada.
68.Collings P . (2001). "If you've got everything, it's good enough": Perspectives on successful aging in a Canadian Inuit community. Journal of Cross-Cultural Gerontology, 16, 127–155. doi:10.1023/A:1010698200870
69.Hopkins S. Kwachka P. Lardon C. , & Mohatt G. V . (2007). Keeping busy: A Yup'ik/Cup'ik perspective on health and aging. International Journal of Circumpolar Health, 66, 42–50. doi:10.3402/ijch.v66i1.18224
70.Lewis J. P . (2009). Successful aging through the eyes of Alaska Native Elders: What it means to be an Elder in Bristol Bay, Alaska (Unpublished doctoral dissertation). University of Alaska, Fairbanks, AK.
71.Lewis J . (2013b). The future of successful aging in Alaska: What can we learn from our Elders to ensure a healthy future. International Journal of Circumpolar Health, 72, 1–5. doi:10.3402/ijch.v72i0.21186
72.Lewis J . (2014). The role of social engagement in the definition of successful aging among Alaska Native Elders in Bristol Bay, Alaska. Psychology of Developing Societies, 26, 263–290. doi:10.1177/0971333614549143
73.Caxaj, C. S., Schill, K., & Janke, R. (2018). Priorities and challenges for a palliative approach to care for rural indigenous populations: a scoping review. Health & social care in the community, 26(3), e329-e336.
74.Bellamy, G., & Gott, M. (2013). What are the priorities for developing culturally appropriate palliative and end-of-life care for older people? The views of healthcare staff working in New Zealand. Health & Social Care in the Community, 21(1), 26-34.
75.Kelley, M. L., Prince, H., Nadin, S., Brazil, K., Crow, M., Hanson, G., ... & Smith, J. (2018). Developing palliative care programs in Indigenous communities using participatory action research: a Canadian application of the public health approach to palliative care. Ann Palliat Med, 7(Suppl 2), S52-S72.

76.Green, M., Anderson, K., Griffiths, K., Garvey, G., & Cunningham, J. (2018). Understanding indigenous Australians' experiences of cancer care: stakeholders' views on what to measure and how to measure it. BMC health services research, 18(1), 1-13.
77.Schill, K., & Caxaj, S. (2019). Cultural safety strategies for rural Indigenous palliative care: a scoping review. BMC palliative care, 18(1), 1-13.
78.Nadin, S., Crow, M., Prince, H., & Kelley, M. L. (2018). Wiisokotaatiwin: development and evaluation of a community-based palliative care program in Naotkamegwanning First Nation. Rural & Remote Health, 18(2).

Appendix I: Full-length Rapid Literature Reviews
Indigenous Approaches and Indicators

Indigenous Peoples and Overall Wellbeing

1. Introduction

Health and wellness are areas of significant concern for many Indigenous communities. Federal, provincial, and territorial health services have sought to address factors related to healthcare provision and access in many Indigenous communities; however, there are significant issues and gaps associated with service delivery and accessibility. Despite the impacts of historical and present-day colonialism, Indigenous peoples and communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience. Indigenous communities conceptualize individual health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. Indicators of Indigenous health should therefore reflect this complexity through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing.

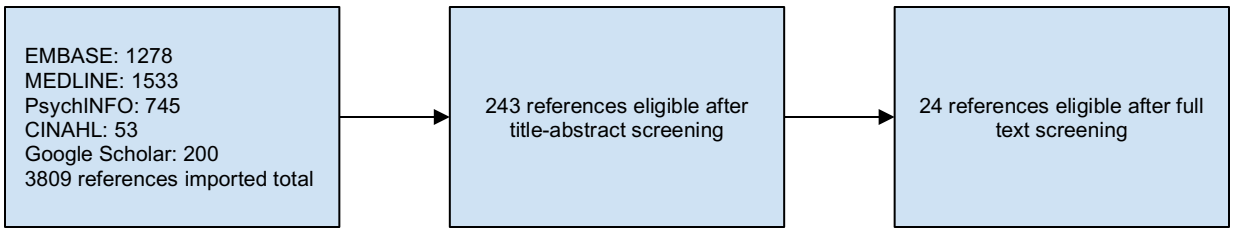
2. Literature Review Search Strategy

The search terms utilized were the following. The search strings were combined using "AND" operators.

i) "approach" or "framework" or "model" or "models, theoretical" or "health system*" or "health polic*" or "ways of knowing" or "health belief" or "health belief model" or "health care reform" or "health planning" or "health priorities" or "indicators" or "understanding" or "perspectives"

ii) "Indigenous health" or "Indigenous Canadians" or "indigenous" or "Health Services, Indigenous" or "Indigenous Peoples" or "Inuits" or "Indians, North American" or "Metis" or "Native American" or "American Natives" or "Alaskan Natives" or "Maori"

The databases searched were: MEDLINE, EMBASE, PsychINFO, CINAHL, as well as Google Scholar.



3. Summary of Literature

Indigenous Conceptualizations of Health

Indigenous communities conceptualize individual health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing (1-5). Indicators of Indigenous health should therefore reflect this complexity through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing (1-8).

Indicators of Overall Wellbeing

Several indicators of overall wellbeing were identified from the literature, including:

- Physical Health: balance in diet and nutrition; food and water security; access and space for physical activity; access to Indigenous healing practices; timely access to healthcare facilities (2, 4-5, 7, 9-13)
- Mental health: social, spiritual, and emotional wellbeing; fostering community cohesion; access to mental health support and services (4, 9, 14-18)
- Natural environment: Environmental protection, maintaining connection with and stewardship of natural environment and the land, animals, plants (2-9, 12, 14, 15, 17, 20-24)
- Community vitality: Connection to the community; facilities for education, community, and culture; economic resources and employment; usage of traditional resources, knowledge, wisdom, arts, and language (10-15, 17, 20, 23-24)
- Community infrastructure: Access to essential services; facilities for healthcare, community services, safety; sports and recreational facilities. (15-20, 23)
- Connection to culture: Connection to cultural and spiritual practices; practice of Indigenous ceremonies and embodiment of Indigenous cultural values; Indigenous leadership at center of initiatives (1, 3, 9-14)

Conclusion

Healthcare improvement initiatives must focus on community development, ownership, and capacity building; culturally responsive and safe care and competency service

delivery; as well as effective collaboration with partners and organizations at the community, provincial, territorial, and national level (1-9, 16-19, 23). It is important that leadership from Indigenous youth, community leaders, and Elders be at the forefront of planning and development strategies for Indigenous healthcare services (1-9, 18, 23). Each Indigenous community is unique and cannot be generalized under one model; it is therefore imperative that healthcare indicators are determined by the community themselves and that interventions are personally tailored to fit the community that they aim to serve. Continued work and efforts are required to address the interrelated and broad structural factors, including historical, political, financial, social, and cultural, that affect Indigenous health and wellbeing. In health systems and policy evaluation, indicators for health status selected should reflect Indigenous peoples' multifaceted and holistic conceptualizations of wellbeing.

References

1. Cairney, S., Abbott, T., Quinn, S., Yamaguchi, J., Wilson, B., & Wakerman, J. (2017). Interplay wellbeing framework: a collaborative methodology 'bringing together stories and numbers' to quantify Aboriginal cultural values in remote Australia. *International journal for equity in health*, *16*(1), 1-13.

2. Chakraborty, A., Howard, N. J., Daniel, M., Chong, A., Slavin, N., Brown, A., & Cargo, M. (2021). Prioritizing Built Environmental Factors to Tackle Chronic and Infectious Diseases in Remote Northern Territory (NT) Communities of Australia: A Concept Mapping Study. International journal of environmental research and public health, 18(10), 5178.

3. Chando, S., Tong, A., Howell, M., Dickson, M., Craig, J. C., DeLacy, J., ... & Howard, K. (2021). Stakeholder perspectives on the implementation and impact of Indigenous health interventions: A systematic review of qualitative studies. *Health Expectations*, *24*(3), 731-743.

4. Donatuto, J., Campbell, L., & Gregory, R. (2016). Developing responsive indicators of indigenous community health. *International Journal of Environmental Research and Public Health*, *13*(9), 899.

5. Donatuto, J., Grossman, E. E., Konovsky, J., Grossman, S., & Campbell, L. W. (2014). Indigenous community health and climate change: integrating biophysical and social science indicators. *Coastal Management*, *42*(4), 355-373.

6. Yap, M., & Yu, E. (2016). Operationalising the capability approach: developing culturally relevant indicators of indigenous wellbeing–an Australian example. *Oxford Development Studies*, *44*(3), 315-331.

7. Donatuto, J. L., Satterfield, T. A., & Gregory, R. (2011). Poisoning the body to nourish the soul: Prioritising health risks and impacts in a Native American community. *Health, Risk & Society*, *13*(2), 103-127.

8. Gregory, R., Easterling, D., Kaechele, N., & Trousdale, W. (2016). Values-Based Measures of Impacts to Indigenous Health. *Risk Analysis*, *36*(8), 1581-1588.

9. Harper, S. L., Edge, V. L., Ford, J., Willox, A. C., Wood, M., IHACC Research Team, ... & McEwen, S. A. (2015). Climate-sensitive health priorities in Nunatsiavut, Canada. BMC public health, 15, 1-18.

10. Isaac, G., Finn, S., Joe, J. R., Hoover, E., Gone, J. P., Lefthand-Begay, C., & Hill, S. (2018). Native American perspectives on health and traditional ecological knowledge. *Environmental health perspectives*, *126*(12), 125002.

11. Jordan, K., Bulloch, H., & Buchanan, G. (2010). Statistical equality and cultural difference in Indigenous wellbeing frameworks: A new expression of an enduring debate. *Australian Journal of Social Issues*, *45*(3), 333-362.

12. Kryzanowski, J. A., & McIntyre, L. (2011). A holistic model for the selection of environmental assessment indicators to assess the impact of industrialization on indigenous health. *Canadian Journal of Public Health*, *102*, 112-117.

13. Oneha, M. F. (2001). Ka mauli o ka'oina a he mauli kanaka: an ethnographic study from an Hawaiian sense of place. Pacific Health Dialog, 8(2), 299-311.

14. Rountree, J., & Smith, A. (2016). STRENGTH-BASED WELL-BEING INDICATORS FOR INDIGENOUS CHILDREN AND FAMILIES: A LITERATURE REVIEW OF INDIGENOUS COMMUNITIES'IDENTIFIED WELL-BEING INDICATORS. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, *23*(3).

15. Spurling, G. K., Bond, C. J., Schluter, P. J., Kirk, C. I., & Askew, D. A. (2018). 'I'm not sure it paints an honest picture of where my health's at'–identifying community health and research priorities based on health assessments within an Aboriginal and

Torres Strait Islander community: a qualitative study. Australian Journal of Primary Health, 23(6), 549-553.

16. Steenkamp, M., Bar-Zeev, S., Rumbold, A., Barclay, L., & Kildea, S. (2010). Pragmatic indicators for remote Aboriginal maternal and infant health care: why it matters and where to start. *Australian and New Zealand journal of public health*, *34*, S5-S8.

17. Taylor, J. (2008). Indigenous peoples and indicators of well-being: Australian perspectives on United Nations global frameworks. *Social Indicators Research*, *87*, 111-126.

18. Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021). Creating an Indigenous Māori-centered model of relational health: A literature review of Māori models of health. Journal of clinical nursing, 30(23-24), 3539-3555.

19. Yap, M., & Yu, E. (2016). Operationalising the capability approach: developing culturally relevant indicators of indigenous wellbeing–an Australian example. Oxford Development Studies, 44(3), 315-331.

20. The Alberta First Nations Information Governance Centre. (2018). Indigenous Health Indicators. Retrieved from https://www.afnigc.ca/main/includes/media/pdf/digital%20reports/Indigenous%20Health%20Indicators.pdf

21. Abonyi et al. (2005). Development of an Evaluative Framework for use by First Nations Health Organizations. Retrieved from http://www2.uregina.ca/fnh/posters/Development%20of%20Evaluative%20Framework%20(Montreal)-%20Sept-05.pdf

22. Sturm, R.; Francis IV, L. (2016). Building an inclusive community-centered evaluation program. Responsive Evaluation.

23. First Nations Health Authority. (2012). First Nations Perspective on Health and Wellness. Retrieved from: https://www.fnha.ca/Documents/FNHA-Wellness-Indicators-Rebecca-Lee.pdf

Indigenous Peoples and Health Governance

1. Introduction

Addressing healthcare disparities and inequities in Indigenous populations requires community capacity strengthening and sound governance and leadership that centers Indigenous peoples. In the Indigenous context, community capacity strengthening is extensively linked with the properties of self-governance and justice. Governance of initiatives to address Indigenous healthcare disparities should be developed and implemented in accordance with the principles of the population it aims to serve and incorporate, namely Indigenous governance and capacity strengthening principles. Capacity strengthening in this way must address and respond to the needs of the Indigenous community that is involved, through whichever means required, with the long-term aim of creating a system that supports and enhances the ability of Indigenous peoples and their systems for self-governance and leadership. Respect and adherence to Indigenous principles of governance and capacity strengthening represent foundational aspects for reconciliation, self-determination and justice. This rapid review sought to identify important aspects and factors of Indigenous health governance from the perspective of Indigenous communities.

2. Key Terms and Definitions

Term	Definition
Capacity Strengthening	"Capacity strengthening is based on a strengths-based perspective that all people have knowledge and skills, all people can improve … at the same time all people need to learn in order to engage in different activities which contribute to their wellbeing and prosperity" Source: Tsey, K., McCalman, J., Bainbridge, R., & Brown, C. (2012). Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 10. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Available at: https://www.aihw.gov.au/getmedia/04fa3771-33c4-448b-b82e-3dce26c4cd97/ctgc-rs10.pdf.aspx?inline=true

Community Governance	"Governance refers to the evolving processes, relationships, institutions and structures by which a group of people, community or society organise themselves collectively to achieve things that matter to them" Source: Tsey et al., 2012
Self-determination and Autonomy	"Indigenous Peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development…Indigenous Peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions." Source: Discussion Paper - Indigenous Peoples' Autonomy and Self-Governance: Outcomes of regional dialogues. Prepared by Indigenous Peoples and Development Branch, DISD/DESA For the 21st session of the Permanent Forum on Indigenous Issues. Available at: https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2022/04/backgroundpaper-virtual-regional-dialogues.pdf

3. Literature Review Search Strategy

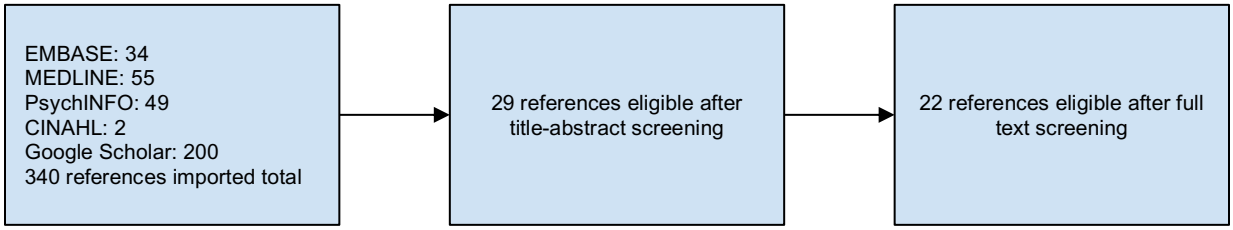
The search terms utilized were the following. The search strings were combined using "AND" operators.

i) "approach" or "framework" or "model" or "models, theoretical" or "health system*" or "health polic*" or "ways of knowing" or "health belief" or "health belief model" or "health care reform" or "health planning" or "health priorities" or "indicators" or "understanding" or "perspectives"

ii) "Indigenous health" or "Indigenous Canadians" or "indigenous" or "Health Services, Indigenous" or "Indigenous Peoples" or "Inuits" or "Indians, North American" or "Metis" or "Native American" or "American Natives" or "Alaskan Natives" or "Maori"

iii) “Health Governance” or “Governance” or “Health Government“ or “Health Leadership” or “Leadership” or “Public Health Administration” or “Decision Making, Organizational” or "Organization and administration" or “Clinical governance” or “Governing board” or “Models, organizational”

The databases searched were: MEDLINE, EMBASE, PsychINFO, CINAHL, as well as Google Scholar.



4. Summary of Literature

Defining Governance and its Importance

Governance is the right for expression of Indigenous peoples’ autonomy and the right to take responsibility for the decisions that affect their lives. Federal, provincial, territorial, and municipal governments must recognize and develop initiatives to foster Indigenous governance in order to achieve autonomy and improve outcomes for Indigenous populations. It is important that this inclusion be instituted from the community level to start with, as without the foundation of effective and stable leadership at the local level, governance and capacity strengthening cannot be sustained and developed into the provincial and federal levels (1-3). Strengthening and fostering Indigenous leadership and governance is critical for improving the healthcare system and wellbeing of Indigenous communities. Improving the governance processes related to Indigenous healthcare will require the strengthening of Indigenous and mainstream government organizational values, goals, structures, and culture. Critical to this aim is the involvement and centering of Indigenous leadership in decision-making processes.

Facilitators for Improving Indigenous Community Governance

The following principles were identified in the literature as effective for improving Indigenous community governance (4-10):

- Positioning of Indigenous leadership in order to establish and foster community ownership of governance improvement with organizational change led by Indigenous people using existing community capacity
- Long-term partnerships with mainstream government and Indigenous leadership, with a focus on strengthening capacity and resources, and development of shared goals and approaches between them
- Tailored approaches that are adapted for each particular issue or situation, that take into account the complexities and opinions of Indigenous governance
- Development and implementation of capacity-strengthening programs and recruitment of Indigenous leadership, with a clear plan for long-term sustainability and measurement of program effectiveness
- Building trust and rapport between mainstream governmental agencies and Indigenous leadership committees
- Thorough assessment of current systemic policies and processes, as well as assessment of constraints, barriers and resources, both logistical and financial
- Training throughout all levels of mainstream government in Indigenous-centered governance, with a focus on shared responsibility and accountability, and creating locally responsive solutions

Barriers to Improving Indigenous Community Governance

The following principles were outlined in the literature review as being ineffective in the establishment of Indigenous governance (5, 10-14):

- Establishing programs that do not reflect the values and priorities of the community involved
- Efforts to change Indigenous governance structures through amalgamation with existing structures instead of attending to and establishing Indigenous governance principles
- Fragmentation or rapidly changing governance policies
- Overloading communities with a sudden influx of new governance policies and change initiatives
- Poorly coordinated and monitored program initiatives without systems in place for measurement of accountability and effectiveness

Steps for Advancing Indigenous Community Governance

Further research is required into how to reach agreed understandings of community governance, taking into consideration the diversity and the variety in various Indigenous governance levels, sectors and institutions. Further efforts are also needed to elucidate the best practices for (10-19):

- Strengthening of the intercultural processes in both Indigenous organizations and governance systems
- How capacity strengthening programs can best be implemented across resource-limited settings
- How to best implement leadership succession and handover between leadership committees
- How to best establish informal processes and cultural values linked with Indigenous governance in developing organizations

Defining Capacity Strengthening

The term ‘capacity strengthening’ is preferred over the term ‘capacity building’ with reference to Indigenous governance; the term ‘capacity building’ reflects a patronizing view, rather than a strengths-based perspective that takes into account that all people have knowledge and skills, and all need to engage and contribute in different activities to contribute to the overall goal of community wellbeing. As stated by Richard Ahmat, Indigenous Chairman of Cape York Land Council, “To restore capacity to our people is to let us be responsible for our own future … we have had 40 to 60,000 years of survival and capacity! The problem is our capacity has been eroded and diminished … the concept of capacity building is the idea that Aboriginal people are innately deficient, or incapable, or lacking … there is a danger of fostering a hidden bureaucratic racism and prejudice against our people … our people do have skills, knowledge and experience.” (5).

Conclusion

Overall in the literature, there is a paucity of studies on well-designed and standardized evaluations of Indigenous governance capacity-strengthening programs. The term itself emerged in the 1990s in international development discourse due to a general shift in initiatives towards focusing on sustainable development and intercultural engagement between Indigenous communities and national governments (3-8). Currently, one of the main concerns of Indigenous leaders is the piece-meal nature of development initiatives between mainstream governments and Indigenous communities. Areas requiring change are each addressed by different segments of mainstream government, each with different teams, internal systems and policies, which makes it very difficult to organize a sustainable and coordinated plan for development in the long-term for Indigenous communities. In Indigenous community settings, community governance needs to focus on strengthening Indigenous decision-making processes rather than more disjointed consulting from different mainstream governmental groups that do not

amount to a coordinated plan with sufficient logistical, financial, and systemic resources for long-term change (1,3,8).

There are many systems of governance that Indigenous communities have applied and continue to exist within. Different communities have developed systems to address various territorial realities and to address different political, social and economic realities and needs. However, the principles that are central to Indigenous governance identified in the literature (1,5-19):

- Respect and centering of shared humanity and the common good at the forefront of all new initiatives
- Acknowledgement and recognition of the interconnectedness between humans, land, water and all things in the development of life
- Belief in the spirit beings/realm and Ancestors as central aspects of daily life and discussion
- Focus on the so-called 'softer' aspects of human communication, and reflection on these complex relationships on a regular basis, in order to keep team dynamics, emotions, culture, values, and beliefs and ensure an accurate reflection of the Indigenous community
- Understanding that leaders are connected to the community through extensive informal and formal social networks, and that both are equally important and valid in decision-making, e.g., Informal social networks such as family, clan group
- Equal involvement from youth, community leaders and Elders, and understanding individuals' credentials cannot be defined by Western values such as degrees/schooling
- Centering of the unique values, principles, and areas of priority regarding development, ownership, control and capacity in each community, through input from members of the community themselves
- De-centering of 'rulers' and 'law-makers' and rather focusing on producing systems that encourage and foster living harmoniously together and with the natural world, with agreements and structures that are consensual and inclusive, rather than having certain people who claim dominion over other species and other humans

These principles can be summarized in the following construct, which places the Nation at the center of a comprehensive and holistic framework for governance and self-determination, in relation with autonomy, capacity, and relationship strengthening. Firstly, relationships include the importance of social cohesion, sharing of respect, and intra/inter community collaboration. Autonomy, both governmental and fiscal, are required for self-determination, strengthened capacity, and decision-making of Indigenous communities over time. Lastly, capability reflects community health,

wellbeing, and resources across social, economic, environmental, and cultural domains. These components are all linked to each other as social capability is linked to economic growth, which is in turn linked with the sustainability of Indigenous cultural practices and environmental guardianship. Economic growth is then re-invested in the community, which creates further social capability and strengthening of cultural practices. All of these aspects of a community's wellbeing and development are needed together to achieve Indigenous wellness and effective governance (19).

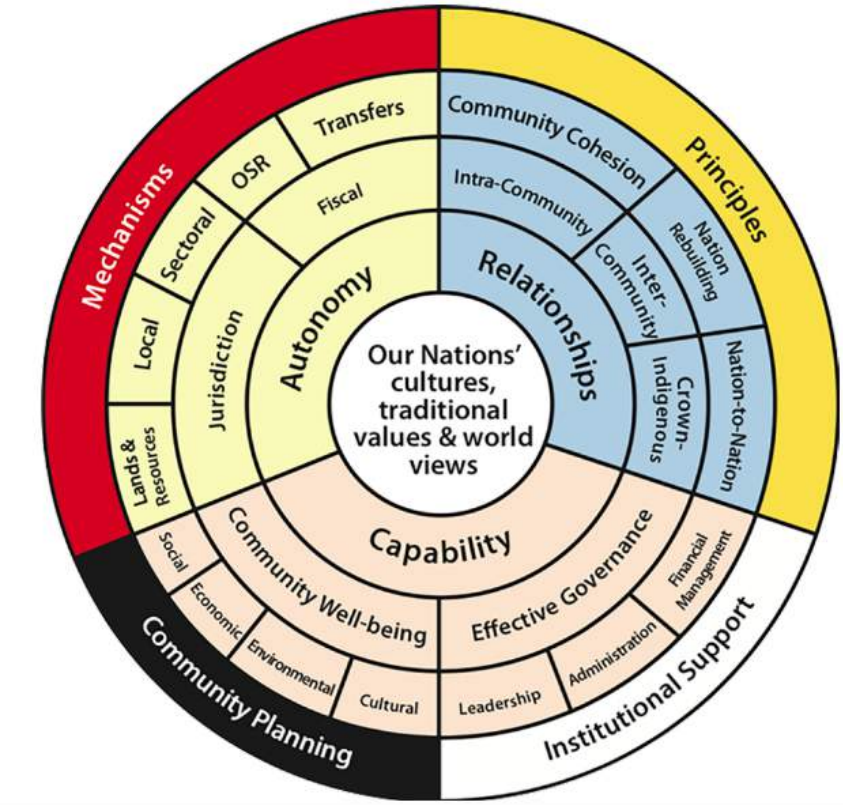


Figure: Framework for governance and self-determination proposed by the First Nations Financial Management Board (FMB) and the Institute of Governance (IOG) (19)

Centering Indigenous governance principles requires assessing the fundamental philosophies, culture, and values embodied by current practices, and creating transformation in organizational development (20). It is also important to recognize that Western approaches cannot be directly applied to Indigenous context. Moreover, each community is different and decisions regarding these principles can differ between areas.

References

1. Ladner, K. L. (2006). Indigenous governance: questioning the status and the possibilities for reconciliation with Canada's commitment to Aboriginal and Treaty Rights. National Centre for First Nations Governance.
2. Tsey, K., McCalman, J., Bainbridge, R., & Brown, C. (2012). Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 10. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Available at: https://www.aihw.gov.au/getmedia/04fa3771-33c4-448b-b82e-3dce26c4cd97/ctgc-rs10.pdf.aspx?inline=true
3. Von Der Porten, S. (2012). Canadian indigenous governance literature: A review. AlterNative: An International Journal of Indigenous Peoples, 8(1), 1-14.
4. Rice, R. (2016). How to decolonize democracy: indigenous governance innovation in Bolivia and Nunavut, Canada. Bolivian Studies Journal, 22, 220-242.
5. Acquaye-Baddoo, N-A., Ekong, J., Mwesige, D., Nass, L., Neefjes, R., Ubels, J. et al. (2010). Multi-actor systems as entry points to capacity development. Capacity.org 41, 4–7.
6. Hunt, J, & Smith, D.E. (2005). Strengthening Indigenous community governance: a step towards advancing reconciliation in Australia. Paper presented at the Peace, Justice and Reconciliation in the Asia-Pacific Region conference, Queesland University, Brisbane, 1–3 April. Topical issue no. 4/2005. Canberra: Centre for Aboriginal Economic Policy Research, The Australian National University.
7. Abdullah, J. & Young, S. (2010). Emergent drivers for building and sustaining capacity in Australian Indigenous communities. In: Kenny S & Clarke M (eds). Challenging capacity building: comparative perspectives. Rethinking international development series. Basingstoke: Palgrave Macmillan, 87–111
8. Von der Porten, S., & de Loë, R. C. (2013). Collaborative approaches to governance for water and Indigenous peoples: A case study from British Columbia, Canada. Geoforum, 50, 149-160.
9. Verity, F. (2007). Community capacity building – a review of the literature. Adelaide: South Australian Department of Health.
10. Phillips, G. (2010). Cultural and personal principles for Indigenous governance. The Journal of Indigenous Policy 10, 86–92.
11. Dodson, M. & Smith, D.E. (2003). Governance for sustainable development: strategic issues and principles for Indigenous Australian communities. Discussion paper no. 250/2003. Canberra: Centre for Aboriginal Economic Policy Research, The Australian National University.

12. Martin, D.F. (2005). Governance, cultural appropriateness and accountability within the context of Indigenous self-determination. In: Austin-Broos D & Macdonald G (eds). Culture, economy and governance in Aboriginal Australia. Proceedings of a Workshop of the Social Sciences in Australia, 30 November–1 December 2004. Sydney: University of Sydney Press
13. Dodson, M. (2002). Leadership and capacity building for community and regional governance. Paper presented at the Indigenous Governance Conference, Canberra, 3–5 April.
14. Jarvie, W. (2008). Working differently to make a difference in Indigenous communities. Public Administration Today 14:5–13
15. Laverack, G., Hill, K., Akenson, L. & Corrie, R. (2009). Building capacity towards health leadership in remote Indigenous communities in Cape York. Australian Indigenous Health Bulletin 9(1),1–11.
16. Martin, D.F. (2003). Rethinking the design of indigenous organisations: the need for strategic engagement. Discussion paper no. 248/2003. Canberra: Centre for 13 Improving Indigenous community governance through strengthening Indigenous and government organisational capacity Aboriginal Economic Policy Research, The Australian National University.
17. Mawson, F., Madgwick, M., Judd, J. & Fergie, D. (2007). Transition to governance: building capacity in an Indigenous community. Paper presented at the Australian Social Policy Conference, Social Policy through the Life Course: Building Community Capacity and Social Resilience, Sydney, 11–13 July.
18. McEwan, A.B., Tsey, K., McCalman, J. & Travers, H.J. (2010). Empowerment and change management in Aboriginal organisations: a case study. Australian Health Review 34(3), 360–7
19. First Nations Financial Management Board & Institute of Governance (2018). First Nations Governance Project's Phase I Governance Report. Available at https://iog.ca/projects-initiatives/indigenous-governance/ .
20. Moran, M.F. (2006). Practising self-determination: participation in planning and local governance in discrete indigenous settlements. PhD thesis. Brisbane: The University of Queensland
21. Milliken, N. & Shea, S. (2007). From oral history to leadership in the Aboriginal community: a five year journey with the Wagga Wagga Aboriginal Elders Group Incorporated. Rural Society 17(3), 299–307.
22. Paul, C.L., Sanson-Fisher, R., Stewart, J. & Anderson, A.E. (2010). Being sorry is not enough: the sorry state of the evidence for improving the health of indigenous populations. American Journal of Preventive Medicine 38(5):566–8

Indigenous Peoples and Patient Intake and Navigation

1. Introduction

Federal, provincial, and territorial health services have sought to address disparities related to healthcare access and delivery of services in many Indigenous communities. There are significant issues and gaps associated with service delivery and accessibility. Indigenous communities and leadership have been calling for the development of a coordinated, comprehensive approach to health services and programming. One aspect of providing effective and comprehensive healthcare to Indigenous populations is the use of a patient intake system that is culturally safe and respectful. Another related aspect is that of culturally safe and supportive patient navigation supports. This rapid review sought to identify important aspects of the patient intake and navigation processes from the perspective of Indigenous communities, and the preferences for patient intake and navigation and processes related to patient intake and navigation from an Indigenous lens.

2. Key Terms and Definitions

Term	Definition
Systemic Racism	"Systemic racism occurs when institutions or systems create or maintain racial inequity often as a result of hidden institutional biases in policies, practices, and procedures that privilege some groups and disadvantage others" Source: Anti-Racism Directorate (2022). Data Standards for the Identification and Monitoring of Systemic Racism. Government of Ontario. Available at: https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism
Cultural Competency	Cultural competency refers to "people development (ability of the practitioner to take knowledge, lessons and experiences about culture learned over time either through their own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient." Source: Indigenous Primary Health Care Council. (2018). Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. Available at: https://www.iphcc.ca/wp-content/uploads/2020/02/Cultural-Competency-Guideline-Report-June-2018.pdf

Cultural safety	"Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care." Source: First Nations Health Authority (2016). Creating a climate for change: Cultural safety and humility resource booklet. Available at: https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf
Patient Navigation	"Patient navigation is used to address fragmentation in the health care system, and to help patients overcome barriers to care and move through an often complex health care continuum." Source: Health Leadership and Learning Network. What Ontario Health Teams need to know about patient navigation. York University Faculty of Health Sciences. Available at: https://www.mcmasterforum.org/docs/default-source/rise-docs/partner-resources/york_patient-navigation.pdf?sfvrsn=a51457d5_3
Patient Intake	Initial steps taken by healthcare organizations when a new or returning patient presents for care, including collection of relevant information
Culturally Appropriate Care	Culturally appropriate care is considered to be "tangible, action oriented, and respectful of diverse cultural practices. It includes the physical structure and environment, how a program or service is delivered and by whom, and it provides choices relative to how each person experiences culture." Source: Indigenous Primary Health Care Council. (2018). Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. Available at: https://www.iphcc.ca/wp-content/uploads/2020/02/Cultural-Competency-Guideline-Report-June-2018.pdf
Health Promotion	"Health promotion enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure."

	Source: World Health Organization (2016). Health promotion. Available at: https://www.who.int/news-room/questions-and-answers/item/health-promotion
Capacity Building	"The World Health Organization (WHO) defines capacity building as the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion." Source: Public Health Ontario (2018). Creating capacity building interventions that work. Available at: https://www.publichealthontario.ca/en/About/News/2018/Capacity-building-interventions
Capacity Strengthening	"Capacity strengthening is based on a strengths-based perspective that all people have knowledge and skills, all people can improve … at the same time all people need to learn in order to engage in different activities which contribute to their wellbeing and prosperity" Source: Tsey, K., McCalman, J., Bainbridge, R., & Brown, C. (2012). Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 10. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Available at: https://www.aihw.gov.au/getmedia/04fa3771-33c4-448b-b82e-3dce26c4cd97/ctgc-rs10.pdf.aspx?inline=true

3. Literature Review Search Strategy

The search terms utilized were the following. The search strings were combined using "AND" operators.

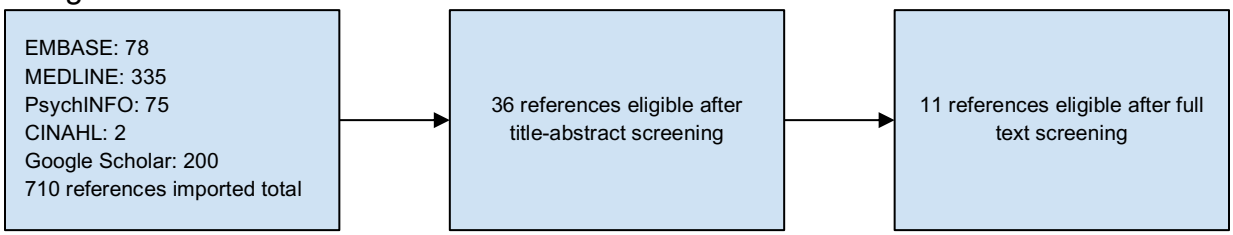
i) "patient intake" or "intake" or "intake form" or "intake questionnaire" or "patient questionnaire" or "patient referral" or "intake process" or "patient admittance" or "patient understanding" or "patient perspectives" or "patient navigation" or "patient navigator" or "patient navigator program" or "Indigenous patient navigator program" or "multidisciplinary healthcare team" or "interprofessional healthcare team"

ii) "Indigenous health" or "Indigenous Canadians" or "indigenous" or "Health Services, Indigenous" or "Indigenous Peoples" or "Inuits" or "Indians, North American" or "Metis" or "Native American" or "American Natives" or "Alaskan Natives" or "Maori"

iii) "Health Services, Indigenous" or "Community Health Planning" or "Health Government" or "Health Leadership" or "Delivery of Health Care" or "Public Health Administration" or "Health Planning" or "Regional Health Planning" or

"Health Care Reform" or "Indigenous Health Care Delivery" or "Community Health Services" or "Comprehensive Health Care" or "Multidisciplinary Health Care" or "Allied Health Care Services" or "Primary Health Care" or "Culturally Competent Care"

The databases searched were: MEDLINE, EMBASE, PsychINFO, CINAHL, as well as Google Scholar.



4. Summary of Literature

Provision of a patient intake process that is culturally safe and tailored to address the needs of the patient population that it serves can enhance the patient experience and improve outcomes. Navigating one's way through the complexities of the healthcare system can be arduous and cause uncertainty and fear for any individual. These difficulties are exacerbated for Indigenous people, especially due to factors such as systemic racism and discrimination from the medical system, language and cultural barriers, and inaccessibility of health services including screening and treatment. Methods to reduce these healthcare disparities are being explored across the world and one such method is the use of culturally safe patient intake processes and forms, and Indigenous patient navigation programs (1).

Indigenous Patient Navigator Programs

In the past decade there has been considerable interest in the role of patient navigators in addressing systemic problems in access to health care and continuity of care for patients. The very first patient navigation program was established in Harlem, New York, in 1990. This program was created to address perceived barriers stemming from mistrust, fatalistic views, and system complexity experienced by medically underserved patients, generally African American women, with breast cancer (2). Since then, patient navigation programs have become more widely used, particularly in the USA and Canada. In addition to informing patients about their health condition and the availability of services, these programs have expanded to also address cultural, educational, and language barriers to screening and treatment through community outreach by utilizing community healthcare workers (1). Patient navigation programs help individuals to navigate their way through their healthcare journey and the healthcare system by

assisting them in understanding the system and helping to overcome barriers they may be facing in receiving timely care.

Successful Navigation Program Examples

Overall, patient navigation and intake programs for Indigenous peoples are poorly studied in the literature. Work in this field is sparse; despite some improvements in the healthcare experience for Indigenous patients via patient navigation and intake programs, there remain many questions about the efficacy and best practices for such programs. Some examples of Indigenous patient navigation programs were found in the literature. One successful program was the “Native Sisters” Program, which focused on increasing the recruitment of Indigenous women into mammography screening (3). It did this by hiring Indigenous women to act as patient navigators, and in this role they recruited women for breast cancer screening, supported them by attending screening appointments with them, assisted in preparing questions to ask healthcare professionals, and also offered support as needed to the patient’s family. The Native Sisters program also assisted women and their families to navigate their way through the system if a cancer diagnosis was made (3).

Another successful program was the “Walking Forward” program. The main purpose of the program was to reduce cancer mortality rates for Indigenous peoples from three Lakota tribes in western South Dakota (4). The program employed community-based patient navigators to deliver culturally appropriate education about the value of screening and early detection. They played an important role in developing a relationship with the community and reducing resistance to engagement in clinical care from the community. Additionally, hospital-based patient navigators were used to provide assistance to participants who developed cancer. These navigators aimed to assist them with navigating the hospital system, assist with intake processes, and help overcome financial, social, and emotional barriers to receiving cancer-related care, including treatment, follow-up, and palliative care (4).

Barriers and Facilitators to Accessing Navigator Programs

All programs included had cultural competency and humility components that included input from the local representative Indigenous council during the planning and development of the program; cultural competency training for all staff which acknowledged Indigenous peoples' history and ensured that staff were culturally sensitive to the needs of the community and individuals; taking the time to educate the community about the program and answer their questions; and gathering feedback from the community with ongoing program evaluation. These initiatives resulted in patients

and the community developing a level of trust with the program and the program's staff, which allowed them to openly discuss their concerns and make full use of the program. Furthermore, having navigators with an Indigenous background, distribution of culturally relevant educational materials, and the use of the local language or an interpreter were also found to be important features of the navigator programs reviewed (1).

The key barriers identified by patients participating in patient navigator programs included: the cost of transport, food and lodging; difficulties in accessing quality care and screening; a lack of satisfaction with interactions with medical providers and a lack of confidence in their own understanding and abilities (5). Overall, patient navigator programs addressed these concerns by providing patients with support in navigating many aspects of healthcare including the intake process, screening programs, preparing for various medical appointments, financial support, facilitating communication both in terms of translation and explaining health terminology, and navigating the logistical aspects of managing healthcare and assisting with arranging transport and childcare. Patient navigators also provided patients with emotional and social support, and served as a ground base for patients as they navigated the system (1, 5). By systematically assessing and addressing patients' needs, patient navigator programs can potentially fill an important gap in the supportive care needs of Indigenous patients (6). Culturally respectful and aware approaches are crucial in enhancing personal empowerment and as a result promote more effective intake and service delivery for Indigenous people. However, the efficacy overall of such programs has not been determined in the literature. There are no consistent approaches to program design or to the definition, role and training of the patient navigators. It remains unclear which navigator characteristics and activities are most pertinent to Indigenous people to improve their healthcare experiences and overall outcomes. This lack of consistency and the absence of comprehensive program evaluation have resulted in unsubstantiated and generalized conclusions being reported. More rigorous evaluations of such programs will be necessary to ensure the efficacy of future programs (5, 8-9).

Culturally Appropriate, Indigenous-Focused Patient Intake Forms

Several examples of culturally appropriate patient intake forms were found in the grey literature. These examples have been compiled in the table below, along with the links to access them:

Selected examples from grey literature:

Organization Name	Indigenous Patient Intake Program	Link to Program Website	Link to Intake Form

	Name		
Southwest Ontario Aboriginal Health Access Centre	Circle of Care Program	https://soahac.on.ca/intake/	https://soahac.on.ca/wp-content/uploads/2015/01/SOAHAC-Intake-Form-V6.1.pdf
Barrie Area Native Advisory Circle	Mamaway Wiidokdaadwin Primary Care Team and Advisory Circle	https://mamaway.ca/	https://mamaway.ca/wp-content/uploads/2019/06/MWIIPCT-Intake-Form.pdf
Vancouver Coastal Health	Aboriginal Health Patient Navigator Program	http://www.vch.ca/your-care/aboriginal-health/programs-and-initiatives	http://www.vch.ca/Documents/Aboriginal-patient-navigator-intake-form.pdf
North Bay Indigenous Hub	Giiwedno mshkikiiwgamig Primary Care Group	https://www.giiwednomshkikiiwgamig.ca/intake/	https://www.giiwednomshkikiiwgamig.ca/download/intake-form/?wpdmdl=6600&refresh=61097afd2c1ae1628011261

Common characteristics across all of the intake forms were noted:

- Questions regarding their preferred name and gender identity
- Questions regarding Indigenous identity that provided patients with the option to select their identity, or to write out their preferred way to identify, or to not identify at all if they so chose
- Questions regarding their current medical and socioemotional health, their personal health history, and current interventions/medications, including Traditional Medicines
- Questions regarding any accommodations or supports they required
- Questions regarding which services they were looking to engage with, including Integrated Wholistic Care Services, or Traditional Healing Practices

- Questions regarding current living arrangements, employment, and other related factors
- Questions regarding their personal history and family story thus far, and related factors regarding Indigenous generational trauma (e.g., Sixties Scoop, residential schooling)

All intake forms found have a specific section for questions specifically related to Indigenous identity and trauma. An example of this, from the Southwest Ontario Aboriginal Health Access Centre Circle of Care program, is below:

8. We Ask Because We Care

Ni-gagwe-kendaamin aaniin ezhi-zhiwebiziyin ****** Wetwaliwa'no:tu'se tsi' teyukwate'ha**

Kwchiimoolulóhmwa eél kiiloóna lxawéélumeengw

Additional Information is required for Health Equity, Statistical Purposes and Funding Eligibility. We are collecting social information from clients to find out who we serve and what unique needs our client have. We will also use this information to understand client experiences and outcomes.

Do I have to answer these questions?

No. The questions are voluntary and you can choose 'prefer not to answer' to any or all questions. This will not affect your care at SOAHAC.

My nation is:

☐ Cayuga ☐ Cree ☐ Delaware ☐ Inuit ☐ Metis ☐ Mississauga ☐ Mohawk ☐ Odawa
☐ Ojibway / Chippewa ☐ Onondaga ☐ Oneida ☐ Potawatomi ☐ Seneca ☐ Tuscarora
☐ Other (please identify): _____ ☐ Do not know ☐ Prefer not to answer

My Band is:_____

Spiritual identity:

☐ Clan _____ ☐ Do not know ☐ Prefer not to answer
☐ Colour(s) _____ ☐ Do not know ☐ Prefer not to answer
☐ Spirit Name _____ ☐ Do not know ☐ Prefer not to answer
☐ Not applicable ☐ Other _____

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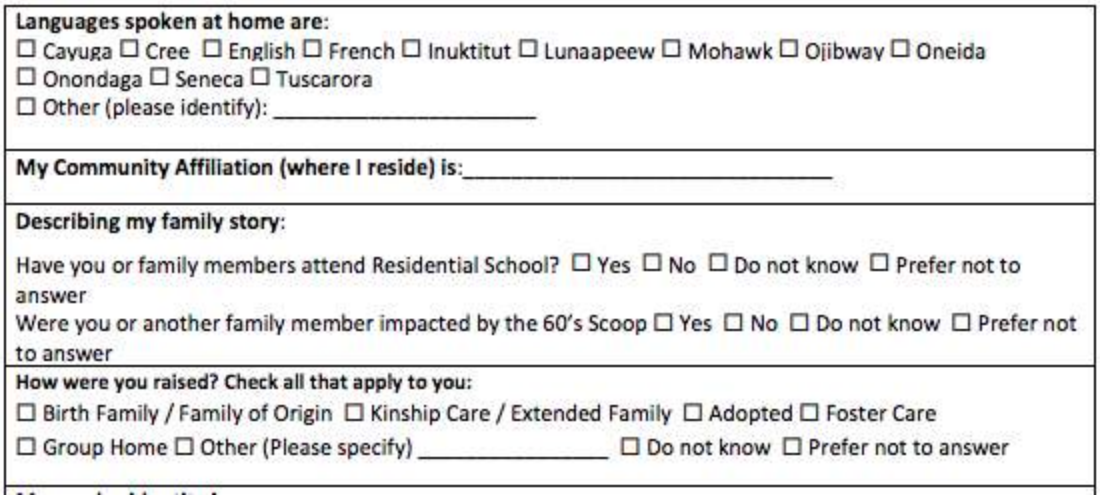


Languages spoken at home are:
☐ Cayuga ☐ Cree ☐ English ☐ French ☐ Inuktitut ☐ Lunaapeew ☐ Mohawk ☐ Ojibway ☐ Oneida
☐ Onondaga ☐ Seneca ☐ Tuscarora
☐ Other (please identify): _____

My Community Affiliation (where I reside) is:_____

Describing my family story:

Have you or family members attend Residential School? ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer
Were you or another family member impacted by the 60's Scoop ☐ Yes ☐ No ☐ Do not know ☐ Prefer not to answer

How were you raised? Check all that apply to you:
☐ Birth Family / Family of Origin ☐ Kinship Care / Extended Family ☐ Adopted ☐ Foster Care
☐ Group Home ☐ Other (Please specify) _____ ☐ Do not know ☐ Prefer not to answer

Figure: Intake form of the Southwest Ontario Aboriginal Health Access Centre Circle of Care program (source: https://soahac.on.ca/intake/)

Importance of Cultural Safety, Cultural Competence, and Role of Community

A full spectrum of culturally safe and culturally competent services is necessary to support Indigenous healthcare. This includes services in health promotion, prevention, community development, and education (8, 9-11). Access to early identification and intervention services, crisis response services, trauma informed emergency care, and coordinated care between different services is also essential. While not all of these services may be available in every community, all communities should have access to key services within reasonable limits through proper communication and comprehensive planning (9, 12-13). It is vitally important that leadership from Indigenous youth, community leaders, and Elders must be at the forefront of planning and development strategies for Indigenous health and wellness (14-15). As every single Indigenous community is unique and cannot be generalized under one model, it is imperative that health services are developed and tailored to fit the community that it aims to serve. Community development, ownership, control and capacity strengthening all have to be taken into account with regards to Indigenous health and wellness. In order to best serve a community, it is important to derive principles and areas of priority from members of the community themselves and center the culture and values of the community in local programs and infrastructure. This helps in ensuring that the health services are relevant, effective, and meet community needs (10-11).

It is essential that Indigenous communities are able to access a full spectrum of culturally competent supports and services, and that those services are part of a quality care system that centers Indigenous culture and values. Provincial, territorial, and federal governments and other key partners will need to collaborate and provide

equitable funding in order to provide the needed support for education, research, and health care services (16-17). It also requires support for continuous quality and performance measurement, Indigenous-centered governance, and culturally competent workforce development. Enhancing and supporting Indigenous health and wellness will require strategic action and planning within government services, Indigenous communities, and services across health, justice, employment, and social service sectors (14).

Conclusion

Achieving a culturally competent system that supports Indigenous wellness through the provision of culturally safe patient intake and navigation systems will require sustained commitment and collaboration, as well as effective leadership that centers Indigenous leaders across the system within agencies, families, and communities. Furthermore, Indigenous indicators related to patient intake and navigation must be tracked and measured in order to monitor progress and detect where additional resources are required to achieve the goal of providing accessible, comprehensive, culturally relevant, and culturally safe health services to Indigenous communities. However, increasing access to navigation or intake services is not sufficient as Indigenous health begins within the family and in the connection with community and culture (12). Therefore, culturally grounded community development and capacity strengthening is required to support physical overall wellbeing from the grassroots level, as well as reduce risk factors and increase protective factors (13). In addition to comprehensive, coordinated, high quality, culturally responsive health and wellness programs and services for Indigenous communities, the development and implementation of culturally safe Indigenous patient intake programs will require the sustained commitment and collaboration of many federal, provincial, and territorial partners supported by strong Indigenous-centered leadership and equitable funding (17).

References

1. Whop, L. J., Valery, P. C., Beesley, V. L., Moore, S. P., Lokuge, K., Jacka, C., & Garvey, G. (2012). Navigating the cancer journey: a review of patient navigator programs for Indigenous cancer patients. Asia-Pacific Journal of Clinical Oncology, 8(4), e89-e96.
2. Freeman HP. Patient navigation: a community based strategy to reduce cancer disparities. J Urban Health 2006; 83, 139–41.
3. Burhansstipanov, L., Wound, D.B., Capelouto, N. et al. (1998). Culturally relevant “navigator” patient support. the Native Sisters. Cancer Pract 6, 191– 4.
4. Kanekar, S., & Petereit, D. (2009). Walking forward: a program designed to lower cancer mortality rates among American Indians in western South Dakota. South

Dakota Medicine: The Journal of the South Dakota State Medical Association, 62(4), 151.
5. Grimes, C., Dankovchik, J., Cahn, M., & Warren-mears, V. (2017). American Indian and Alaska Native Cancer Patients' Perceptions of a Culturally Specific Patient Navigator Program. Journal of Primary Prevention, 38(1-2), 121.
6. Bernardes, C. M., Martin, J., Cole, P., Kitchener, T., Cowburn, G., Garvey, G., ... & Valery, P. C. (2018). Lessons learned from a pilot study of an Indigenous patient navigator intervention in Queensland, Australia. European journal of cancer care, 27(1), e12714.
7. Guadagnolo, B. A., Boylan, A., Sargent, M., Koop, D., Brunette, D., Kanekar, S., ... & Petereit, D. G. (2011). Patient navigation for American Indians undergoing cancer treatment: utilization and impact on care delivery in a regional healthcare center. Cancer, 117(12), 2754-2761.
8. Nixon, L. M. (2013). Coordinating First Nations health care: Policy and implementation challenges and opportunities.
9. Canadian Institute for Health Information, ed., (2009). Mentally Healthy Communities: Aboriginal Perspectives. Ottawa: CIHI
10. O'Brien, A. P., Boddy, J. M., Hardy, D. J., & O'Brien, A. J. (2004). Clinical indicators as measures of mental health nursing standards of practice in New Zealand. International Journal of Mental Health Nursing, 13(2), 78-88.
11. Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. International Journal of Health Promotion and Education, 46(2), 49-56.
12. Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for First Nations youth. The journal of primary prevention, 38(1-2), 67-86.
13. Day, A., & Francisco, A. (2013). Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. Australian and New Zealand journal of public health, 37(4), 350-355.
14. Durie, M. (2011). Indigenous mental health 2035: Future takers, future makers and transformational potential. Australasian Psychiatry, 19(1_suppl), S8-S11.
15. MacMillan, H. L., Jamieson, E., Walsh, C. A., Wong, M. Y. Y., Faries, E. J., McCue, H., ... & Offord, D. D. R. (2008). First Nations women's mental health: results from an Ontario survey. Archives of Women's Mental Health, 11(2), 109-115.
16. Novins, D., LeMaster, P., Thurman, P. J., & Plested, B. (2004). Describing Community Needs: Examples From the Circles of Care Initiaive. American Indian and Alaska Native Mental Health Research The Journal of the National Center, 11(2), 42-58.
17. Health Canada. (2015). First nations mental wellness continuum framework.

Indigenous Peoples and Coordinated Discharge

1. Introduction

Early and avoidable hospital readmissions have been recognized as a common and costly occurrence among Indigenous patients. Provision and delivery of culturally competent and safe healthcare services for Indigenous patients with regards to coordinated and comprehensive discharge is an area of significant concern for many Indigenous communities. While some health systems have made attempts to address factors related to the gaps in coordinated discharge for Indigenous peoples in Canada, there continue to be persistent disparities and issues associated with service delivery and accessibility. Indigenous communities and leadership have been calling for the development of a coordinated, comprehensive approach to hospital discharge in order to prevent avoidable hospital readmission (1).

This rapid review sought to identify needs and components of coordinated discharge from the perspective of Indigenous communities, and how successful hospital discharge is conceptualized from the Indigenous lens. Existing models, frameworks, and approaches were searched in the literature in Canada, USA, Australia, and New Zealand.

2. Key Terms and Definitions

Term	Definition
Systemic Racism	"Systemic racism occurs when institutions or systems create or maintain racial inequity often as a result of hidden institutional biases in policies, practices, and procedures that privilege some groups and disadvantage others" Source: Anti-Racism Directorate (2022). Data Standards for the Identification and Monitoring of Systemic Racism. Government of Ontario. Available at: https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism
Cultural Competency	Cultural competency refers to "people development (ability of the practitioner to take knowledge, lessons and experiences about culture learned over time either through their own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient."

	Source: Indigenous Primary Health Care Council. (2018). Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. Available at: https://www.iphcc.ca/wp-content/uploads/2020/02/Cultural-Competency-Guideline-Report-June-2018.pdf
Cultural safety	"Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care." Source: First Nations Health Authority (2016). Creating a climate for change: Cultural safety and humility resource booklet. Available at: https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf
Epigenetics	"Epigenetics is the study of how your behaviors and environment can cause changes that affect the way your genes work. Unlike genetic changes, epigenetic changes are reversible and do not change your DNA sequence, but they can change how your body reads a DNA sequence." Source: Centers for Disease Control and Prevention (2022). What is Epigenetics? Available at: https://www.cdc.gov/genomics/disease/epigenetics.htm
Comorbidities	Comorbidity is "a disease or condition that coexists with but often is independent of another disease or condition." Source: Britannica (2023). Comorbidity (medicine). Available at: https://www.britannica.com/science/comorbidity
Subsistence	"Subsistence is generally thought to relate to the activities through which food is acquired, processed, prepared, and consumed (i.e., what people eat, how they produce or acquire it, and whether those activities emphasize hunting, gathering, and fishing or horticulture and agriculture" Source: Burnette, C. E., Clark, C. B., & Rodning, C. B. (2018). "Living off the Land": How Subsistence Promotes Well-Being and Resilience among Indigenous Peoples of the Southeastern United States. The Social Service Review, 92(3), 369–400. https://doi.org/10.1086/699287
Medication Reconciliation	"Medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions."

	Source: Barnsteiner, J.H. (2008). Medication Reconciliation. In: Hughes, R.G., editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); Chapter 38. Available from: https://www.ncbi.nlm.nih.gov/books/NBK2648/

3. Literature Review Search Strategy

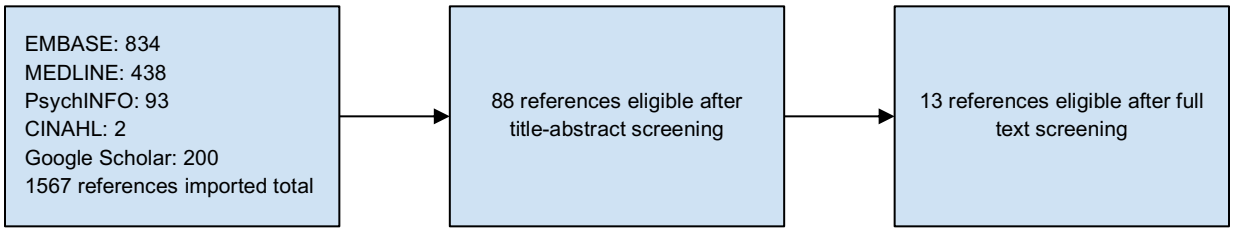
The search terms utilized were the following. The search strings were combined using "AND" operators.

i) "approach" or "framework" or "model" or "models, theoretical" or "health system*" or "health polic*" or "ways of knowing" or "health belief" or "health model" or "understanding" or "perspectives"

ii) "Indigenous health" or "Indigenous Canadians" or "indigenous" or "Health Services, Indigenous" or "Indigenous Peoples" or "Inuits" or "Indians, North American" or "Metis" or "Native American" or "American Natives" or "Alaskan Natives" or "Maori"

iii) "Patient Discharge" or "Patient Readmission" or "Postoperative Complications" or "Coordinated Discharge" or "Hospital Transition Support Services" or "Hospital Discharge" or "Hospital Experience" or "Health Facility Administration" or "Hospitals" or "Hospitalization" or Health Services Administration" or "Health Care Quality, Access and Evaluation" or "Discharge planning" or "Health service intervention" or "Readmission prevention" or "Transitional care"

The databases searched were: MEDLINE, EMBASE, PsychINFO, CINAHL, as well as Google Scholar.



4. Rapid Review of Literature

Indigenous Conceptualization of Health

Indigenous communities conceptualize individual health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic

wellbeing. Indicators of Indigenous health should therefore reflect this complexity through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing (1). Indigenous health is supported by the relationships within families and the larger community, as well as deep connections with culture, language, Elders, and Earth, and is required for healthy functioning of individual and community life. Wellbeing and health are therefore a balance of several spheres within life: the mental, physical, spiritual, and emotional. Despite the impacts of historical and present-day attempts at colonization, Indigenous peoples and communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience (1,2).

Indigenous Health Risks and Inequities Surrounding Hospital Discharge

The existing literature outlines that Indigenous peoples, especially those who are older in age and at risk for hospital admission, are at high risk for poorer health outcomes as a result of historical and structural factors. These factors include the epigenetic and intergenerational trauma inflicted by colonization, residential schools, and the ongoing racism, violence, and health inequity faced by Indigenous communities today. Furthermore, traditional subsistence activities have been disrupted due to environmental degradation by settler governments and corporate organizations, the dispossession of land, and the relocation to urban communities for many Indigenous peoples (3,4). This disruption has resulted in higher levels of sedentary behaviour and poorer access to healthier and traditional diet choices for Indigenous peoples. Indigenous peoples are more likely to have risk factors for chronic disease, have multiple comorbidities, and be readmitted to hospital for avoidable medical complications (5). As a result, Indigenous groups in Canada have a lower life expectancy compared to the rest of the population (6).

The literature on coordinated discharge and preventing hospital readmission for Indigenous populations is very sparse. Most studies in the literature have focused on short-term outcomes, including hospital survival, until discharge from hospital. While Indigenous patients admitted to the hospital in either the general inpatient ward or in the intensive care unit (ICU) tend to be of lower age compared to the rest of the population, their burdens of chronic metabolic, renal, and hepatic disease on admission are greater than non-Indigenous patients; they are also more frequently admitted as emergency cases following trauma, sepsis, or exacerbation of chronic diseases (7-9). It is known that rigorous and detailed follow-up of Indigenous patients recovering from critical illness, especially those recently discharged from hospital, is essential to ensuring that patients are connected with the right services post-discharge; it is a key component of preventing hospital readmission for avoidable medical complications (7-9).

Post-discharge mortality is higher in Indigenous patients, due to several factors including higher levels of chronic disease and inequitable access to timely healthcare services. Another notable factor is earlier discharge from hospital by way of self-discharge. Self-discharge rates for Indigenous hospital patients are the highest in the world and have been linked in the literature to discriminatory practices within the hospital environment and systemic racism within healthcare, leading to inequity, discomfort, and differences in care experienced by Indigenous patients. Experiences of personal and cultural isolation, poor communication by healthcare professionals and racist and discriminatory practices in healthcare services have been stated in several studies (10, 11). These findings highlight how pivotal an episode of hospitalization can be for Indigenous people, and how health outcomes and mortality risk are affected even after discharge from the hospital. The difference in long-term mortality shows how important it is for patients to access timely follow-up care after discharge from hospital (10).

Evidence-based Interventions to Improve Hospital Discharge

In the literature, there are many programs that have been developed in order to improve the process of hospital discharge and prevent avoidable readmissions. Tested interventions are effective at reducing readmissions, and the most effective interventions are complex and support patient capacity for self-care and capacity after discharge (12). One example of a successful care transition model is Project Re-Engineered Discharge (RED), created by researchers at Boston Medical Center to reduce readmissions by preparing patients for the transition from hospital to home (13).

RED consisted of the following 12 components (13):
“1. Ascertain need for and obtain language assistance.
2. Make appointments for follow-up care (e.g., medical appointments and post-discharge tests/labs).
3. Plan for the follow-up of results from lab tests or labs that are pending at discharge.
4. Organize post-discharge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis and medicines.
9. Review with the patient what to do if a problem arises.
10. Assess the degree of the patient's understanding of the discharge plan.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.

12. Provide telephone reinforcement of the discharge plan."

Project RED focused on key aspects of the discharge process, including patient education, medication reconciliation, communication with and among health professionals, and follow-up care. Supportive and engaged leadership, a multi-disciplinary implementation team, an appropriately adapted roll-out strategy and a hospital culture that empowered the program were all needed for RED to be sustainably integrated into hospital protocol, as shown in Figure 1 (13-15). The RED program was designed to be carried out by specific "Discharge Educators," which were either existing staff trained to carry out the Discharge Educator duties, or staff members who were newly hired in order to fulfill the duties of the role. The goal of the Discharge Educator is to educate and advocate for patients in order to prepare them and their support network for success following discharge; this is done by ensuring that all of the steps of the RED program are followed and that all multidisciplinary medical teams involved in the patient's care are informed about what happened during the hospital stay and what needs to be done in order to ensure a safe transition back home.

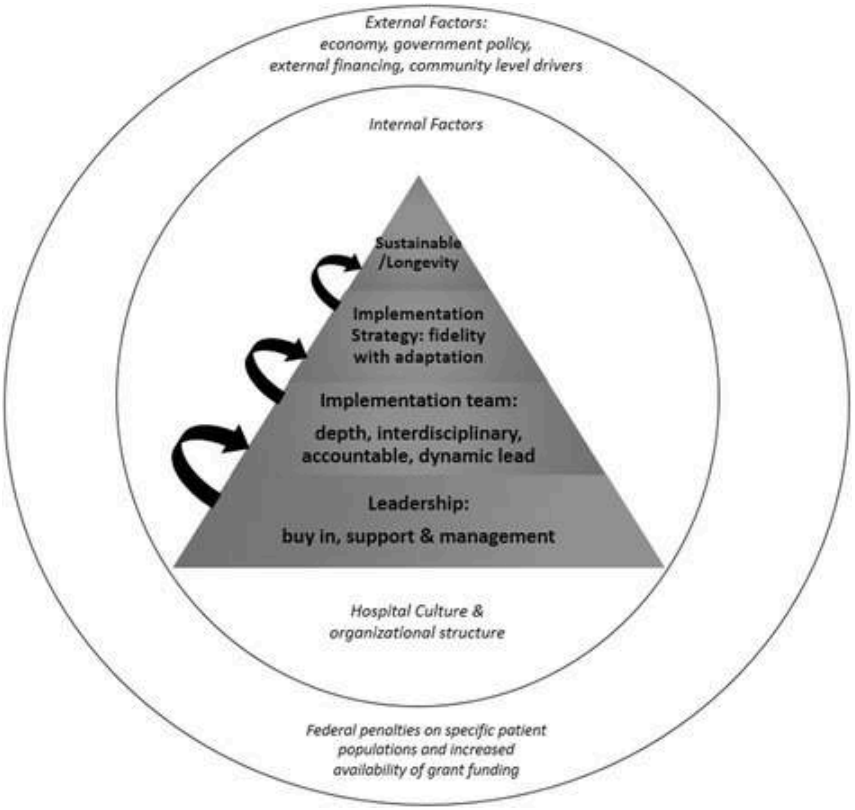


Figure 1: Schematic profile of the components needed for sustainable implementation of Project Re-Engineered Discharge (RED) (13)

Overall, in the literature, the following factors were identified as components of a successful and coordinated discharge plan for patients:

Factors that can help improve coordinated discharge identified from the literature (12-19):

Administrative Tasks

- Designate a central person or team in charge of discharge planning (e.g., Discharge educator) who can lead the discharge planning process
- Develop an individualized discharge plan for patient prior to leaving hospital, and review the discharge plan with the patient directly
- Find out about preferred languages for all forms of communication and arrange for language assistance as needed
- With regards to the results of tests or labs that are still pending, discuss and determine who will review the results and when and how the patient will receive this information
- Document all contact information for medical equipment companies and at-home services for the patient in their discharge plan
- Collaborate with the medical team and case managers to arrange necessary at-home services
- Review all medication lists with the patient and pharmacy, including inpatient medication list, the outpatient medication list, and the outpatient pharmacy list, as well as what the patient reports taking. Ensure a realistic plan for obtaining medications is in place for after the patient leaves the hospital.
- Sending out the discharge summary and care plan to clinicians accepting care of the patient within 24 hours of discharge

Barriers and Facilitators

- Identify any service gaps and address gaps by arranging for appropriate services (e.g., diabetic education, outpatient physiotherapy)
- Identify barriers to the discharge plan and strategies to overcome these barriers (e.g., transportation issues, cost of medications, anticipated medication side effects)

Patient Preferences and Education

- Determine primary care, sub-specialty, social support, and other follow up needs in order to make appointments based on patient preferences, and confirm that the patient knows where to go and has a plan about how to get to appointments
- Inquire about traditional healers and healing practices, and arrange for these services according to patient preferences
- Educate the patient and their family/support network on all aspects of the discharge plan and their medical needs, including the primary diagnosis, comorbidities, medications, follow-up care, what to watch out for/red flags, as well as any questions/concerns that the patient may have

- Calling the patient within 3 days of discharge to reinforce the discharge plan and help with problem solving and any issues that may have come up
- Ensuring that there is a discharge help line that is available for patients and family to call if they have any questions about the care plan, hospitalization, or follow up plan in order to help patients transition from hospital care to outpatient care setting smoothly
- Provision of a personalized guide/booklet known as the “After Hospital Care Plan” (*components of this care plan listed below) for patients to take with them when they leave the hospital. It is important to go through this plan before discharge and teach it in a way that enables patients and their support networks to understand what to do and what to expect once they go home.

Components of the After Hospital Care Plan for patients to take home (13):

Administrative Tasks

- A personalized cover page with the patient's name, date of discharge, name of hospital, and name and phone numbers of the people to contact with questions
- Updated list of all medications with appropriate doses and dosing schedule information.
- A list of medication-related allergies.
- A list of upcoming appointments for the next 30 days, with the location of appointments and numbers to call if the patient needs to reschedule.
- A diagnosis information page.
- A list of outstanding test results (when applicable).
- A list of medical equipment the patient has or needs to obtain or have delivered to his or her home (when applicable). This includes contact information of the company providing equipment, when it will be delivered, and whom to call if the equipment is not delivered or if there are malfunctions.

Patient Preferences and Future Recommendations

- A patient activation page for the patient to record questions, concerns, and symptoms to be discussed at the follow-up clinician appointment.
- The patient's advance directives for his or her end-of-life care.
- Recommendations for diet modifications (when applicable).
- Recommendations for exercise or physical activity limitations (when applicable).

Conclusion

The literature suggests that a coordinated discharge plan tailored to the individual patient brings about a reduction in length of hospital stay and helps to prevent avoidable readmission. Specific interventions and programs designed to achieve this goal include factors such as a formal assessment for patient risk factors, patient education, medication reconciliation with pharmacy, discussion and dissemination regarding discharge care plans and post discharge follow-up including telephonic review, home

visits and timely review with a primary care provider. Having a dedicated discharge team or staff member to coordinate and lead this process has been highlighted as an important contributor to the success of such programs (13,17-18). Many hospitals are already making a significant investment in attempting to reduce the length of inpatient stays and prevent avoidable hospital readmission through Indigenous patient navigator programs, designated discharge planning staff, and follow-up support programs. Connecting patients to follow-up care post-discharge, as well as services such as pharmacy, addiction services, social work, mental health, rehabilitation and palliative care services, can all assist in preventing hospital readmission and improving wellbeing once back home in the community. While such services are variably available to all patients, the need is even greater for Indigenous patients, who already face limited access to health care, and are more likely to face issues relating to a greater burden of comorbidity, sociocultural barriers, and economic and environmental limitations (19).

References

1. Prince, H., Nadin, S., Crow, M., Maki, L., Monture, L., Smith, J., & Kelley, M. L. (2019). “If you understand you cope better with it”: the role of education in building palliative care capacity in four First Nations communities in Canada. BMC public health, 19(1), 1-18.
2. Shahid, S., Taylor, E. V., Cheetham, S., Woods, J. A., Aoun, S. M., & Thompson, S. C. (2018). Key features of palliative care service delivery to Indigenous peoples in Australia, New Zealand, Canada and the United States: a comprehensive review. BMC palliative care, 17(1), 1-20.
3. Pace, J. E., & Grenier, A. (2017). Expanding the circle of knowledge: Reconceptualizing successful aging among North American older Indigenous peoples. Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 72(2), 248-258.
4. Pace J . (2013). Meanings of memory: Understanding aging and dementia in First Nations communities on Manitoulin Island, Ontario (Unpublished doctoral dissertation). McMaster University, Hamilton, Canada.
5. Wilson K. Rosenberg M. W. Abonyi S. , & Lovelace R . (2010). Aging and health: An examination of differences between older Aboriginal and non-Aboriginal people. Canadian Journal on Aging, 29, 369–382. doi:10.1017/S0714980810000309
6. Statistics Canada . (2015). Projected life expectancy at birth by sex and Indigenous Identity, Canada, 2017. Retrieved from http://www.statcan.gc.ca/pub/89-645-x/2010001/c-g/c-g013-eng.htm
7. Trout MI, Henson G, Senthuran S. Characteristics and outcomes of critically ill Aboriginal and/or Torres Strait Islander patients in North Queensland. Anaesth. Intensive Care 2015; 43: 216–223.
8. Ho KM, Finn J, Dobb GJ, Webb SAR. The outcome of critically ill Indigenous patients. Med J Aust 2006; 184: 496–499.

https://www.mja.com.au/journal/2006/184/10/outcome-critically-ill-indigenous-patients.
9. Magee F, Wilson A, Bailey MJ, et al. Trauma-related admissions to intensive care units in Australia: the influence of Indigenous status on outcomes. Med J Aust 2019; 210: 493–498. https://www.mja.com.au/journal/2019/210/11/trauma-related-admissions-intensive-care-units-australia-influence-indigenous.
10. Mitchell, W. G., Deane, A., Brown, A., Bihari, S., Wong, H., Ramadoss, R., & Finnis, M. (2020). Long term outcomes for Aboriginal and Torres Strait Islander Australians after hospital intensive care. Medical Journal of Australia, 213(1), 16-21.
11. Wilson, D., & Barton, P. (2012). Indigenous hospital experiences: A New Zealand case study. Journal of clinical nursing, 21(15-16), 2316-2326.
12. Leppin, A. L., Gionfriddo, M. R., Kessler, M., Brito, J. P., Mair, F. S., Gallacher, K., ... & Montori, V. M. (2014). Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. JAMA internal medicine, 174(7), 1095-1107.
13. Re-Engineered Discharge (RED) Toolkit. Content last reviewed February 2020. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
14. Mitchell, S. E., Weigel, G. M., Laurens, V., Martin, J., & Jack, B. W. (2017). Implementation and adaptation of the re-engineered discharge (RED) in five California hospitals: a qualitative research study. BMC health services research, 17(1), 1-14.
15. Adams, C. J., Stephens, K., Whiteman, K., Kersteen, H., & Katruska, J. (2014). Implementation of the Re-Engineered Discharge (RED) toolkit to decrease all-cause readmission rates at a rural community hospital. Quality Management in Healthcare, 23(3), 169-177.
16. Mitchell, S. E., Martin, J., Holmes, S., van Deusen Lukas, C., Cancino, R., Paasche-Orlow, M., ... & Jack, B. (2016). How hospitals reengineer their discharge processes to reduce readmissions. Journal for healthcare quality: official publication of the National Association for Healthcare Quality, 38(2), 116.
17. Jenq, G. Y., Doyle, M. M., Belton, B. M., Herrin, J., & Horwitz, L. I. (2016). Quasi-experimental evaluation of the effectiveness of a large-scale readmission reduction program. JAMA internal medicine, 176(5), 681-690.
18. Kash, B. A., Baek, J., Davis, E., Champagne-Langabeer, T., & Langabeer II, J. R. (2017). Review of successful hospital readmission reduction strategies and the role of health information exchange. International journal of medical informatics, 104, 97-104.
19. Diplock, G., Ward, J., Stewart, S., Scuffham, P., Stewart, P., Reeve, C., ... & Maguire, G. (2017). The alice springs hospital readmission prevention project (ashrapp): a randomised control trial. BMC health services research, 17(1), 1-11.

Indigenous Peoples and Mental Health

1. Introduction

Mental health and mental wellness are areas of significant concern for many Indigenous communities. Federal, provincial, and territorial mental health services have sought to address factors related to mental health in many Indigenous communities; however there are significant issues and gaps associated with service delivery and accessibility. Indigenous communities and leadership have been calling for the development of a coordinated, comprehensive approach to mental health and addictions programming. This rapid review sought to identify mental health indicators from the perspective of Indigenous communities, and how mental health and wellbeing is conceptualized from the Indigenous lens.

2. Key Terms and Definitions

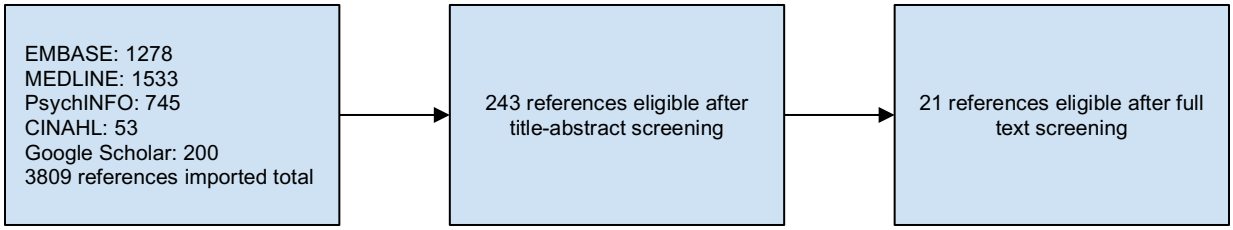
Term	Definition
Systemic Racism	"Systemic racism occurs when institutions or systems create or maintain racial inequity often as a result of hidden institutional biases in policies, practices, and procedures that privilege some groups and disadvantage others" Source: Anti-Racism Directorate (2022). Data Standards for the Identification and Monitoring of Systemic Racism. Government of Ontario. Available at: https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism
Cultural Competency	Cultural competency refers to "people development (ability of the practitioner to take knowledge, lessons and experiences about culture learned over time either through their own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient." Source: Indigenous Primary Health Care Council. (2018). Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. Available at: https://www.iphcc.ca/wp-content/uploads/2020/02/Cultural-Competency-Guideline-Report-June-2018.pdf

Cultural safety	"Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care." Source: First Nations Health Authority (2016). Creating a climate for change: Cultural safety and humility resource booklet. Available at: https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf
Mental Health	"Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood." Source: Substance Abuse and Mental Health Services Administration (2023). What is mental health? Available at: https://www.samhsa.gov/mental-health
Mental Wellness	"Mental wellness comes from feeling balanced, connected to others and ready to meet life's challenges." Source: HealthLinkBC (2021). Well-being. Available at: https://www.healthlinkbc.ca/mental-health-substance-use/well-being
First Nations Mental Wellness Continuum	"The First Nations Mental Wellness Continuum (FNMWC) is a national framework that addresses mental wellness among First Nations in Canada. It identifies ways to enhance service coordination among various systems and supports culturally safe delivery of services." Source: https://thunderbirdpf.org/fnmwc/
Health Promotion	"Health promotion enables people to increase control over their own health. It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure." Source: World Health Organization (2016). Health promotion. Available at: https://www.who.int/news-room/questions-and-answers/item/health-promotion

Capacity Building	"The World Health Organization (WHO) defines capacity building as the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion." Source: Public Health Ontario (2018). Creating capacity building interventions that work. Available at: https://www.publichealthontario.ca/en/About/News/2018/Capacity-building-interventions
Capacity Strengthening	"Capacity strengthening is based on a strengths-based perspective that all people have knowledge and skills, all people can improve … at the same time all people need to learn in order to engage in different activities which contribute to their wellbeing and prosperity" Source: Tsey, K., McCalman, J., Bainbridge, R., & Brown, C. (2012). Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 10. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Available at: https://www.aihw.gov.au/getmedia/04fa3771-33c4-448b-b82e-3dce26c4cd97/ctgc-rs10.pdf.aspx?inline=true

3. Literature Review Search Strategy

The search terms utilized were the following. The search strings were combined using "AND" operators.
i) Cultural Competency, Cultural Diversity, Evaluation, Evaluation Study, Indicators, Health Assessment, Health Priorities, Delivery of Health Care
ii) Indigenous Health, Indigenous Health Services, Indigenous Canadians, Indigenous Health Services, Indigenous Peoples, Aboriginal, Inuit, Eskimo, First Nations, Indigenous, Metis, American Indian, North American Indian, Native American, American Natives, Alaskan Native, Maori
iii) Mental Health, Mental Health Services, Indigenous mental health
The databases searched were: MEDLINE, EMBASE, PsychINFO, CINAHL, as well as Google Scholar.



4. Summary of Literature

Indigenous Conceptualization of Health and Mental Health Care Needs

Indigenous communities conceptualize individual health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing (1). Indicators of Indigenous mental health should therefore reflect this complexity through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing. Indigenous mental health is supported by the relationships within families and the larger community, as well as deep connections with culture, language, Elders, and Earth, and is required for healthy functioning of individual and community life (1). Mental health is therefore a balance of several spheres within life: the mental, physical, spiritual, and emotional. Despite the impacts of historical and present-day attempts at colonization, many Indigenous communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience (1-4).

A full spectrum of culturally safe and culturally competent services is necessary to support Indigenous mental wellness. This includes services in health promotion, prevention, community development, and education (4-5). Access to early identification and intervention services, crisis response services, trauma-informed emergency care, and coordinated care between different services is also essential. While not all of these services may be available in every community, all communities should have access to key services within reasonable limits through proper communication and comprehensive planning (1, 4-5).

Indigenous Priorities for Mental Health

The key overarching themes that emerged from the literature as priorities for mental health in Indigenous communities were connection to Indigenous culture and community; valuing and centering Indigenous knowledge, language, and culture at the forefront of all initiatives; community development, ownership, and capacity strengthening; culturally responsive and safe care and competency service delivery; effective collaboration with mental health service partners and organizations at the community, regional, provincial, territorial, federal, and national level (6). It is vitally important that leadership from Indigenous youth, community leaders, and Elders must be at the forefront of planning and development strategies for Indigenous mental health and wellness (6-7). As every single Indigenous community is unique and cannot be generalized under one model, it is imperative that mental health services are developed and tailored to fit the community that it aims to serve. Community development, ownership, control, and capacity strengthening all have to be taken into account with regards to Indigenous mental health and wellness. In order to best serve a community,

it is important to derive principles and areas of priority from members of the community themselves and center the culture and values of the community in local programs and infrastructure. This helps in ensuring that the mental health services are relevant, effective, and meet community needs (3,8).

Mental Health Indicators

Mental health and wellness is difficult to measure through statistics as it is a concept that is closely intertwined with social connection, community, culture, ecological health, and spiritual wellbeing. Despite this, some papers noted certain statistics as potential indicators of mental wellness within Indigenous communities, namely: overall life expectancy, level of Indigenous participation within community and health sector services, overall population growth, percentage of population under age 22, number of community support organizations, number of speakers of traditional languages, number of networks of traditional healers, high school graduation rates, level of adequate housing, food insecurity rates, unemployment and poverty rates, arrest, accident or substance abuse rates, rates of suicide and related-behaviors, juvenile delinquency rates, rates of domestic violence, child abuse/neglect, foster care placements, teenage pregnancy, infant mortality, alcohol abuse, depression, domestic violence, and number of single parent families (3-4, 9-10). However, these factors cannot be generalized to all Indigenous communities. Overall, several papers noted that the mental health of Indigenous communities is poorly studied and described, and the priorities, culture, and perspectives of one community cannot be applied to all (10-12).

Government Supports and Frameworks

It is essential that Indigenous communities are able to access a full spectrum of culturally competent supports and services, and that those services are part of a quality care system that centers Indigenous culture and values. Provincial, territorial, and federal governments and other key partners will need to collaborate and provide equitable funding in order to provide the needed support for education, research and health care services (1, 13). Support is also required for continuous quality and performance measurement, Indigenous-centered governance, and culturally competent workforce development. Enhancing and supporting Indigenous mental health and wellness will require strategic action and planning within government services, Indigenous communities, and services across health, justice, employment, and social service sectors (6).

In 2015, Health Canada and the Assembly of First Nations published a mental wellness continuum framework for Indigenous communities in Canada (13). This model, entitled

the First Nations Mental Wellness Continuum, is a complex model, rooted in culture and composed of several layers and elements foundational to supporting Indigenous mental wellness (Figure 1). Embedded within the model are the key themes that emerged through dialogue with partners as well as the social determinants of health that are critical to supporting and maintaining mental wellness for Indigenous peoples. The continuum model must be supported by a full spectrum of culturally competent and safe supports and services. This continuum includes: Health Promotion, Prevention, Community Development, and Education; Early Identification and Intervention; Crisis Response; Coordination of Care and Care Planning; Detox; Trauma-Informed Treatment; Support and Aftercare. During regional discussion sessions, the National Gathering, the federal discussion, and the National Validation and Implementation Session, several key themes emerged that have shaped the Framework and the Continuum (13). These themes are: Culture as Foundation, Community Development, Ownership, and Capacity Building, Quality Care System and Competent Service Delivery, Collaboration with Partners, and Enhanced Flexible Funding. Overall, the model showcases that Indigenous mental wellness is a balance of the mental, physical, spiritual, and emotional. This balance is enriched as individuals have: purpose in their daily lives whether it is through education, employment, care-giving activities, or cultural ways of being and doing; hope for their future and those of their families that is grounded in a sense of identity, unique Indigenous values, and having a belief in spirit; a sense of belonging and connectedness within their families, to community, and to culture; and finally a sense of meaning and an understanding of how their lives and those of their families and communities are part of creation and a rich history (13). The framework includes a number of elements that support the health system which include governance, research, workforce development, change and risk management, self-determination, and performance measurement. Service integration among federal, provincial, and territorial programs is central to its success. It also identifies a continuum of services needed to promote mental wellness and provides advice on policy and program changes that will enhance First Nations mental wellness outcomes. This enables communities to adapt, optimize, and realign their mental wellness programs and services based on their own priorities.

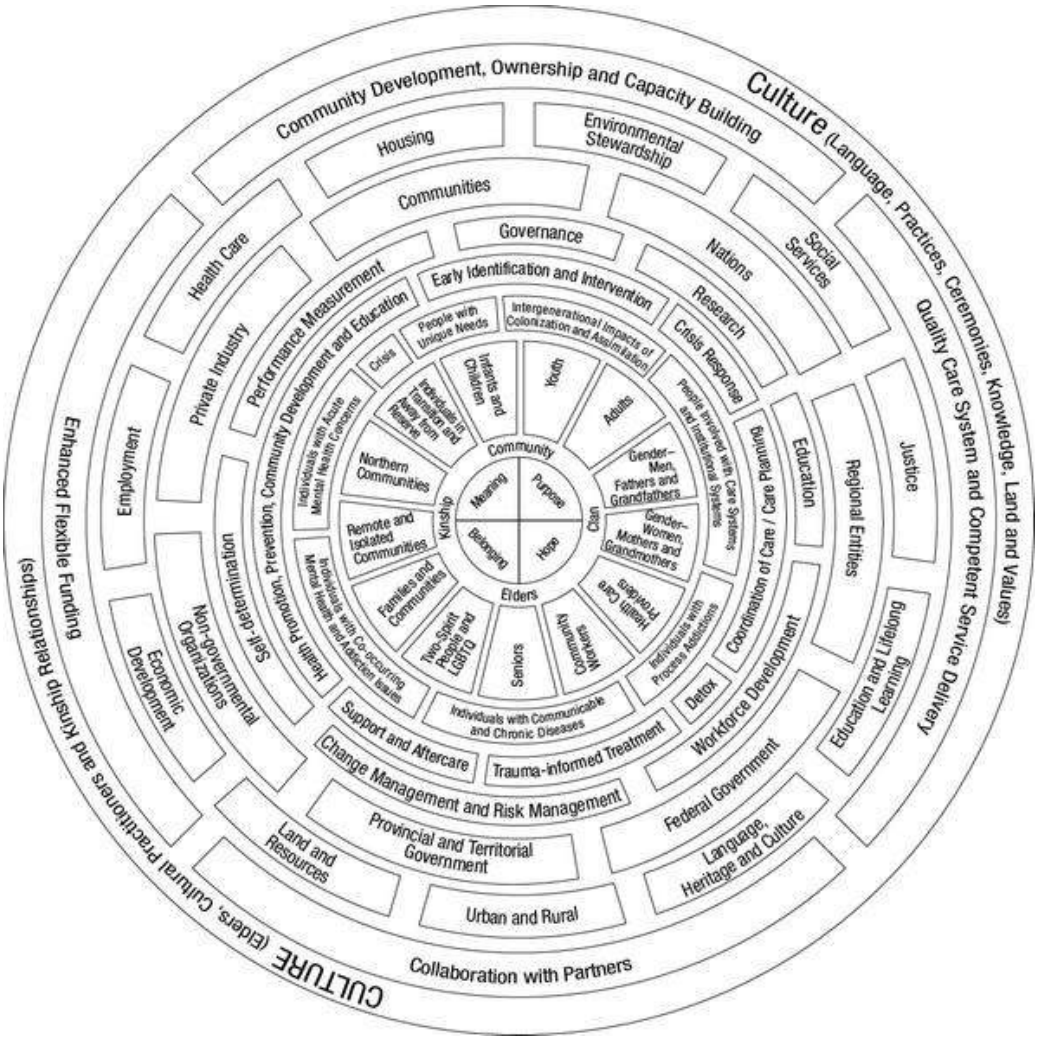


Figure 1: First Nations Mental Wellness Continuum, published by Health Canada and the Assembly of First Nations (13)

A similar effort was undertaken by the First Nations Health Authority of BC in 2015 with the development of their visual model for Indigenous health and wellness (14). It aims to create a shared understanding of a holistic vision of wellness. They stated that the model is only a snapshot of a fluid concept of wellness, and that it can and should be adapted and customized freely to fit the needs of the population and is not confined to remain the same. It was developed from feedback and ideas gathered from Indigenous community members of British Columbia (14). The Centre Circle represents individual human beings, as wellness begins with individuals taking responsibility for our own health and wellness. The Second Circle illustrates the importance of Mental, Emotional, Spiritual, and Physical facets of a healthy, well and balanced life. It is critically important that there is balance between these aspects of wellness and that they are all nurtured together to create a holistic level of wellbeing in which all four areas are strong and healthy. The Third Circle represents the overarching values that support and uphold

wellness: Respect, Wisdom, Responsibility and Relationships. Respect is about honouring Indigenous cultures, traditions, and communities. It is intergenerational and passed on through communities and families, through consideration and appreciation of others. Wisdom includes the knowledge of language, traditions, culture, and medicine. Like Respect, it is also passed on by Ancestors from generation to generation. Responsibility is the shared duty to ourselves, families, communities, and the land. It represents the roles that people play within families, work, and experiences within the world. Relationships represent connections between people, families, communities, and the land. Like responsibilities, relationships involve mutual accountability and reciprocity. They require togetherness, team-building, capacity-strengthening, sharing, strength, and love. The Fourth Circle depicts the people that surround us and the places from which people come. Land, Community, Family and Nations are all critical components of a healthy experience as human beings and are part of the Indigenous approach to mental health and overall wellness (14).

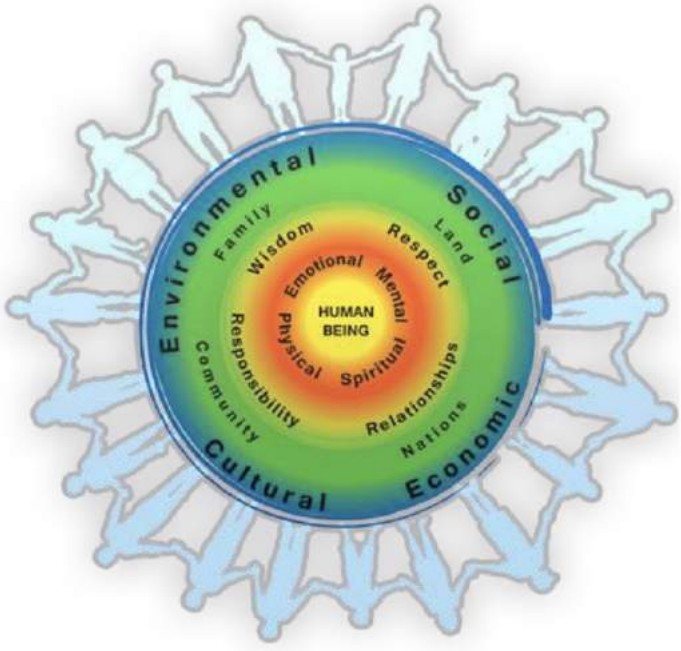


Figure 2: Holistic Wellness Model, published by the First Nations Health Authority of British Columbia (14)

Conclusion

Overall, it is clear from the literature that Indigenous mental health is not a sector of wellness that can be addressed individually, as it is intricately and irrevocably interwoven with physical health, spirituality, culture, healing, community, and connection

to the land. This is a major difference between Indigenous conceptualization of mental health and the way it is usually approached in 'Western' medicine. Indigenous wellness is centered around balance between physical, emotional, mental, and spiritual components. Indigenous knowledge, culture, and identity are all also considered vital, through connections with community and relationship to the land. This is conceptualized in the model shown in Figure 3 below, published by Stewart in 2008 (3).

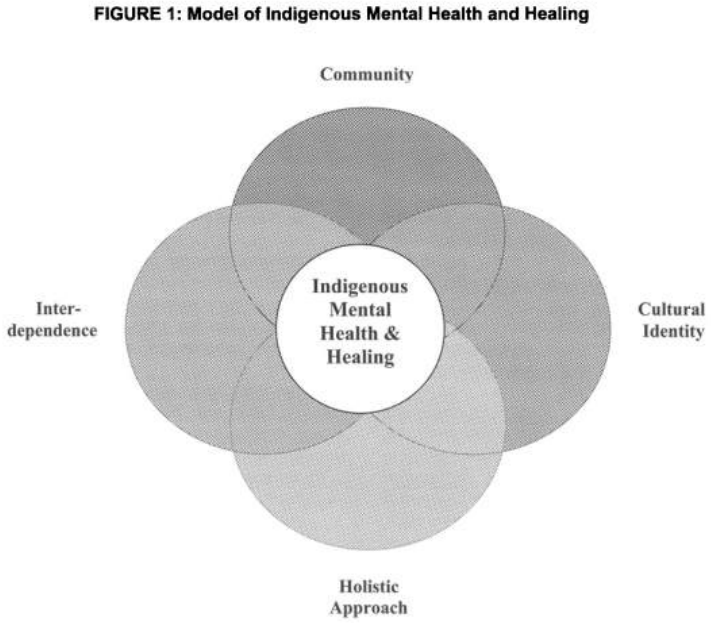


Figure 3: Model of Indigenous Mental Health and Healing, published by Stewart (3)

Achieving a culturally competent and safe system that supports Indigenous mental wellness will require sustained commitment and collaboration, as well as effective leadership that centers the Indigenous leaders across the system within agencies, families, and communities. Furthermore, Indigenous indicators must be tracked and measured in order to monitor progress and detect where additional resources are required to achieve the goal of providing accessible, comprehensive, culturally relevant, and culturally safe mental health services to Indigenous communities. However, increasing access to services is not sufficient as Indigenous mental health begins within the family and in the connection with community and culture (4). Therefore culturally-grounded community development and capacity strengthening are required to support mental and overall wellbeing from the grassroots level, as well as reduce risk factors and increase protective factors (5). In addition to comprehensive, coordinated, high quality, culturally responsive mental wellness programs and services for Indigenous communities, mental health and overall wellbeing will require the sustained commitment and collaboration of many federal, provincial, and territorial partners supported by strong Indigenous-centered leadership and equitable funding (13).

References

1. Canadian Institute for Health Information, ed. (2009). Mentally Healthy Communities: Aboriginal Perspectives. Ottawa: CIHI.
2. O'Brien, A. P., Boddy, J. M., Hardy, D. J., & O'Brien, A. J. (2004). Clinical indicators as measures of mental health nursing standards of practice in New Zealand. International Journal of Mental Health Nursing, 13(2), 78-88.
3. Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. International Journal of Health Promotion and Education, 46(2), 49-56.
4. Snowshoe, A., Crooks, C. V., Tremblay, P. F., & Hinson, R. E. (2017). Cultural connectedness and its relation to mental wellness for First Nations youth. The journal of primary prevention, 38(1-2), 67-86.
5. Day, A., & Francisco, A. (2013). Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. Australian and New Zealand journal of public health, 37(4), 350-355.
6. Durie, M. (2011). Indigenous mental health 2035: Future takers, future makers and transformational potential. Australasian Psychiatry, 19(1_suppl), S8-S11.
7. MacMillan, H. L., Jamieson, E., Walsh, C. A., Wong, M. Y. Y., Faries, E. J., McCue, H., ... & Offord, D. D. R. (2008). First Nations women's mental health: results from an Ontario survey. Archives of Women's Mental Health, 11(2), 109-115.
8. O'Brien, A. P., Boddy, J. M., & Hardy, D. J. (2007). Culturally specific process measures to improve mental health clinical practice: indigenous focus. Australian & New Zealand Journal of Psychiatry, 41(8), 667-674.
9. Novins, D., LeMaster, P., Thurman, P. J., & Plested, B. (2004). Describing Community Needs: Examples From the Circles of Care Initiaive. American Indian and Alaska Native Mental Health Research The Journal of the National Center, 11(2), 42-58.
10. Scott, K. M., Sarfati, D., Tobias, M. I., & Haslett, S. J. (2000). A challenge to the cross-cultural validity of the SF-36 health survey: Factor structure in Māori, Pacific and New Zealand European ethnic groups. Social Science & Medicine, 51(11), 1655-1664.
11. Rountree, J., & Smith, A. (2016). STRENGTH-BASED WELL-BEING INDICATORS FOR INDIGENOUS CHILDREN AND FAMILIES: A LITERATURE REVIEW OF INDIGENOUS COMMUNITIES'IDENTIFIED WELL-BEING INDICATORS. American Indian & Alaska Native Mental Health Research: The Journal of the National Center, 23(3).

12. Cianconi, P., Lesmana, C. B. J., Ventriglio, A., & Janiri, L. (2019). Mental health issues among indigenous communities and the role of traditional medicine. International Journal of Social Psychiatry, 65(4), 289-299.
13. Health Canada. (2015). First Nations Mental Wellness Continuum Framework.

Indigenous Peoples and Aging Well

1. Introduction

Provision and delivery of culturally competent and safe health care services for seniors and elderly individuals is an area of significant concern for many Indigenous communities. While some health systems have made attempts or developed initiatives to address factors related to the gaps in care for older Indigenous peoples in Canada, there continue to be persistent disparities and issues associated with service delivery and accessibility. Indigenous communities and leadership have been calling for the development of a coordinated, comprehensive approach to care delivery and programming (1). In order to plan, develop and deliver healthcare for older Indigenous peoples, it is vital to understand the perspectives and the needs of the population, especially how aging and successful aging is defined.

Indigenous older peoples' voices and experiences are largely absent in the dominant models of aging and late life. This rapid review sought to identify needs and components of aging well from the perspective of Indigenous communities, and how successful aging is conceptualized from the Indigenous lens. Existing models, frameworks, and approaches were searched in the literature in Canada, USA, Australia, and New Zealand.

2. Key Terms and Definitions

Term	Definition
Systemic Racism	"Systemic racism occurs when institutions or systems create or maintain racial inequity often as a result of hidden institutional biases in policies, practices, and procedures that privilege some groups and disadvantage others" Source: Anti-Racism Directorate (2022). Data Standards for the Identification and Monitoring of Systemic Racism. Government of Ontario. Available at: https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism

Cultural Competency	Cultural competency refers to “people development (ability of the practitioner to take knowledge, lessons and experiences about culture learned over time either through their own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient.” Source: Indigenous Primary Health Care Council. (2018). Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. Available at: https://www.iphcc.ca/wp-content/uploads/2020/02/Cultural-Competency-Guideline-Report-June-2018.pdf
Cultural safety	“Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.” Source: First Nations Health Authority (2016). Creating a climate for change: Cultural safety and humility resource booklet. Available at: https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf

3. Literature Review Search Strategy

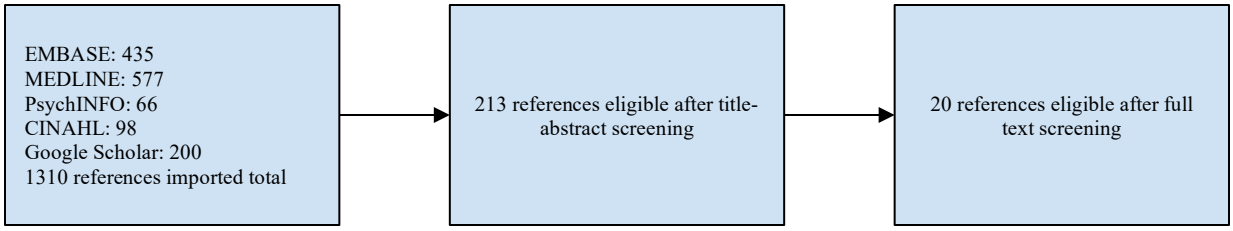
The search terms utilized were the following. The search strings were combined using “AND” operators.

i) “approach” or “framework” or “model” or “models, theoretical” or “health system*” or “health polic*” or “ways of knowing” or “health belief” or “health model” or “understanding” or “perspectives”

ii) “Indigenous health” or “Indigenous Canadians” or “indigenous” or “Health Services, Indigenous” or “Indigenous Peoples” or “Inuits” or “Indians, North American” or “Metis” or “Native American” or “American Natives” or “Alaskan Natives” or “Maori”

iii) “Aging” or “Aging Well” or “Home Care” or “Home Care Services” or “Seniors” or “Elders” or “Life Transitions” or “Elder Wellbeing” or “Cultural Generativity” or “Self Management” or “Independence”

The databases searched were: MEDLINE, EMBASE, PsychINFO, CINAHL, as well as Google Scholar.



4. Rapid Review of Literature

Indigenous Conceptualization of Health and Care Needs for Aging Well

Indigenous communities conceptualize individual health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. Indicators of Indigenous health should therefore reflect this complexity through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing (1). Indigenous health is supported by the relationships within families and the larger community, as well as deep connections with culture, language, Elders, and Earth, and is required for healthy functioning of individual and community life. Wellbeing and health are therefore a balance of several spheres within life: the mental, physical, spiritual, and emotional. Despite the impacts of historical and present-day attempts at colonization, Indigenous peoples and communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience (1,2).

Successful aging as a concept was developed in the 1980s as a response to interpretations of aging as a period of decline and dependency. The dominant model was developed by Rowe and Khan in 1987, and it includes three main criteria: (a) low probability of disease and disability, (b) high physical and cognitive functional capacity, and (c) active engagement with life (3). Over time, this model has become the leading model in academia and has been widely used across international contexts for over 30 years. However, questions have been raised about how applicable the model is to minority populations, diverse cultural contexts, and equity-deserving peoples (4). The primary criterion in the Rowe and Khan model asserts that individuals can control certain aspects of their behavior in order to prevent the onset of disease and disability as they get older (3). However, this emphasis on singular individual responsibility overlooks the impact of social, political, and historical influences, as well as socioeconomic and health disparities that may limit older people from engaging in positive health behaviors. Indigenous older peoples' voices and experiences are largely absent in the dominant models of aging and late life; therefore, the goal of this rapid review was to summarize how aging and successful aging is conceptualized from the perspective of older Indigenous peoples.

Health Risks of Aging in Indigenous Communities

The existing literature outlines that Indigenous peoples, especially those who are older in age, are at high risk for poorer health outcomes as a result of historical and structural factors, specifically the epigenetic and intergenerational trauma inflicted by colonization, residential schools, and the ongoing racism, violence, and health inequities faced by Indigenous communities today. Indigenous peoples are more likely to have risk factors for chronic disease and are more likely to have multiple comorbidities including conditions such as arthritis, hypertension, cardiovascular disease, cancer, and diabetes (5). As a result, Canadian Indigenous groups have a lower life expectancy compared to the rest of the population (6).

Indigenous perceptions of wellness and successful aging are holistic and include participation in the community and being able to engage in a healthy lifestyle (7). However, the holistic vision of successful aging and traditional subsistence activities have been disrupted by environmental degradation by the settler government and other corporate organizations, the dispossession of land, and the relocation to urban communities for many Indigenous peoples (7,8). This disruption has resulted in higher levels of sedentary behaviour and poorer access to healthier and traditional diet choices for Indigenous peoples. Despite these challenges, qualitative research on the subjective perceptions of older Indigenous peoples reports positive feelings about old age, aging, and determination to overcome the challenges that may accompany aging (7).

Successful Aging in Indigenous Communities

When outlining what successful aging looks like for Indigenous peoples, it is important to first acknowledge that there is no universal experience of Indigeneity or a singular model of successful aging that is accepted as a standard by all Indigenous peoples. There is great diversity among Indigenous populations in North America, with various cultural traditions, diverse languages, histories, spiritual practices, geographical differences, and belief systems. Overall, perceptions of aging according to Indigenous lenses have been noted to differ from mainstream North American understandings of aging and wellness in later life. Indigenous perspectives include a view of the life course as cyclical rather than linear, and of a life that continues after death through one's progeny and descendants, as well as through the spirit world (8). The literature on aging among Indigenous older people also focuses on the respected status of Elders as Indigenous knowledge keepers, teachers, and mentors (8). The distinction between the terms "Elder" and "older person" is important to make in Indigenous contexts. The term "Elder" indicates individuals who have a specific and distinguished role in their community by acting as repositories of cultural knowledge, practices, and traditions. The

term “older person” is a more general term that refers to those that are over a certain age threshold, usually set somewhere between 55-65 (8).

Concerns identified in the literature from Indigenous older people include: maintaining cultural norms of respect and care; the ongoing impacts of colonization, government policy, and technological change; and the long-term impacts of the intergenerational transmission of trauma, poverty, and oppression (7). Across the literature, findings also suggest that understandings of successful aging among Indigenous older people focus on a positive attitude towards the challenges that can accompany aging, rather than a lack of disease, disability, and decline (7-9). Indigenous peoples have reported that factors such as diet and exercise also are important for successful aging; however, social connectedness to family, community and culture as the fulfillment of traditional roles were far more important for wellness in aging (10). A systematic review conducted on successful aging for Indigenous peoples in North America explored the current state of the field of successful aging among Indigenous peoples and suggested four overall dimensions related to successful aging that may be more reflective of Indigenous voices and experiences. These four general dimensions that may broaden understanding of successful aging to be more inclusive of Indigenous older people include: health and wellness, empowerment and resilience, engagement and behavior, and connectedness (7). There were more factors related to successful aging identified across the literature, which are summarized below.

Contributors to successful aging identified from the literature (7-17):

Cultural and Community Supports

- Contributions to community life and civic engagement
- Transmission of cultural knowledge through ongoing teaching and learning
- Strong family and community support and social networks
- Humor and laughter (fosters healing and engagement with community)
- Embodying traditional cultural values (values mentioned include cohesion, spirituality, empowerment, resilience, healing, determination, balance, freedom)
- Restoration of traditional values and Elder’s roles, and supporting Elder wellness

Autonomy

- Maintenance of personal agency
- Aging in place/at home
- Wellness in physical health (balanced diet, physical activity, drug/alcohol abstinence)
- Secure economic circumstances (financial resources, housing, access to transport)

- Fulfilling daily activities (community engagement, subsistence activities, passion and excitement for life)
- Strong cognitive health, emotional wellness and positive attitude towards aging and associated challenges

Conclusion

Overall, this rapid review shows that Indigenous perspective and experiences are beginning to be heard and recognized in the literature on successful aging. This inclusion signifies an important starting point from which the current conceptualizations of successful aging can be expanded to be more accurate and encompassing of all perspectives and of Indigenous knowledge. Descriptions of successful aging among Indigenous older peoples have some overlapping points with mainstream conceptualizations, including having a positive outlook and attitude towards aging, personal agency and autonomy, personal wellness and social interaction, as well as maintaining and managing physical health (18). However, Indigenous conceptualizations of successful aging place more emphasis on sociocultural knowledge, cultural generativity, and community health. An inclusive model of Indigenous aging and priorities for aging older people in Indigenous communities is vital for the development of research, policy, and practice in this field (7,12). Furthermore, Indigenous models of aging include the significant importance of the social determinants of health, the health and social inequities that Indigenous communities continue to face, as well as the ongoing impacts of colonization, genocide, and racism. A more inclusive model of successful aging for Indigenous peoples should include a focus on the balance between physical, social, mental, spiritual and emotional wellness, as well as the importance of family, community, healing, and the relationship with the environment (19-23). Acknowledging the ongoing resilience, healing, strength, and adaptability of Indigenous older peoples were also identified as being very important to the conceptualization of successful aging. Further work is required to fully capture successful aging from the Indigenous perspective, and to develop research, policy, and practice that is more inclusive of Indigenous peoples in this field. Moving forward, initiatives and policy changes in the area of successful aging and the health of older people must be culturally informed and take into account the unique challenges and needs of marginalized groups like Indigenous peoples as they unfold across the life course (24-26).

References

1. Prince, H., Nadin, S., Crow, M., Maki, L., Monture, L., Smith, J., & Kelley, M. L. (2019). “If you understand you cope better with it”: the role of education in building palliative care capacity in four First Nations communities in Canada. BMC public health, 19(1), 1-18.
2. Shahid, S., Taylor, E. V., Cheetham, S., Woods, J. A., Aoun, S. M., & Thompson, S. C. (2018). Key features of palliative care service delivery to Indigenous peoples in Australia, New Zealand, Canada and the United States: a comprehensive review. BMC palliative care, 17(1), 1-20.
3. Rowe J. W. , & Kahn R. L . (1987). Human aging: Usual and successful. Science, 237, 143–149. doi:0.1126/science.3299702
4. Katz S . (2013). Active and successful aging. Lifestyle as a gerontological idea. Recherches Sociologiques et Anthropologiques, 44, 33–49. doi:10.4000/rsa.910
5. Wilson K. Rosenberg M. W. Abonyi S. , & Lovelace R . (2010). Aging and health: An examination of differences between older Aboriginal and non-Aboriginal people. Canadian Journal on Aging, 29, 369–382. doi:10.1017/S0714980810000309
6. Statistics Canada . (2015). Projected life expectancy at birth by sex and Indigenous Identity, Canada, 2017. Retrieved from http://www.statcan.gc.ca/pub/89-645-x/2010001/c-g/c-g013-eng.htm
7. Pace, J. E., & Grenier, A. (2017). Expanding the circle of knowledge: Reconceptualizing successful aging among North American older Indigenous peoples. Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 72(2), 248-258.
8. Pace J . (2013). Meanings of memory: Understanding aging and dementia in First Nations communities on Manitoulin Island, Ontario (Unpublished doctoral dissertation). McMaster University, Hamilton, Canada.
9. Baskin C. , & Davey C. J . (2015). Grannies, elders, and friends: Aging Aboriginal women in Toronto. Journal of Gerontological Social Work, 58, 46–65. doi:10.1080/01634372.2014.912997
10. Lewis J. (2013a). The importance of optimism in maintaining healthy aging in rural Alaska. Qualitative Health Research, 23, 1521–1527. doi:10.1177/1049732313508013
11. Abonyi S. , & Favel M . (2012). Marie’s story of aging well: Toward new perspectives on the experience of aging for Aboriginal seniors in Canada. Anthropology and Aging Quarterly, 33, 11–20. doi:10.1037/e682002011-001
12. Brass E. R . (2004). Empowerment and wellness of Aboriginal Elders (Unpublished master’s thesis). University of Regina, Regina, Canada.

13. Collings P . (2001). “If you’ve got everything, it’s good enough”: Perspectives on successful aging in a Canadian Inuit community. Journal of Cross-Cultural Gerontology, 16, 127–155. doi:10.1023/A:1010698200870
14. Hopkins S. Kwachka P. Lardon C. , & Mohatt G. V . (2007). Keeping busy: A Yup’ik/Cup’ik perspective on health and aging. International Journal of Circumpolar Health, 66, 42–50. doi:10.3402/ijch.v66i1.18224
15. Lewis J. P . (2009). Successful aging through the eyes of Alaska Native Elders: What it means to be an Elder in Bristol Bay, Alaska (Unpublished doctoral dissertation). University of Alaska, Fairbanks, AK.
16. Lewis J . (2013b). The future of successful aging in Alaska: What can we learn from our Elders to ensure a healthy future. International Journal of Circumpolar Health, 72, 1–5. doi:10.3402/ijch.v72i0.21186
17. Lewis J . (2014). The role of social engagement in the definition of successful aging among Alaska Native Elders in Bristol Bay, Alaska. Psychology of Developing Societies, 26, 263–290. doi:10.1177/0971333614549143
18. Jervis, L. L. (2010). Aging, health, and the indigenous people of North America.
19. Rowe, G., Straka, S., Hart, M., Callahan, A., Robinson, D., & Robson, G. (2020). Prioritizing Indigenous Elders’ knowledge for intergenerational well-being. Canadian Journal on Aging/La Revue canadienne du vieillissement, 39(2), 156-168.
20. Brooks-Cleator, L., & Giles, A. (2018). Indigenous Older Adults’ Perspectives on Aging Well in an Urban Community in Canada. Innovation in Aging, 2(Suppl 1), 175.
21. Nelson, S. E. (2021). Aging in Indigenous Canada. Aging People, Aging Places: Experiences, Opportunities, and Challenges of Growing Older in Canada, 4, 197.
22. Hillier, S., & Al-Shammaa, H. (2020). Indigenous Peoples Experiences with Aging. Canadian Journal of Disability Studies, 9(4), 146-179.
23. Lanting, S., Crossley, M., Morgan, D., & Cammer, A. (2011). Aboriginal experiences of aging and dementia in a context of sociocultural change: Qualitative analysis of key informant group interviews with Aboriginal seniors. Journal of Cross-Cultural Gerontology, 26(1), 103-117.
24. Brooks-Cleator, L. A., & Lewis, J. P. (2020). Alaska Native elders’ perspectives on physical activity and successful aging. Canadian Journal on Aging/La Revue canadienne du vieillissement, 39(2), 294-304.
25. Radford, K., Mack, H. A., Robertson, H., Draper, B., Chalkley, S., Daylight, G., ... & Broe, G. A. (2014). The Koori growing old well study: investigating aging and dementia in Urban Aboriginal Australians. International Psychogeriatrics, 26(6), 1033-1043.

26. Arkles, R., Jackson Pulver, L., Robertson, H., Draper, B., Chalkley, S., & Broe, A. (2010). Ageing, cognition and dementia in Australian Aboriginal and Torres Strait Islander peoples: a life cycle approach.

Indigenous Peoples and Palliative Care

1. Introduction

Provision and delivery of culturally competent and safe palliative care services is an area of significant concern for many Indigenous communities. While some health systems have made attempts or developed initiatives to address factors related to the gaps in palliative care for Indigenous peoples in Canada, there continue to be persistent disparities and issues associated with service delivery and accessibility. Indigenous communities and leadership have been calling for the development of a coordinated, comprehensive approach to palliative care delivery and programming (1). This rapid review sought to identify needs and components of effective and competent palliative care from the perspective of Indigenous communities, and how palliative medicine and end-of-life care is conceptualized from an Indigenous lens. Existing models, frameworks, and approaches were searched in the literature in Canada, USA, Australia, and New Zealand.

2. Key Terms and Definitions

Term	Definition
Systemic Racism	"Systemic racism occurs when institutions or systems create or maintain racial inequity often as a result of hidden institutional biases in policies, practices, and procedures that privilege some groups and disadvantage others" Source: Anti-Racism Directorate (2022). Data Standards for the Identification and Monitoring of Systemic Racism. Government of Ontario. Available at: https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism
Cultural Competency	Cultural competency refers to "people development (ability of the practitioner to take knowledge, lessons and experiences about culture learned over time either through their own life and/or through formal learning) and being able to apply them to their practice to improve the health outcomes for the service user or patient." Source: Indigenous Primary Health Care Council. (2018). Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. Available at: https://www.iphcc.ca/wp-content/uploads/2020/02/Cultural-Competency-Guideline-Report-June-2018.pdf

Cultural safety	"Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care." Source: First Nations Health Authority (2016). Creating a climate for change: Cultural safety and humility resource booklet. Available at: https://www.fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf
Capacity Building	"The World Health Organization (WHO) defines capacity building as the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion." Source: Public Health Ontario (2018). Creating capacity building interventions that work. Available at: https://www.publichealthontario.ca/en/About/News/2018/Capacity-building-interventions
Capacity Strengthening	"Capacity strengthening is based on a strengths-based perspective that all people have knowledge and skills, all people can improve … at the same time all people need to learn in order to engage in different activities which contribute to their wellbeing and prosperity" Source: Tsey, K., McCalman, J., Bainbridge, R., & Brown, C. (2012). Improving Indigenous community governance through strengthening Indigenous and government organisational capacity. Resource sheet No. 10. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. Available at: https://www.aihw.gov.au/getmedia/04fa3771-33c4-448b-b82e-3dce26c4cd97/ctgc-rs10.pdf.aspx?inline=true
Culturally Appropriate Care	Culturally appropriate care is considered to be "tangible, action oriented, and respectful of diverse cultural practices. It includes the physical structure and environment, how a program or service is delivered and by whom, and it provides choices relative to how each person experiences culture." Source: Indigenous Primary Health Care Council. (2018). Cultural competency guideline for Ontario public health units to engage successfully with Aboriginal communities. Available at: https://www.iphcc.ca/wp-content/uploads/2020/02/Cultural-Competency-Guideline-Report-June-2018.pdf

Culturally Grounded Care	"Culturally grounded approaches place the culture of the participant at the center of the intervention." Source: Okamoto, S. K., Helm, S., Pel, S., McClain, L. L., Hill, A. P., & Hayashida, J. K. (2014). Developing empirically based, culturally grounded drug prevention interventions for indigenous youth populations. The Journal of Behavioral Health Services & Research, 41(1), 8–19. https://doi.org/10.1007/s11414-012-9304-0

3. Literature Review Search Strategy

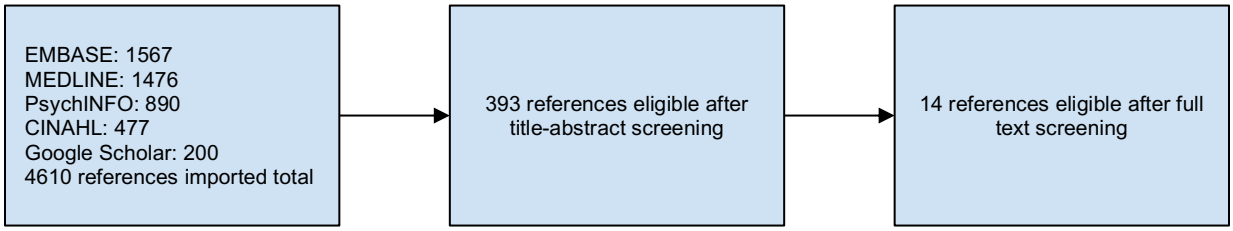
The search terms utilized were the following. The search strings were combined using "AND" operators.

i) "approach" or "framework" or "model" or "models, theoretical" or "health system*" or "health polic*" or "ways of knowing" or "health belief" or "health belief model" or "health care reform" or "health planning" or "health priorities" or "indicators" or "understanding" or "perspectives"

ii) "Indigenous health" or "Indigenous Canadians" or "indigenous" or "Health Services, Indigenous" or "Indigenous Peoples" or "Inuits" or "Indians, North American" or "Metis" or "Native American" or "American Natives" or "Alaskan Natives" or "Maori"

iii) "Palliative Care" or "end-of-life Care" or "end-of-life" or "Attitude to Death" or "Supportive Care" or "Pain Management" or "Death" or "Dying"

The databases searched were: MEDLINE, EMBASE, PsychINFO, CINAHL, as well as Google Scholar.



4. Summary of Literature

Indigenous Conceptualization of Health and Palliative Care Needs

Indigenous communities conceptualize individual health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. Indicators of Indigenous health should therefore reflect this complexity

through a coordinated and comprehensive model that respects and values Indigenous knowledge, culture, language, and ways of knowing (1). Indigenous health is supported by the relationships within families and the larger community, as well as deep connections with culture, language, Elders, and Earth, and is required for healthy functioning of individual and community life. Wellbeing and health are therefore a balance of several spheres within life: the mental, physical, spiritual, and emotional. Despite the impacts of historical and present-day attempts at colonization, Indigenous peoples and communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience (1,2).

Indigenous peoples have intricate and complex cultural practices surrounding end-of-life and palliative care. Death is seen and understood as a sacred part of the life cycle, not the end of it. A full spectrum of culturally safe and culturally competent services is necessary to support Indigenous palliative care and end-of-life care. This includes services in palliative care promotion, community development, and palliative care education, as palliative care and the services they provide can be commonly misunderstood. Access to early identification and palliative care services, crisis response services, as well as coordinated care between different services is also essential. While not all of these services may be available in every community, all communities should have access to key services within reasonable limits through proper communication and comprehensive planning (2,3).

One paper by Prince and colleagues that looked at building capacity in Indigenous communities in Canada conceptualized palliative care as a three-tiered care system (1). The model is shown below in Figure 1. It is important that the primary caregiving circle is composed of the individual themselves and the care and support they receive from their family members. The next component, the internal caregiving network, is composed of extended family members, community members, community leadership, Elders, and other Knowledge Carriers. The external network is the healthcare system and the health services provided and located outside of the community. In this way, physicians and other healthcare providers involved in palliative care services outside of the community are supporting services to the central caregiving provided by the family members and community (1).

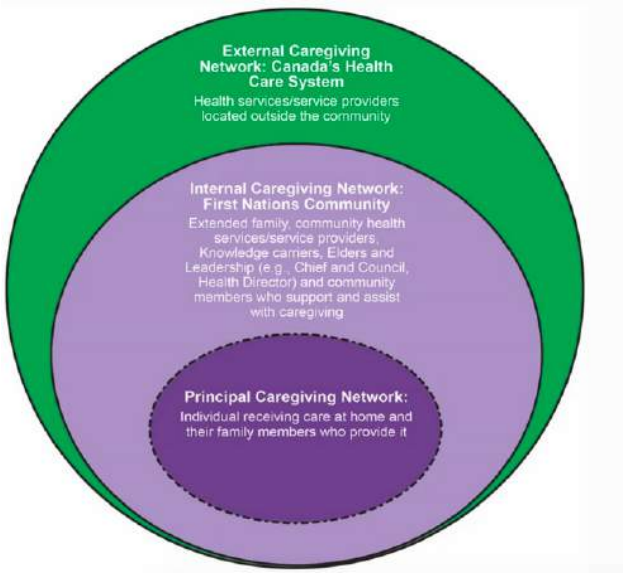


Figure 1: Palliative care for Indigenous peoples, as proposed by Prince and colleagues (1)

Indigenous Priorities for Palliative Care

There were several key overarching themes that emerged from the literature as priorities for palliative care in Indigenous communities. A primary priority was the connection to Indigenous culture and community. As death and dying are seen as a natural part of the life cycle, it is important that primary care and support are provided by family and communities. There are long-standing traditions for preparing for death and established social processes for supporting community members through dying, loss, grief and bereavement. Connection to the land (the homeland or home community) is especially important for people who are dying (1-3).

Current gaps in palliative care include a lack of knowledge around services that are available in and for Indigenous communities; lack of knowledge surrounding palliative care as a whole; lack of trained providers from Indigenous communities; and lack of centralized Band leadership (Chief and council members, health directors and band managers who supervise staff). For the provision of comprehensive and culturally competent palliative care services for Indigenous patients, it is important to incorporate respect of Indigenous culture, end-of-life care planning, and the role of family; recognize the importance of the Indigenous community (sense of home); and value and center Indigenous knowledge, language, and culture at the forefront of all initiatives (1,3). Moeke-Maxwell and colleagues conducted a study within the New Zealand Māori (Indigenous) peoples and found that palliative care for their community and peoples is profoundly relationship-oriented and must uphold the older person's mana (authority, status, spiritual power) across four critical health domains (4). However, poor healthcare

on one level impacted on all four domains affecting (reducing) mana (status). The four critical domains are whānau (social/family), hinengaro (emotional/mental), wairua (spiritual) and tinana (physical) health domains (4). Certain studies looked at palliative care specific to patients with cancer, and what aspects of their palliative care were identified as being critical to their experience and satisfaction with their healthcare. Key aspects included: feeling safe in the system; importance of Indigenous staff being involved and present in their care; addressing geographical, financial, social, and other barriers to care; the role of family and friends; effective communication and education between healthcare team members and patient family; and the streamlined coordination of care and transition between services (5,6).

It is vital for healthcare improvement initiatives to take these factors into consideration when working to improve the quality of palliative care programs and resources, as well as healthcare provider training in palliative care and Indigenous end-of-life care. Palliative care improvement initiatives must focus on community development, ownership, and capacity strengthening; culturally responsive and safe care and competent service delivery; as well as effective collaboration with palliative care service partners and organizations at the community, regional, provincial, territorial, federal, and national level (7,8). It is vitally important that leadership from Indigenous youth, community leaders and Elders be at the forefront of planning and development strategies for Indigenous palliative care and end-of-life services. Furthermore, each Indigenous community is unique and cannot be generalized under one model; it is therefore imperative that palliative care services are developed and personally tailored to fit the community that it aims to serve (7-9). Community development, ownership, control, and capacity strengthening all have to be taken into account with regards to Indigenous palliative care and end-of-life care. In order to best serve a community, it is important to derive principles and areas of priority from members of the community themselves and center the culture and values of the community in local programs and infrastructure. This helps in ensuring that the health services are relevant, effective, and meet community needs. Overall, palliative care delivery and accessibility in Indigenous communities require further study and research investment; and the priorities, culture and perspectives of one community cannot be applied to all (8-10).

Indigenous Community-based Palliative Care Program Example

An evaluation study of a community-based palliative care program titled Wiisokotaatiwin, based in Naotkamegwanning First Nations found several essential activities were vital for the delivery of culturally competent and high quality palliative care for Indigenous patients: comprehensive education of community members and healthcare providers; effective coordination of palliative care services and providers;

development and implementation of partnerships and service agreements with provincial and territorial health services; and evidence-based development of program guidelines with input and direction from Indigenous leadership (8). Their palliative care program included palliative care assessment that was provided within the community; 24/7 access to care and support for patients and their families; as well as access to individualized, community-based coordinated care planning that is developed in collaboration with patients and families. The palliative care program, including the pathway to palliative care specialists, as well as culturally competent education and support, was formalized and well understood by all internal and external providers and healthcare delivery networks. The program delivery and the indicators used to measure program outcomes were: number of unnecessary emergency department (ED) visits in the last year of life, unnecessary hospital admissions in the last year of life, reduced length of hospital stay at end-of-life, and in-hospital deaths (8). (Figure 2)

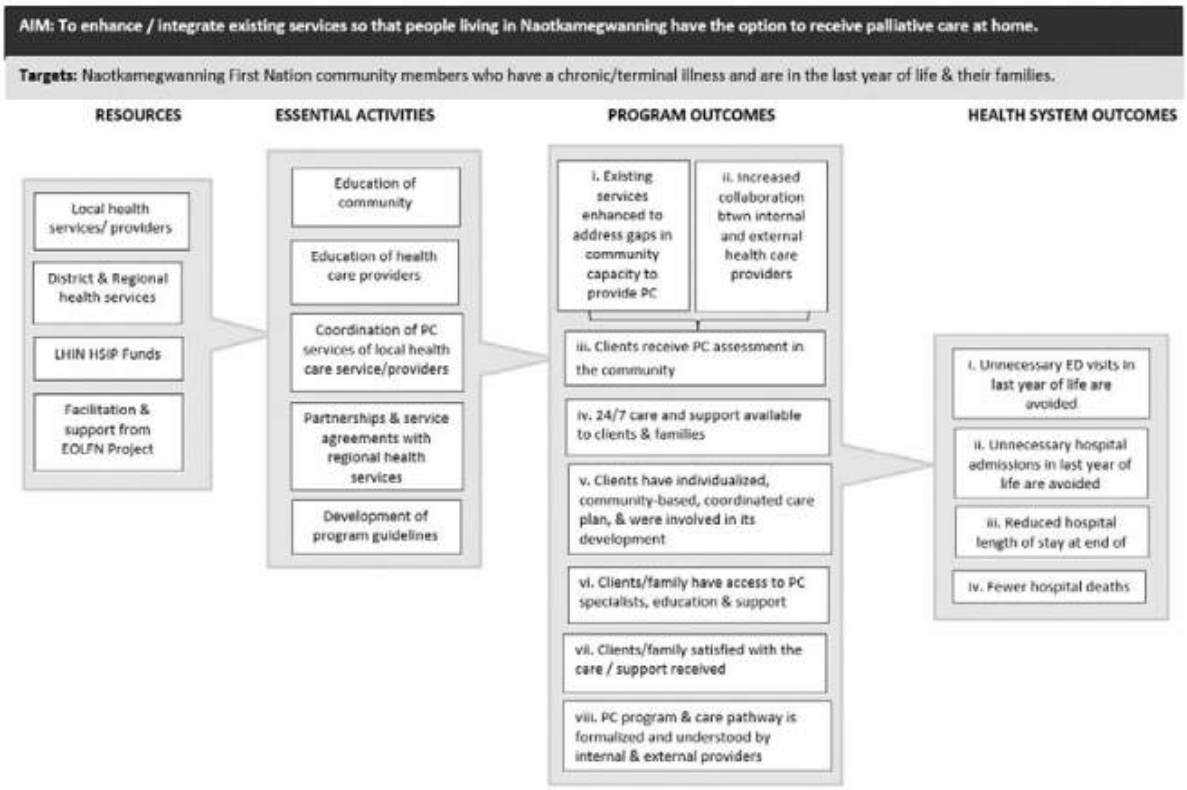


Figure 2: Indicators used in the evaluation of the community-based palliative care program Wiisokotaatiwin (8)

Family, Community, and Autonomy

The literature shows that it is generally accepted across Indigenous communities that there is a strong preference for living with family and within the home community at end-of-life. It is essential that the patient's family be at the center of all decision-making processes. Better communication between providers and patients, greater commitment to quality improvement in end-of-life care at the policy level, increased staff capacity strengthening, and improved physical environment and access to services, were identified as key service delivery needs for Indigenous peoples (7,8). More education and training for both the Indigenous communities and the healthcare staff in palliative care was identified repeatedly. Community and/or gathering of extended family members was regarded as significant and part of providing culturally competent palliative care for Indigenous patients. Key preferences identified are: strong family and community involvement in the palliative care decision-making processes; decision to choose regarding location of service delivery, with most preferring dying at home; provision for cultural and spiritual ceremonies within service settings; open and honest communication from health professionals; respectful treatment by healthcare providers, and availability of Indigenous staff when requested. There is a strong preference to spend time with families and communities at end-of-life, as families are pivotal to the wellbeing of dying Indigenous patients (8-11).

One study conducted in 2018 regarding end-of-life preferences for Indigenous peoples in Canada found that key priorities included: ability to maintain and involve family connections throughout the dying process; building local capacity for palliative care to provide more relevant and culturally appropriate care; and flexibility and multi-sectoral partnerships to address the complexity of day-to-day needs for patients and families (12). These findings point to several areas for change and action that can improve the relevance, access and comprehensiveness of palliative care programming for rural Indigenous communities in Canada and elsewhere. Taking into account the diversity and unique strengths of each Indigenous community will be vital in developing sustainable and meaningful change. It is essential that Indigenous communities are able to access a full spectrum of culturally competent supports and services that are part of a quality care system that centers Indigenous culture and values. Provincial, territorial, and federal governments and other key partners will need to collaborate and provide equitable funding in order to provide the needed support for education, research and healthcare services. Support is also required for continuous quality and performance measurement, Indigenous-centered governance, and culturally competent workforce development (11,12). A review conducted in 2012 from New Zealand found similar results (10). The findings demonstrated that Indigenous participants viewed the involvement of family as fundamental to the provision of palliative care. Priorities for

patients included: enabling family members to provide ‘hands-on’ care; centering the role of family in decision-making and in the delivery of and satisfaction with care; and being cognizant of individual preferences both within and across cultures as a fundamental aspect of palliative care provision. The role of family in ‘hands-on’ palliative care and decision-making requires care staff to relinquish their role as ‘expert provider.’ Counter to the prioritization of autonomy in Western healthcare, collective decision-making may be favoured in culturally competent Indigenous palliative care provision (10).

Barriers and Facilitators to Accessing Culturally Appropriate Palliative Care

Providing families with the requisite knowledge and skills to give care to older family members is important. Whilst assumptions are sometimes made about preferences for end-of-life care based on cultural values alone, these data suggest that care preferences need to be ascertained by working with family members on an individual basis and in a manner that respects their involvement in palliative care provision (2, 3, 10). The barriers surrounding palliative care provision in remote Indigenous communities are cultural and geographic. Culturally sensitive care requires that patients have access to family support and traditional services if requested. Geographic isolation requires that: patient-specific care plans be created for use in the remote community; effective lines of communication are established between remote healthcare providers and urban specialists; healthcare providers and family care-givers be properly trained to fill their respective roles; and that appropriate guidelines and resources are available in the community to support this type of care (10). A similar model was developed by McGrath, entitled the “Living Model” and shown in Figure 3 (13). This model incorporates several factors that can be applied to the healthcare services working with Indigenous populations during end-of-life. Seven principles (equity; autonomy/empowerment; trust; humane, non-judgmental care; seamless care; emphasis on living; and cultural respect) were articulated by those interviewed by the study team and also affirmed by experts in Indigenous health as foundational values for the model. The “Living Model” is not a static model to be imposed on services or communities, but rather a living, flexible model to assist with service delivery, health advocacy, and health policy for palliative care development. Kinship and the extended family network - rather than the autonomous individual, as in the Western model - should be central in the delivery of palliative care for Indigenous populations. The model is intended to serve as a practical representation of factors for use in healthcare provision and advocacy work. It is comprised of twelve interlocking ovals that outline key processes in the provision of effective palliative care, which include: employing Indigenous health workers; ensuring effective communication/respect for language; addressing psychosocial and practical problems; building services in the communities;

encouraging family meetings; organizing educational activities; addressing relocation issues, with a focus on staying home; understanding and supporting cultural practices; developing culturally appropriate health care facilities; offering carer and escort support; and providing respite. The model reaffirms several important components that are significant to Indigenous palliative care provision, including the importance of end-of-life care being carried out within the family and home community; the importance of cultural, spiritual, and ceremonial differences; the centrality of language; the significance of connection with the land; the difficulties encountered due to relocation; the lack of local services; the importance of kinship and family networks; the practical obstacles to service provision; concerns about pain management; the importance of culturally appropriate communication; and the need for respect for cultural practices associated with end-of-life (13).

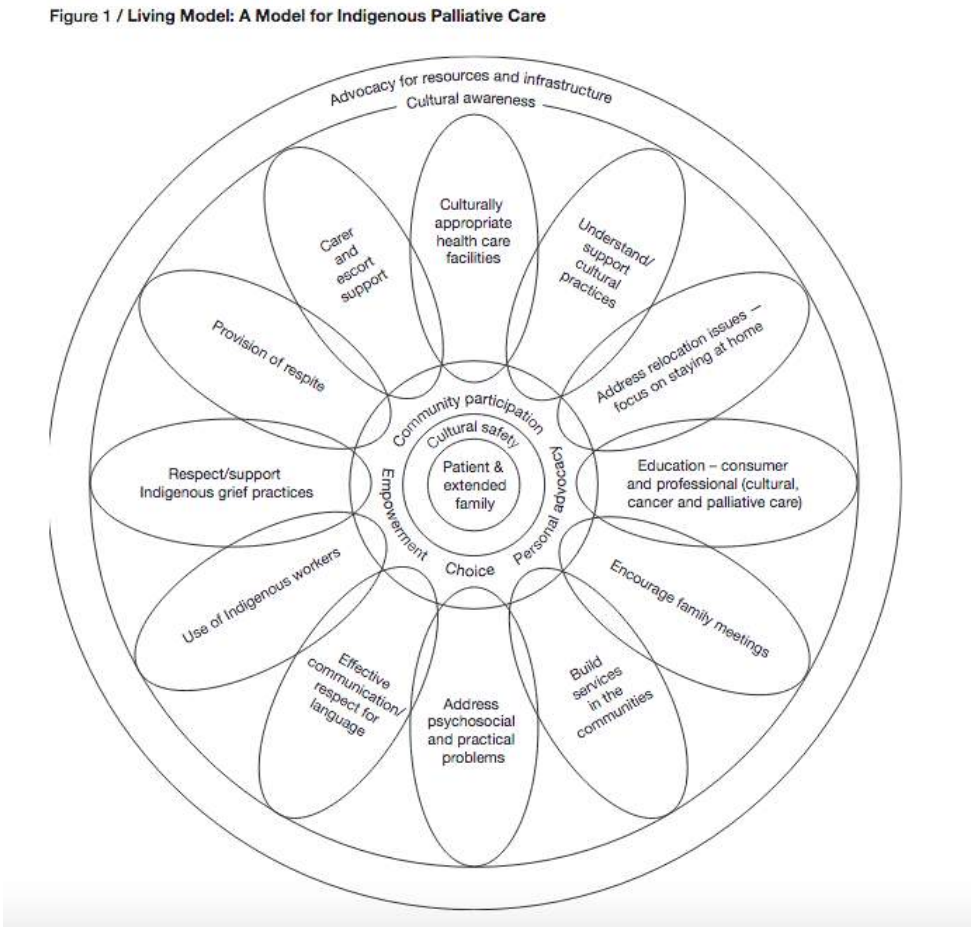


Figure 3: Living Model for Indigenous Palliative Care proposed by McGrath (13)

Conclusion

Achieving a culturally competent system that supports Indigenous palliative and end-of-life care will require sustained commitment and collaboration, as well as effective

leadership that centers Indigenous leaders across the system within agencies, families, and communities. Furthermore, Indigenous indicators must be tracked and measured in order to monitor progress and detect where additional resources are required to achieve the goal of providing accessible, comprehensive, culturally relevant, and culturally safe services to Indigenous communities. However, increasing access to services is not sufficient as Indigenous health begins within the family and in the connection with community and culture. Furthermore, jurisdictional issues experienced by Indigenous peoples in Canada affect access access, continuity and appropriateness of care (2-7, 14-15). Culturally safe palliative care is associated with worldview, spirituality, the role of family and community relationships and communication norms, and thereby with the alignment of values and language in the provision of care. A model visually representing the process of palliative care program development for Indigenous communities, proposed by Kelley and colleagues, is shown in Figure 4 below (12). Culturally grounded community development and capacity strengthening is required. In addition to comprehensive, coordinated, high quality, culturally responsive palliative care programs and services for Indigenous communities, palliative care and overall end-of-life care will require the sustained commitment and collaboration of many federal, provincial, and territorial partners supported by strong Indigenous-centered leadership and equitable funding. Enhancing and supporting Indigenous palliative care services and end-of-life care will require strategic action and planning within government services, Indigenous communities, and services across health, justice, employment, and social service sectors (14-15).

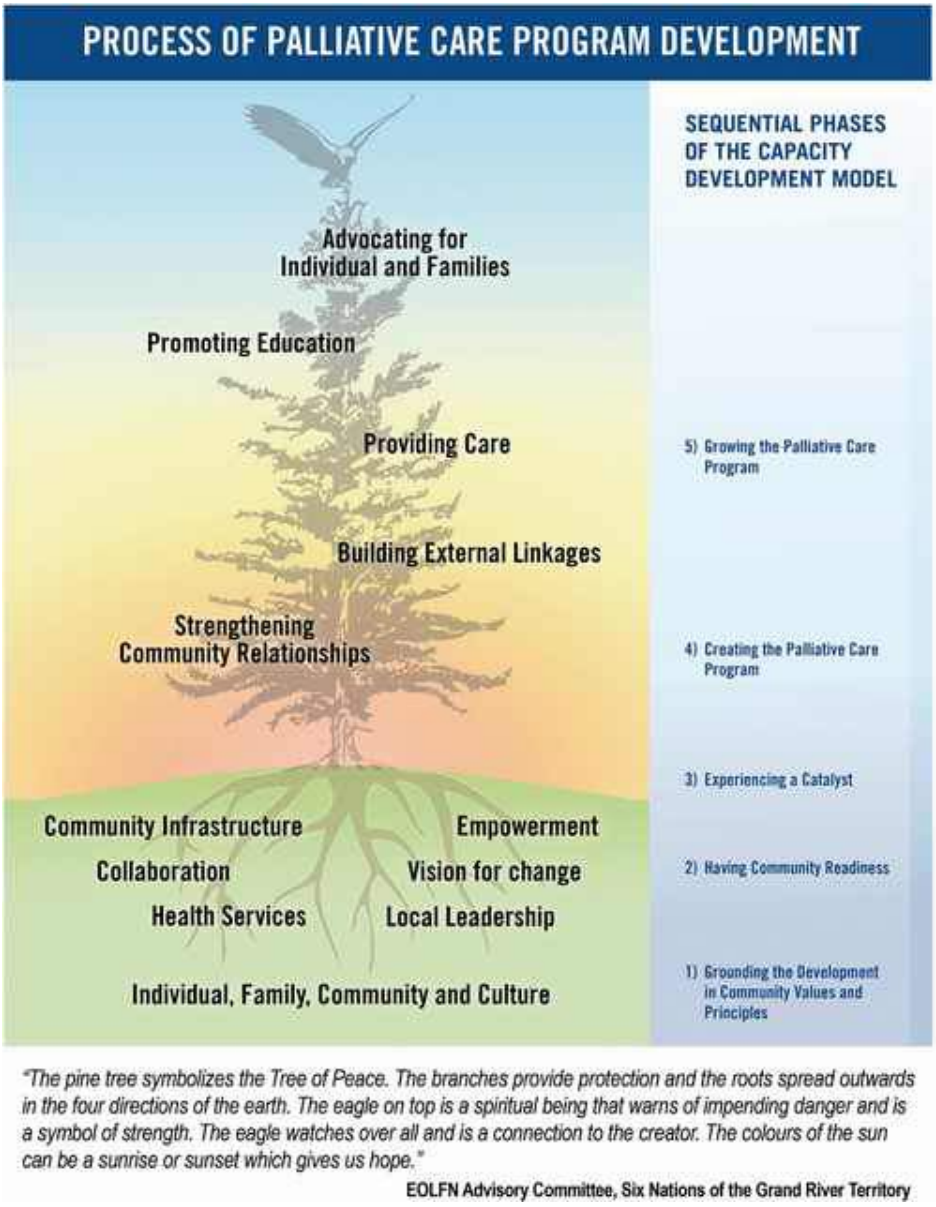


Figure 4: Process of palliative care program development for Indigenous communities, proposed by Kelley and colleagues (12)

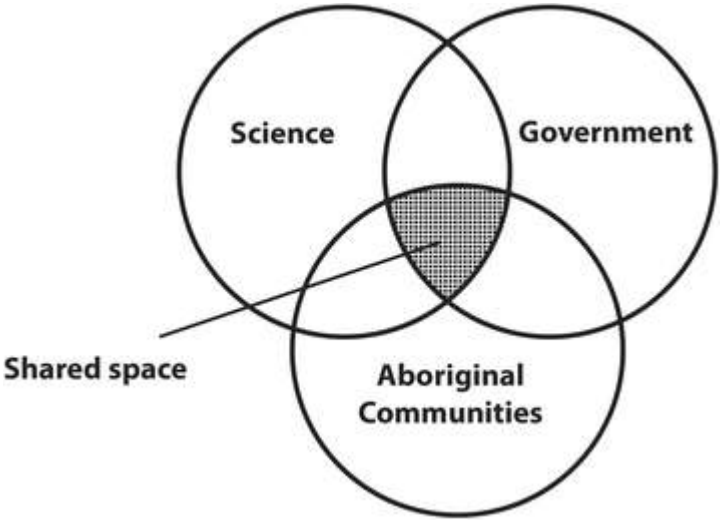
References

1. Prince, H., Nadin, S., Crow, M., Maki, L., Monture, L., Smith, J., & Kelley, M. L. (2019). “If you understand you cope better with it”: the role of education in building palliative care capacity in four First Nations communities in Canada. BMC public health, 19(1), 1-18.
2. Shahid, S., Taylor, E. V., Cheetham, S., Woods, J. A., Aoun, S. M., & Thompson, S. C. (2018). Key features of palliative care service delivery to Indigenous peoples in Australia, New Zealand, Canada and the United States: a comprehensive review. BMC palliative care, 17(1), 1-20.
3. Caxaj, C. S., Schill, K., & Janke, R. (2018). Priorities and challenges for a palliative approach to care for rural indigenous populations: a scoping review. Health & social care in the community, 26(3), e329-e336.
4. Moeke-Maxwell, T., Collier, A., Wiles, J., Williams, L., Black, S., & Gott, M. (2020). Bereaved families’ perspectives of end-of-life care. Towards a bicultural whare tapa Whā older person’s palliative care model. Journal of cross-cultural gerontology, 35(2), 177-193.
5. Green, M., Anderson, K., Griffiths, K., Garvey, G., & Cunningham, J. (2018). Understanding indigenous Australians’ experiences of cancer care: stakeholders’ views on what to measure and how to measure it. BMC health services research, 18(1), 1-13.
6. Schill, K., & Caxaj, S. (2019). Cultural safety strategies for rural Indigenous palliative care: a scoping review. BMC palliative care, 18(1), 1-13.
7. Vincent, D., Rice, J., Chan, J., & Grassau, P. (2019). Provision of comprehensive, culturally competent palliative care in the Qikiqtaaluk region of Nunavut: Health care providers’ perspectives. Canadian Family Physician, 65(4), e163-e169.
8. Nadin, S., Crow, M., Prince, H., & Kelley, M. L. (2018). Wiisokotaatiwin: development and evaluation of a community-based palliative care program in Naotkamegwanning First Nation. Rural & Remote Health, 18(2).
9. Johnston, G., Vukic, A., & Parker, S. (2013). Cultural understanding in the provision of supportive and palliative care: perspectives in relation to an indigenous population. BMJ supportive & palliative care, 3(1), 61-68.
10. Bellamy, G., & Gott, M. (2013). What are the priorities for developing culturally appropriate palliative and end-of-life care for older people? The views of healthcare staff working in New Zealand. Health & Social Care in the Community, 21(1), 26-34.
11. Hotson, K. E., MacDonald, S. M., & Martin, B. D. (2004). Understanding death and dying in select first nations communities in northern Manitoba: issues of

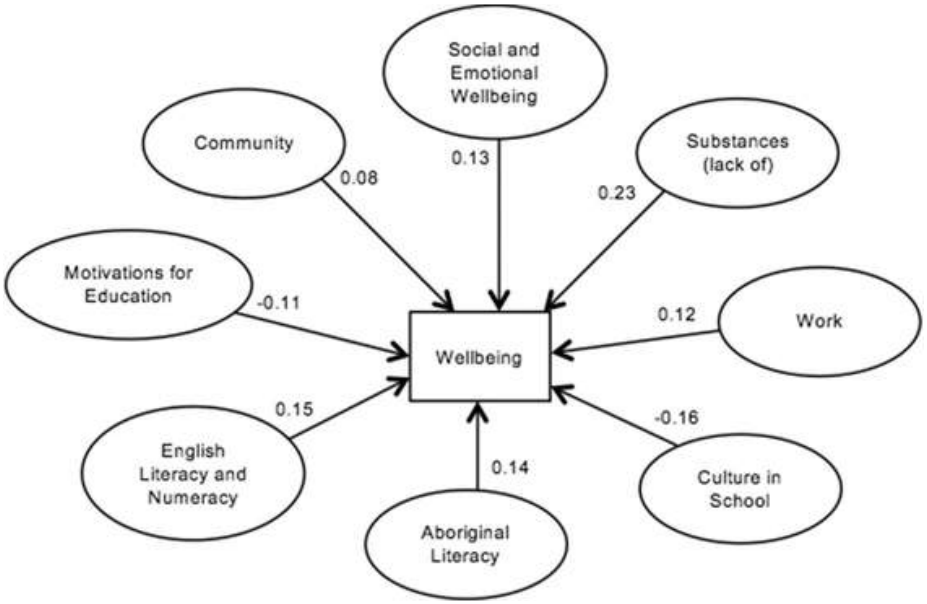
culture and remote service delivery in palliative care. International Journal of Circumpolar Health, 63(1), 25-38.
12. Kelley, M. L., Prince, H., Nadin, S., Brazil, K., Crow, M., Hanson, G., ... & Smith, J. (2018). Developing palliative care programs in Indigenous communities using participatory action research: a Canadian application of the public health approach to palliative care. Ann Palliat Med, 7(Suppl 2), S52-S72.
13. McGrath, P. (2010). The living model: an Australian model for Aboriginal palliative care service delivery with international implications. Journal of palliative care, 26(1), 59-64.
14. Phillips, E. L., & McGrath, P. D. (2009). Insights from the Northern Territory on factors that facilitate effective palliative care for Aboriginal peoples. Australian Health Review, 33(4), 636-644.
15. Schill, K., & Caxaj, S. (2019). Cultural safety strategies for rural Indigenous palliative care: a scoping review. BMC palliative care, 18(1), 1-13

Appendix II: Overview of Included Papers

Indigenous Peoples and Overall Wellbeing

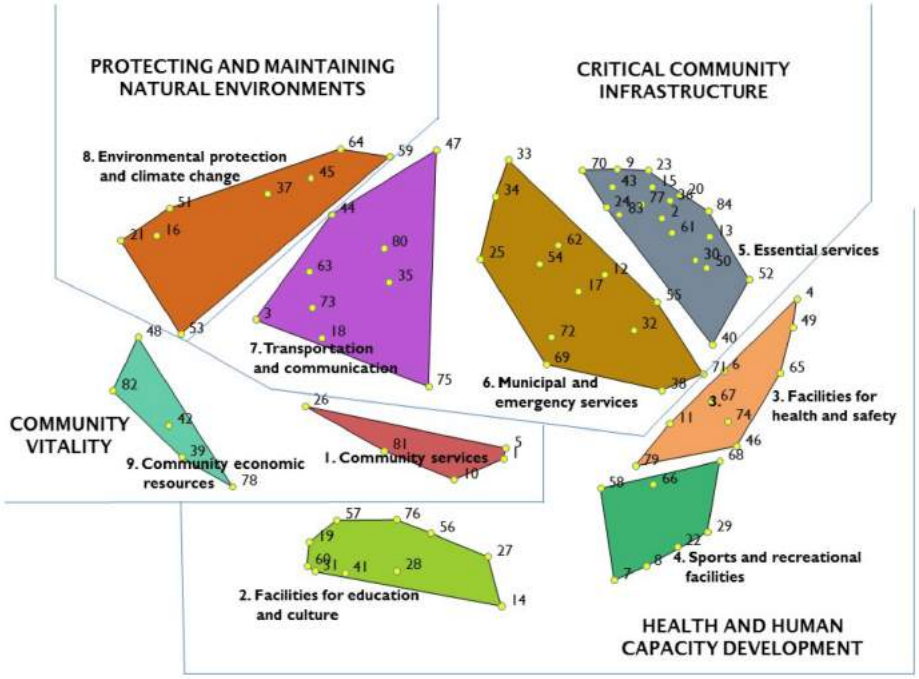
#	Paper Title and Link	Authors (Year)	Country of Intervention	Relevant Indicators Identified
1	Interplay wellbeing framework: a collaborative methodology 'bringing together stories and numbers' to quantify Aboriginal cultural values in remote Australia. https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-017-0563-5	Cairney, Sheree; Abbott, Tammy; Quinn, Stephen; Yamaguchi, Jessica; Wilson, Byron; Wakerman, John (2017)	Australia	Culture, empowerment and community play key roles in the interplay with education, employment and health, as part of a holistic and quantifiable system of wellbeing. This research supports the holistic concept of wellbeing confirming that everything is interrelated and needs to be considered at the 'whole of system' level in policy approaches. Aboriginal cultural values and practices are grounded in spiritual connection to the land, or 'country' and practiced as language, law, kinship/family systems and ceremony. People exist as part of an interrelated continuum with all of nature – including plants, animals and the land. 

				The ‘Shared Space’ approach to working collaboratively between communities, government and scientists  ‘Interplay Wellbeing Framework’ was then developed bringing together government priorities (based on national ‘Closing the Gap’ policies) of education, employment and health, together with community identified priorities of culture, empowerment and community.

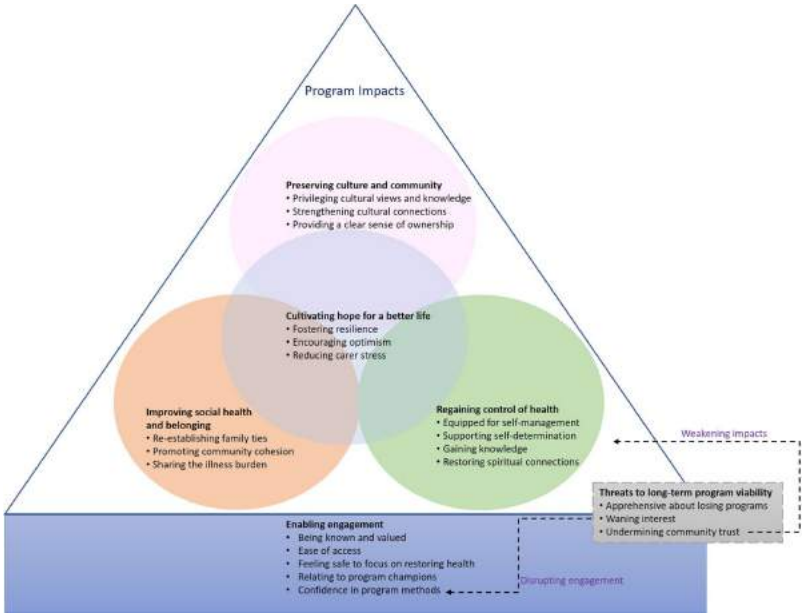


Domains	Sub-domains
Culture	Language, country, law, ceremony, family, importance of culture, practicing culture, culture in school
Community	Leadership, safety, connectedness, trust and respect, services
Empowerment	Inclusiveness, mobility, resilience, self-efficacy, identity, agency, hope
Education	Achievements/outcomes, English literacy and numeracy, focus, motivations, barriers, pathways to work
Work	Paid job, volunteer work, cultural and family work, pathways from education, culture at work, motivations, barriers, work life balance, value/meaning in work
Health	Nutrition, food security, exercise, substance use, anxiety, depression, medical conditions, physical health, dental health, health services, barriers
Wellbeing	Now, past, future

Aboriginal literacy has a direct positive impact on wellbeing and other cultural factors appear to have equally important but less direct impacts on wellbeing. These include learning about culture at school, strong links between the community and school, learning in one's first language at school (bilingual education), practicing culture through 'caring for country' and hunting for food sources, together with the importance of law and ceremony in one's life. Validation of these indicators confirms the foundational role they

				play in the wellbeing of Aboriginal people in remote Australia. These analyses confirm statistically the holistic nature of wellbeing for Aboriginal people in remote Australia, and the importance of culture, empowerment and community to government priority areas of education, work, health and wellbeing.
2	Prioritizing Built Environmental Factors to Tackle Chronic and Infectious Diseases in Remote Northern Territory (NT) Communities of Australia: A Concept Mapping Study. https://www.mdpi.com/1660-4601/18/10/5178/htm	Chakraborty, Amal; Howard, Natasha J; Daniel, Mark; Chong, Alwin; Slavin, Nicola; Brown, Alex; Cargo, Margaret (2021)	Australia	PDF supplementary: Table S1. Indicator statements with accompanying mean importance ratings (chronic disease and infectious disease), combined average importance ratings (chronic disease and infectious disease), and bridging values, by cluster. 

				The ‘essential services’ and ‘facilities for health and safety’ clusters had the highest perceived importance ratings for infectious disease and chronic disease respectively. The results from this study can inform public health planning efforts by identifying priority areas to guide the systematic collection of indicators to monitor progress of health service provision aimed at improving environmental living conditions and Closing the Gap in remote Indigenous communities. As a policy implication, knowing which aspects of community environments are perceived as most important to the development of diseases is essential, as actions can then be taken to address those unhealthy aspects of the environments.
3	Stakeholder perspectives on the implementation and impact of Indigenous health interventions: A systematic review of qualitative studies* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8235882/	Chando, Shingisai ; Tong, Allison; Howell, Martin; Dickson, Michelle; Craig, Jonathan C; DeLacy, Jack; Eades, Sandra J; Howard, Kirsten (2021)	Australia	The prominence of social, emotional and spiritual well-being as important aspects of the health journey for participants in this review highlights the need to reframe evaluations of health programmes implemented in Indigenous communities away from assessments that focus on commonly used biomedical measures.

				 Six themes were identified: enabling engagement, regaining control of health, improving social health and belonging, preserving community and culture, cultivating hope for a better life, and threats to long-term programme viability.
4	Developing Responsive Indicators of Indigenous Community Health https://www.mdpi.com/1660-4601/13/9/899/htm	Donatuto, Jamie; Campbell, Larry; Gregory, Robin (2016)	USA	The identified Indigenous Health Indicators and respective attributes: **Community Connection** Work—Community members have a job or role that they and other community members respect and they work together (mutual appreciation, respect, cooperation). Sharing—Community members engage in active sharing networks, which are integral to a healthy community, ensuring that everyone

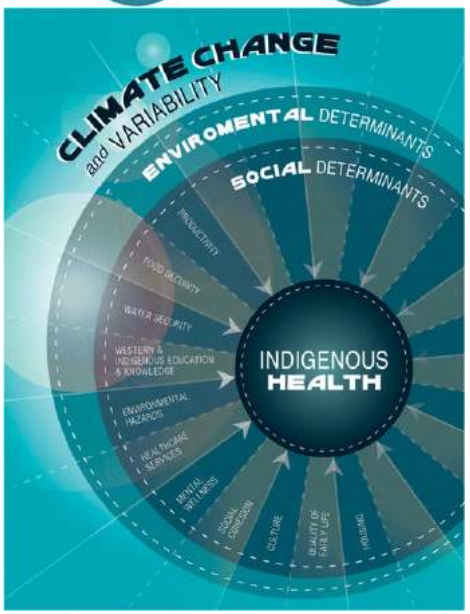
				in the community receives traditional foods and other natural resources such as plant medicines, especially Elders. Relations—Community members support, trust and depend on each other. **Natural Resources Security** Quality—The natural resources, including the elements (e.g., water), are abundant and healthy. Access—All resource use areas (i.e., Usual and Accustomed areas in WA) are open to harvest/use (not closed or privatized) by community members. Safety—The natural resources themselves are healthy, not affected by pollution, climate change, etc. **Cultural Use** Respect/Stewardship—Community members are conferring respect of/to the natural resources and connections between humans, environment and spirit world; ensuring cultural resources are properly maintained. Sense of Place—Community members are engaging in traditional resource-based activities, which is a continued reminder/connection to ancestors and homeland. Practice—Community assemblies able to follow appropriate customs (e.g., can obtain specific natural resources if needed such as cedar, certain foods, etc.), and are able to honor proper rituals, prayers and thoughtful intentions. Community members feel that they are able to satisfy spiritual/cultural needs, e.g., consume foods and medicines in order to satisfy Spirit's "hunger". **Education** The Teachings—The community maintains the knowledge, values and beliefs important to them.

				Elders—The knowledge keepers are valued and respected, and able to pass on the knowledge. Youth—The community's future is able to receive, respect, and practice the Teachings. **Self-Determination** Healing/restoration—The availability of and access to healing opportunities (e.g., traditional medicines, language programs) for community members, as well as the community's freedom to define and enact their own, chosen environmental, health, and habitat restoration programs. Development—The ability for a community to determine and enact their own, chosen community enrichment activities in their homelands without detriment from externally imposed loss of resources. Trust—The community trusts and supports its government. **Resilience** Self-Esteem—The beliefs and evaluations community members hold about themselves are positive, providing an internal guiding mechanism to steer and nurture people through challenges, and improving control over outcomes. Identity—Community members are able to strongly connect with who they are as a community (Tribe or Nation) in positive ways. Sustainability—The community is to adapt (e.g., people hunt with guns and use motorboats today but that doesn't discount the significance of harvesting) and move within homelands voluntarily in response to changes (the "7 generations thinking"). The six IHIs (community connection, natural resources security, cultural use, education, self-determination, and resilience) advanced in this paper reflect multiple connections between

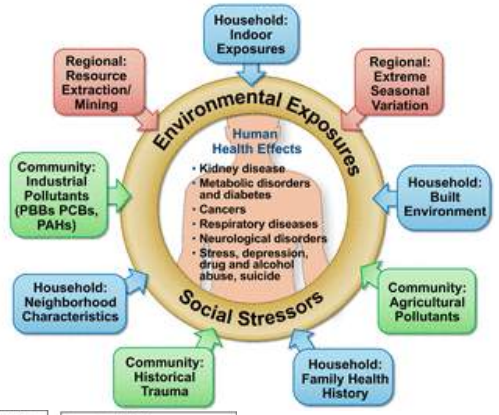
				Indigenous community members and between community members and the non-human world.
5	Indigenous community health and climate change: integrating biophysical and social science indicators https://swinomish.org/media/53935/swin_pr_2014_01.pdf	Donatuto, Jamie; Grossman, Eric E; Konovsky, John; Grossman, Sarah; Campbell, Larry W (2014)	USA	**Community Connection:** Members actively participate in community functions and help each other, particularly in connection with the harvest, preparation, and storage of natural resources. **Natural Resources Security:** Local natural resources (air, water, land, plants and animals) are abundant, accessible and support a healthy ecosystem(s) and healthy human community. The community equitably shares these natural resources. **Cultural Use:** The community is able to perform their cultural traditions in a respectful and fulfilling way using the local natural resources. **Education:** Knowledge, values and beliefs are actively passed from elders to youth. **Self Determination:** Communities develop and enact their own healing, development and restoration programs. **Well-being:** Community members maintain connections to meaningful locations, confident that their health and the health of the next seven generations are not at risk due to contaminated natural resources. **Figure 1.** Indigenous Health Indicators (Donatuto, Gregory, and Campbell In review).

6	Poisoning the body to nourish the soul: Prioritising health risks and impacts in a Native American community https://www-tandfonline-com.proxy.queensu.ca/doi/full/10.1080/13698575.2011.556186	Donatuto, Jamie L; Satterfield, Terre A; Gregory, Robin (2011)	USA	Table 6 of 6 **Table 6. The four main non-physical aspects of Swinomish health, key components of the aspects, and impacts, if any, from contaminated shellfish.** **Health factor** / **Health indictor, definition and ranked impact from contaminated shellfish** / **Averaged ranking of impacts of contaminated shellfish on health factor** **Community cohesion** — **Participation & cooperation:** the community depends on each other; strong support network. **Not at all.** **Roles (harvest, prepare, preserve food):** each member has a role that is respected. **Not at all.** **Familiarity:** food roles are known and trusted; therefore, it is assumed that the food is 'safe'. **A lot.** **A little.** At times, contaminated shellfish restrict / close harvest sites to members that still harvest, forcing people to purchase seafood, which is not considered a 'safe' alternative. Overall, other factors affect this factor much more than contaminated shellfish. **Food security** — **Availability:** seafood is abundant and the stocks are healthy. **A lot.** **Access:** all traditional areas allowed to be harvested. A lot. **Sharing:** ensuring that everyone in the community receives traditional foods, esp. Elders. **Somewhat.** **A lot.** Pollution depletes shellfish populations and closes beaches. With shellfish more difficult to acquire, there is less to distribute in the community. **Ceremonial use** — **Gatherings & ceremonies:** particular community assemblies that require seafood **A lot.** **Give thanks:** thanking the Spirit for providing the food when harvesting and preparing it; done with prayers and thoughtful intentions. **A little.** **Feed the Spirit:** consuming seafood to satisfy a spiritual 'hunger'. **A lot.** **Somewhat.** Contaminated shellfish impact all categories of ceremonial use due to lower availability and access; yet people continue to eat seafood, even if it's contaminated, because it 'feeds the spirit'. **Knowledge transmission** — **The Teachings:** knowledge, values and beliefs about seafood and its importance for the community. **A lot.** **Elders:** the knowledge keepers who pass on the knowledge. **Not at all.** **Youth:** the future; they receive and respect the knowledge. **Somewhat.** **Somewhat.** Lower shellfish populations and restricted access exacerbates intergenerational knowledge transfer loss, as youth do not have the opportunity to learn about the importance of shellfish, harvest practices, etc. Overall, other factors more strongly affect loss of cultural education. Table 5 of 6 **Table 5. Definitions of the 12 health components and their grouping within the key four health indicators.** **Fours health indicators** / **Twelve health components with definitions for each** Food Security — Availability: seafood is abundant and the stocks are healthy Access: all resource use areas (also called Usual and Accustomed areas) are allowed to be harvested Sharing: ensuring that everyone in the community receives traditional foods, esp. Elders Ceremonial use — Gatherings & ceremonies: particular community assemblies that require seafood Give thanks: thanking Nature/ the Spirit for providing the food when harvesting and preparing it; done with prayers and thoughtful intentions Feed the Spirit: consuming seafood to satisfy a spiritual 'hunger' Knowledge transmission — The Teachings: knowledge, values and beliefs about seafood, its importance, and connections to it Elders: the knowledge keepers Youth: the future Community cohesion — Participation & cooperation: the community depends on each other Roles (harvest, prepare, preserve food): each member has a role that is respected Familiarity: food roles are known and trusted; therefore, it is assumed that the food is 'safe' Swinomish consider the intrinsic and multi-dimensional meaning of health, including as it does: physical health, food security, ceremonial use, knowledge transmission and community cohesion.

				The Swinomish relationship to seafood follows more closely an understanding that is akin to seafood as a keystone species and not just a source of protein per se.
7	Values-Based Measures of Impacts to Indigenous Health. https://onlinelibrary.wiley.com/doi/10.1111/risa.12533	Gregory, Robin; Easterling, Doug; Kaechele, Nicole; Trousdale, William (2016)	USA	**Table II.** Coast Salish Indicators of Indigenous Health Community connection: Members actively participate in community functions and help each other, particularly in connection with the harvest, preparation, storage, and sharing of natural resources (work, sharing, family) Natural resources security: Local natural resources (air, water, land, plants, and animals) are abundant, accessible, and support a healthy ecosystem(s) and healthy human community (quality, access, safety) Cultural use: The community is able to perform its cultural traditions in a respectful and fulfilling way using the local natural resources (respect/stewardship, practice) Education: Knowledge, values, and beliefs are actively passed from elders to youth (knowledge, elders, youth) Self-determination: Communities develop and enact their own healing, development, and restoration programs; the community trusts and supports its government (healing/restoration, development, trust) Balance: Community members maintain connections to meaningful locations, confident that their health and the health of the next seven generations can voluntarily adapt to changes, temporary or permanent, and strongly connect with who they are in positive ways (sense of place, identity, resilience)

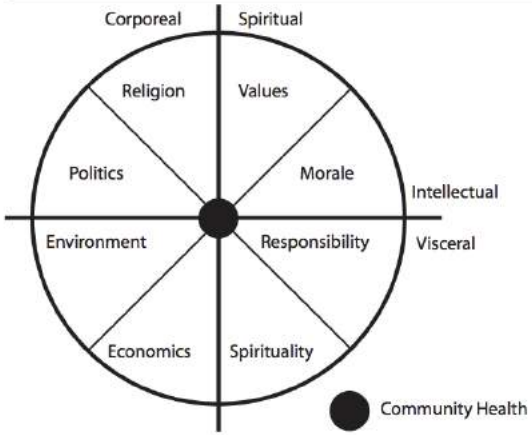
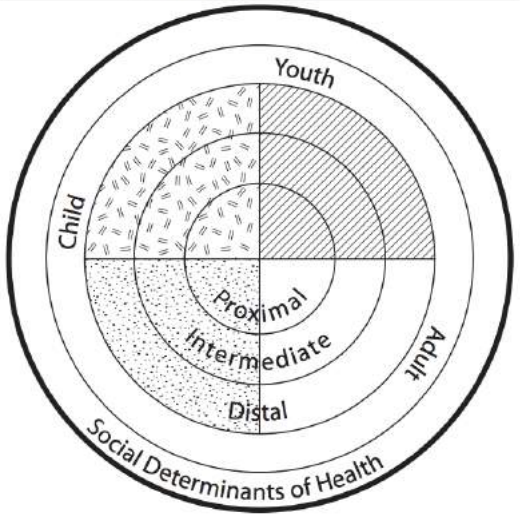
8	Climate-sensitive health priorities in Nunatsiavut, Canada. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1874-3	Harper, Sherilee L; Edge, Victoria L; Ford, James; Willox, Ashlee Cunsolo; Wood, Michele; IHACC Research Team; RICG; McEwen, Scott A (2015)	Canada	  Climate-sensitive health pathways were described in terms of inter-relationships between environmental and social determinants of Inuit health. The climate-sensitive health priorities for the region

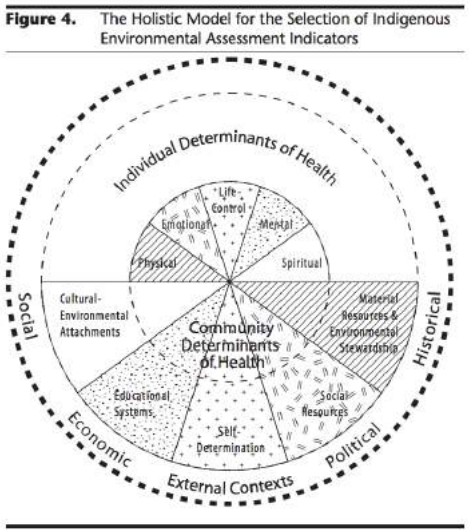
				included food security, water security, mental health and wellbeing, new hazards and safety concerns, and health services and delivery.

9	Native American Perspectives on Health and Traditional Ecological Knowledge.
	
	https://ehp.niehs.nih.gov/doi/10.1289/ehp1944
		Isaac, Gwyneira; Finn, Symma; Joe, Jennie R; Hoover, Elizabeth; Gone, Joseph P; Lefthand-Begay, Clarita; Hill, Stewart (2016)	USA	**Environmental Exposures and Social Stressors Affecting Tribal Communities**
				Research Addressing Tribal Health Disparities at Regional, Community, and Household Levels
				
				The Exposome considers the totality of environmental exposures and pyschosocial stressors across the lifespan
				
				An approach consistent with the perspective of **Traditional Ecological Knowledge** that considers the interactions and interconnectedness of human and environmental health
				
				Research is increasingly embracing a more holistic approach to promoting health and understanding the combined factors that lead to disease
				
				 
				
				Environmental Exposures and Social Stressors at Regional, Community and Household and Personal (Family) Levels
				• Regional Level: Resource Extraction/Mining
				  ○ Oil spills, chemical spills
				  ○ Gas flaring/air pollution
				  ○ Heavy metals in water, soil, and air (mine tailings and coal ash)
				• Regional Level: Extreme Seasonal Variation
				  ○ Wildfires, tornados, hurricanes
				  ○ Land and icecap loss from floods/sea level rise
				  ○ Loss of arable land to drought/soil contamination and depletion
				  ○ Extreme heat/cold
				  ○ Ocean warming/harmful algal blooms
				• Regional Level: Ongoing Historical (Social) Trauma
				  ○ Disruption of traditional fishing rights/depletion of food supply
				  ○ Development encroaching on tribal lands (water supply)
				• Community Levels: Industrial Pollutants (PBBs PCBs, PAHs)
				  ○ Air and water pollution
				  ○ Contamination of traditional foods
				  ○ Migration of POPs to Arctic
				• Community Levels: Agricultural Pollutants
				  ○ Pesticide exposures workers and families
				  ○ Confined Animal Feeding Operations (CAFOs)
				  ○ Air pollution, water and soil contamination
				• Household/Personal Level: Neighborhood Characteristics
				  ○ Built environment (walkability, density, green space)
				  ○ Food deserts
				  ○ Contaminated soils/urban gardens
				  ○ Access to healthcare
				  ○ Socioeconomic status (SES) of the community/tribal nation
				• Household/Personal Level: Household Exposures
				  ○ Chemicals in cleaning products and personal care products
				  ○ Indoor air pollution from biomass fuel burning
				  ○ Built environment (asthma triggers)
				  ○ Social factors (noise, violence, density/multi-family residence)
				  ○ SES of the family/individual
				• Household/Personal Level: Family Health History
				  ○ Epigenetic response to exposures and pollutants
				  ○ Genetic characteristics that increase risk
				
				Human Health Effects
				• Kidney disease
				• Metabolic disorders and diabetes (obesity)
				• Cancers
				• Respiratory diseases
				• Cardiovascular disease
				• Neurological disorders, neurodevelopmental delays
				• Stress, depression, drug and alcohol abuse, suicide
				
				Examples of Research with Tribal Communities Utilizing TEK and Exposomic Approaches
				• Gold King Mine Spill, Arizona
				• Deepwater Horizon Oil Spill, Louisiana
				• Uranium mining effects, New Mexico and Arizona
				• PCBs in breastmilk, New York
				• Contaminated fish, Great Lakes
				• Persistent Organic Pollutants (POPs), Alaska
				• Indoor air pollution effects on children and elderly, Montana
				• Drought effects on traditional foods and heavy metals in soil, Arizona
				• Asthma triggers in poorly built homes, North Carolina
				• Arsenic in wells, Maine, Arizona, Oklahoma, and North/South Dakota
				• Harmful algal blooms effect on traditional seafood, Northwest Coast
				• Epigenetic modifications affecting arsenic related CVD, Arizona, Oklahoma and Dakotas

<table>
<tr>
<td>10</td>
<td>Statistical equality and cultural difference in Indigenous wellbeing frameworks: A new expression of an enduring debate

https://onlinelibrary.wiley.com/doi/abs/10.1002/j.1839-4655.2010.tb00183.x</td>
<td>Jordan, Kirrily; Bulloch, Hannah; Buchanan, Geoff (2010)</td>
<td>Australia</td>
<td>Indicators of wellbeing developed by the United Nations Permanent Forum on Indigenous Issues:
Table 3: UNPFII proposed indicators relevant to Indigenous peoples' wellbeing, poverty and sustainability, selected indicators
<table>
<tr><th>Themes and issues</th><th>Proposed Indicators</th></tr>
<tr><td colspan="2">Security of rights to territories, lands and natural resources</td></tr>
<tr><td rowspan="5">Actual control of territories, lands and natural resources</td><td>Control/ownership of lands and territories by Indigenous peoples</td></tr>
<tr><td>Application of free, prior, informed consent</td></tr>
<tr><td>Protection from alienation of land and displacement of people</td></tr>
<tr><td>Respect for Indigenous peoples' rights to manage and use natural resources</td></tr>
<tr><td>Fairness of distribution of benefits generated from Indigenous peoples' territories, lands and natural resources</td></tr>
<tr><td rowspan="2">Integrity of Indigenous cultural heritage</td><td>Condition of territories, lands and natural resources controlled by Indigenous peoples</td></tr>
<tr><td></td></tr>
<tr><td>Promotion of Indigenous languages</td><td>Status and trends of linguistic diversity and numbers of speakers of Indigenous languages</td></tr>
<tr><td rowspan="4">Measures to protect traditional production and subsistence</td><td>Inclusion of hunting and gathering practices in modern economic systems—economic pluralism</td></tr>
<tr><td>Programmes to restore degraded lands and endangered plants and animals</td></tr>
<tr><td>Proportion of intact traditional subsistence lands, resource and habitats vs. contaminated or degraded lands and products</td></tr>
<tr><td>Laws and policies protecting traditional subsistence</td></tr>
<tr><td colspan="2">Material well-being (Note: Indigenous peoples' own definition of development can be included here)</td></tr>
<tr><td rowspan="5">Development, including participation in development policy; and policies, plans and programmes to improve Indigenous well-being</td><td>Income/consumption</td></tr>
<tr><td>Health</td></tr>
<tr><td>Education</td></tr>
<tr><td>Percentage of Indigenous economy generated through traditional subsistence activities</td></tr>
<tr><td>Service available, quality and level of coverage of programmes and projects in Indigenous communities</td></tr>
<tr><td></td><td>Levels of access of Indigenous residents to economic opportunities</td></tr>
</table>
Source: Tauli-Corpuz (2008).</td>
</tr>
</table>

11	A holistic model for the selection of environmental assessment indicators to assess the impact of industrialization on indigenous health. https://link-springer-com.proxy.queensu.ca/article/10.1007/BF03404158	Kryzanowski, Julie A; McIntyre, Lynn (2011)	Canada	**Figure 2.** The Community Life Indicators Wheel[30]  **Figure 3.** The Integrated Life Course and Social Determinants Model of Aboriginal Health[28]*  * Adapted to emphasize relationships among proximal, intermediate and distal determinants.

				
12	Ka mauli o ka 'oina a he mauli kanaka: an ethnographic study from an Hawaiian sense of place. https://pubmed.ncbi.nlm.nih.gov/12180509/	Oneha, M F (2001)	Hawai'i (USA)	The findings suggest that the relationship between sense of place and health embodies four categories: (1) relationship to akua (god, spirit), (2) relationship to natural elements, (3) relationship to self and others, and (4) belonging to a particular place. Three major traditional Hawaiian concepts, which defined how the relationship between sense of place and health are experienced, were pono, mana, and kuleana. The relationship between these concepts revealed five cultural themes. Health for Hawaiians: I. is having a spiritual connection to their ancestral place; II. relates to the past, present, and future; III. is experienced with intention and understanding; IV. means an openness to the flow and use of energy; and

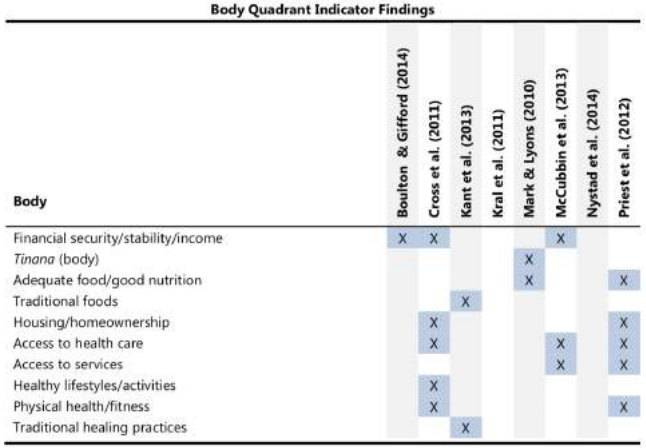
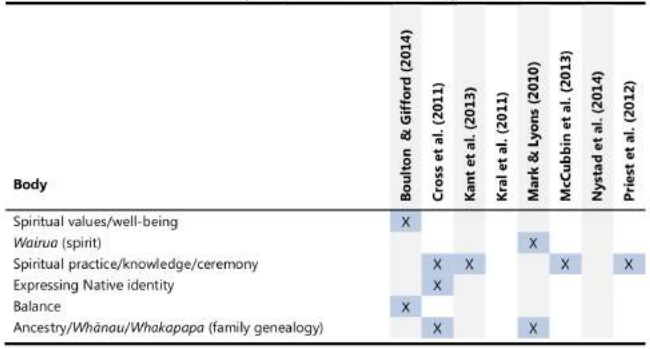
				V. is experienced as a pu'uhonua or safe place. These themes suggest implications for Hawaiian health education, practice, and further research, including that health professionals provide care from these perspectives in order to raise the health status of Hawaiians to the highest possible level.
13	Strength-based well-being indicators for Indigenous children and families: A literature review of Indigenous communities' identified well-being indicators https://coloradosph.cuanschutz.edu/docs/librariesprovider205/journal_files/vol23/23_3_2016_206_rountree.pdf?sfvrsn=8dd1e0b9_2	Rountree, Jennifer; Smith, Addie (2016)	USA	 These quadrants are context (family, culture, community, environment, history), mind (cognition, emotion, identity), body (physical needs and genetic makeup, practical needs—including financial needs), and spirit (spiritual practices and teachings, dreams, stories.)

Table 1
Context Indicator Findings

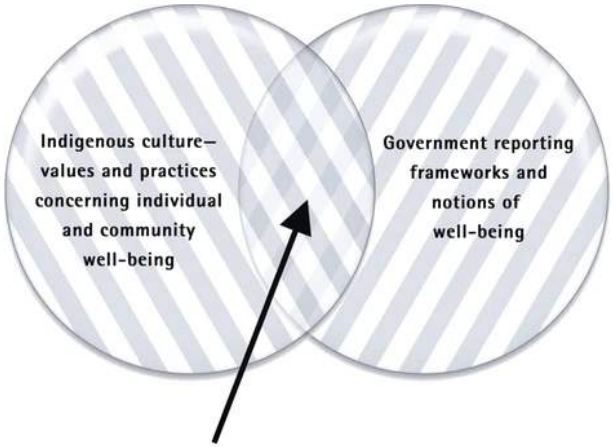
Context	Boulton & Gifford (2014)	Cross et al. (2011)	Kant et al. (2013)	Kral et al. (2011)	Mark & Lyons (2010)	McCubbin et al. (2013)	Nystad et al. (2014)	Priest et al. (2012)
Support (family, friends, community)/interdependence	X							X
Connection to land					X		X	X
Community involvement/participation/contribution	X	X				X		
Family commitment						X		
Kinship/elders/community connection/ties			X	X			X	X
Life cycle events/traditional activities/practices				X		X	X	X
Healthy relationships		X		X				
Safety		X						X
Connecting with resources		X						
Access to cultural sites			X					

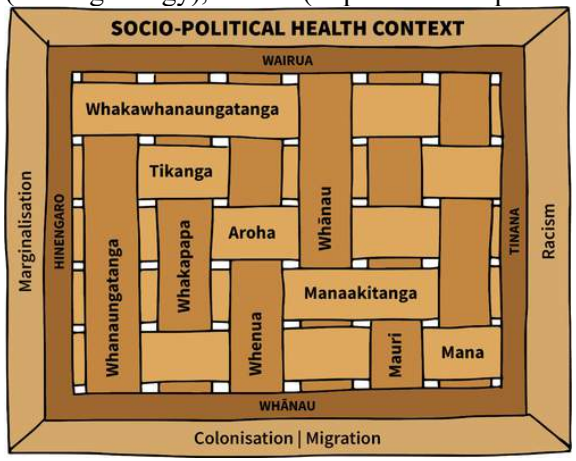
Table 2
Mind Quadrant Indicator Findings

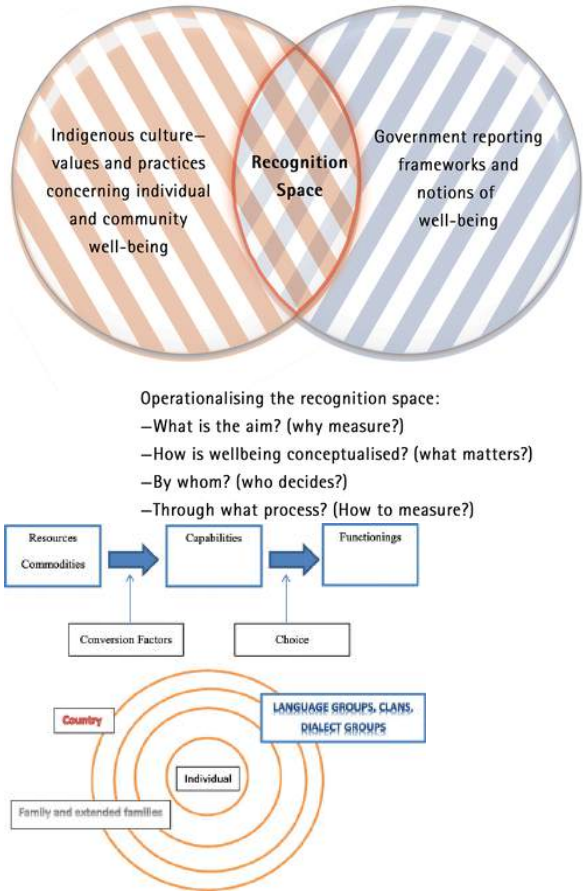
Mind	Boulton & Gifford (2014)	Cross et al. (2011)	Kant et al. (2013)	Kral et al. (2011)	Mark & Lyons (2010)	McCubbin et al. (2013)	Nystad et al. (2014)	Priest et al. (2012)
Cultural identity/sense of belonging to cultural group	X	X	X					X
Ethnic pride							X	X
Self-esteem								X
Happiness	X							X
Focus/determination		X						
Hope/looking forward/optimism	X							
Hinengaro (mind)					X			
Educational enrollment/achievement		X						
Resilience						X		X
Speaks Native language						X	X	
Cultural teachings/knowledge		X						X
Coping skills		X						
Personal qualities/capacities		X						X
Employment/employability		X						

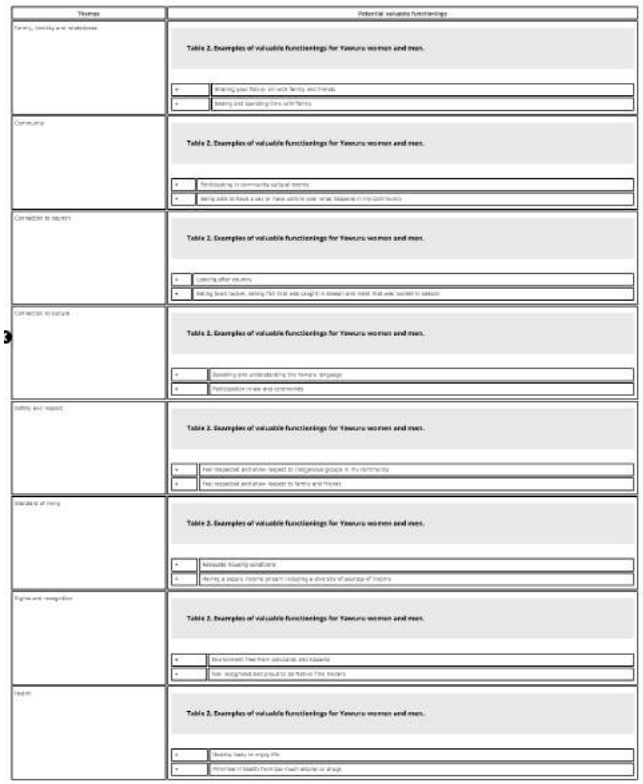
				Table 3 **Body Quadrant Indicator Findings**  **Table 4** **Spirit Quadrant Indicator Findings** 
14	'I'm not sure it paints an honest picture of where my health's at' - identifying community health and research	Spurling, Geoffrey K; Bond, Chelsea J; Schluter, Philip J;	Australia	Key informants articulated an authoritative understanding of how interrelated, intergenerational, social, cultural and environmental determinants operated in a 'cycle' to influence the community's health. Key informant views supported the inclusion of these determinants in health assessments, reinforced the importance of comprehensive primary healthcare and strengthened referral pathways to community resources.

	priorities based on health assessments within an Aboriginal and Torres Strait Islander community: a qualitative study. https://www.proquest.com/docview/2210347251?pq-origsite=gscholar&fromopenview=true	Kirk, Corey I; Askew, Deborah A (2017)		The three central themes that emerged included: (1) complex, interrelated, intergenerational nature of health involving social, cultural and environmental determinants of health (SCEDH); (2) ambivalence about health assessments; and (3) community strength. These accounts were consistent with the holistic Aboriginal definition of health, which is not merely the provision of doctors or absence of disease, but involves all aspects of life including grief and loss. Although HAs have a role in individual preventive health, they may be less useful in responding to the complex, interrelated SCEDH that are important to key community informants' conception of health.
15	Pragmatic indicators for remote Aboriginal maternal and infant health care: why it matters and where to start.* https://onlinelibrary.wiley.com/doi/10.1111/j.1753-6405.2010.00545.x	Steenkamp, Malinda; Bar-Zeev, Sarah; Rumbold, Alice; Barclay, Lesley; Kildea, Sue (2010)	Australia	Many indicator sets included measures dealing with similar topics, especially where sets had the same focus, e.g., to monitor hospital clinical care. There were some indicator topics that appeared in nearly all sets: antenatal coverage, maternal tobacco smoking and/or alcohol use during pregnancy, delivery type, labour induction, caesarean section occurrence, perineal trauma, birth weight, perinatal mortality rate, Apgar score at 5 minutes, breastfeeding, and immunisation status. The 300 topics were grouped into 16 themes and organised by indicator type and stage of patient journey.

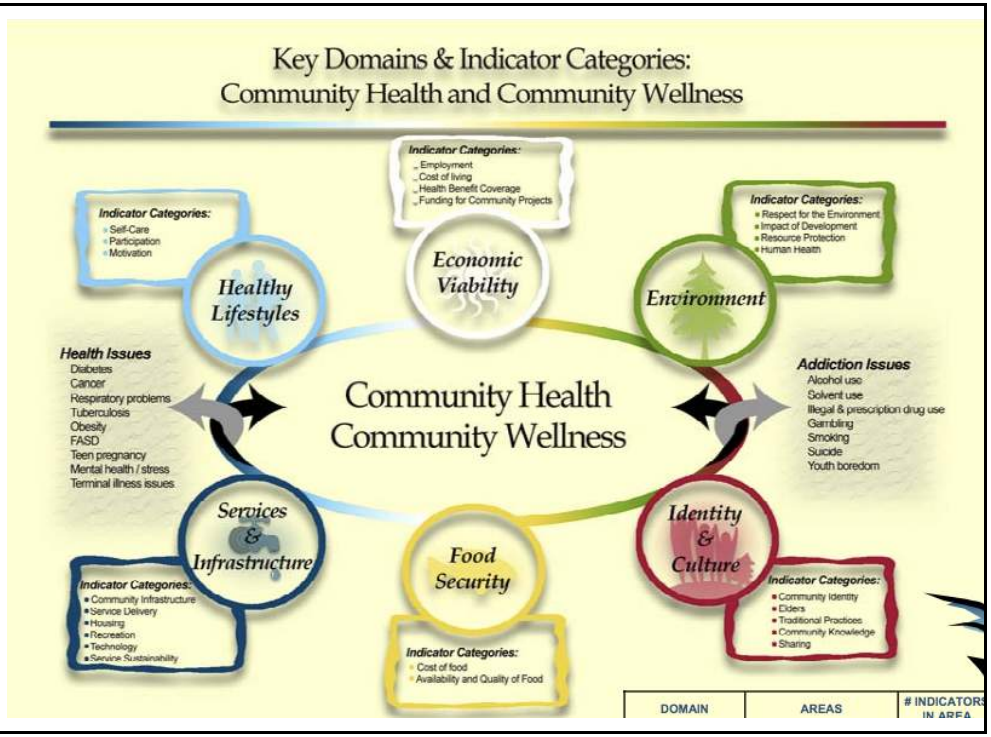
16	Indigenous peoples and indicators of well-being: Australian perspectives on United Nations global frameworks* https://link.springer.com/article/10.1007/s11205-007-9161-z	Taylor, John (2008)	Australia	 Translation in the recognition space: from 'culture' and 'well-being' to appropriate 'social indicators' Cultural geography (governance and planning should be based on the local social geography such as concerning family groups, clans with information collected on this basis); Decision-making (locally generated indicators enhance the capacity to make evidence-based informed decisions); Organisational performance (data is required for effective service delivery); Strategic direction (projections of future population numbers/characteristics provide for the development of long-term perspectives); Participation and voice (information dissemination raises stakeholder awareness both internally and externally); Resource governance (data on human capital resources informs economic development potential); The governance environment (data on fiscal flows illuminates the impact of wider

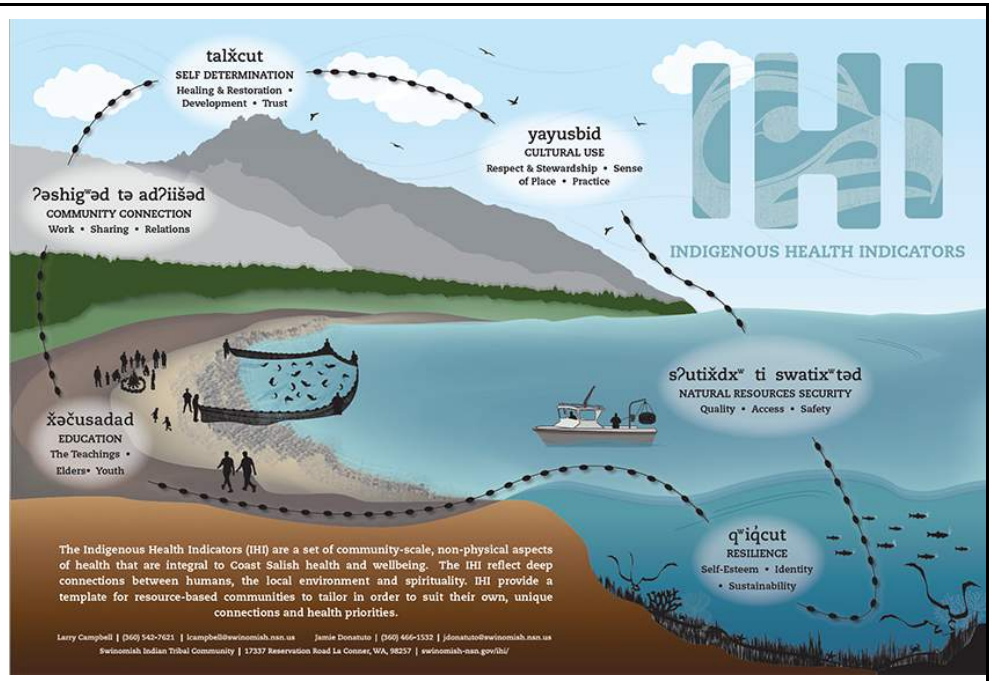
				state and national relationships), and Governance capacity (participation in data collection, analysis, application and dissemination builds local capacity).
17	Creating an Indigenous Maori-centred model of relational health: A literature review of Maori models of health. https://onlinelibrary.wiley.com/doi/10.1111/jocn.15859	Wilson, Denise; Moloney, Eleanor; Parr, Jenny M; Aspinall, Cathleen; Slark, Julia (2021)	New Zealand	Four overarching themes were identified that included dimensions of health and wellbeing; whanaungatanga (connectedness); whakawhanaungatanga (building relationships); and socio-political health context (colonisation, urbanisation, racism, and marginalisation). Health and wellbeing for Māori is a holistic and relational concept. Building relationships that include whānau (extended family) is a cultural imperative. Key elements for a Māori-centred model of relational care include whakawhanaungatanga (the process of building relationships) using tikanga (cultural protocols and processes) informed by cultural values of aroha (compassion and empathy), manaakitanga (kindness and hospitality), mauri (binding energy), wairua (importance of spiritual well being). 

18	Operationalising the capability approach: developing culturally relevant indicators of indigenous wellbeing–an Australian example https://www.tandfonline.com/doi/full/10.1080/13600818.2016.1178223	Yap, Mandy; Yu, Eunice (2016)	Australia	

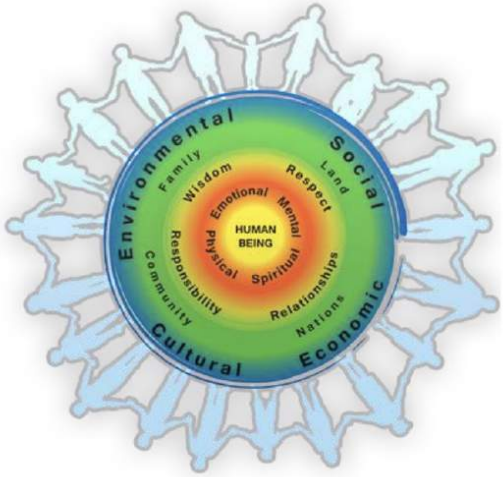
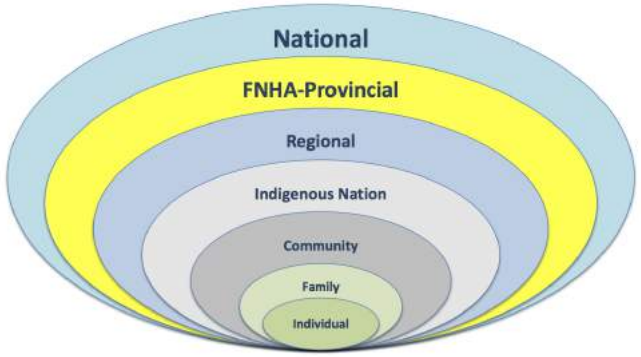
				
19	Indigenous Health Indicators A participatory approach to co-designing indicators to monitor and measure First Nations health http://www.afnigc.ca/main/includes/media/p	Paulette Fox, Amelia Crowshoe (2018)	Canada	1. Health, social, & environmental security 2. Health, socio-cultural, & environmental services access 3. Self-determination 4. Holistic health 5. Food sovereignty 6. Climate & water security 7. Environment & energy stewardship Community Connection: Members actively participate in community functions and help each other,

	df/digital%20reports/Indigenous%20Health%20Indicators.pdf			particularly in connection with the harvest, preparation, storage, and sharing of natural resources (work, sharing, family) Natural Resources Security: local natural resources (air, water, land, plants, and animals) are abundant, accessible, and support a healthy ecosystem(s) and healthy human community (quality, access, safety) Cultural Use: the community is able to perform its cultural traditions in a respectful and fulfilling way using the local natural resources (respect/stewardship, practise) Education: Knowledge, values, and beliefs are actively passed from elders to youth (knowledge, elders, youth) Self-determination: communities develop and enact their own healing, development, and restoration programs; the community trusts and supports its government (healing/restoration, development, trust) Balance: community members maintain connections to meaningful locations, confident that their health and the health of the next seven generations can voluntarily adapt to changes, temporary or permanent, and strongly connect with who they are in positive ways (sense of place, identity, resilience)

20	Development of an Evaluative Framework for use by First Nations Health Organizations http://www2.uregina.ca/fnh/posters/Development%20of%20Evaluative%20Framework%20(Montreal)-%20Sept-05.pdf	Sylvia Abonyl, Bonnie Jeffrey, Colleen Hamilton (2005)	Canada	

21	Indigenous Health Indicators https://swinomish-nsn.gov/ihi2/background.html	Swinomish Indian Tribal Community (2014)	USA	 Current U.S. government public health regulations and policies are based on a position that views risks and impacts as objective measures of dose-response assessments and physiological morbidity or mortality outcomes but does not otherwise connect them to social or cultural beliefs and values integral to Native American definitions of health. By constructing a more complex, narrative set of indicators beyond the physiological for tribal communities, a more accurate picture of health status is gained with which to better evaluate and manage tribal public health risks and impacts.

22	Indigenous Health Model (IHM) https://nb3foundation.org/indig-health-mod/	NB3 Foundation (2016)	USA	 The IHM includes an ecological systems framework that considers the many personal and environmental factors that impact a person's health. Additionally, the IHM blends this framework with the five principles of indigenous knowledge and worldviews by connecting to the place of the people, and the gifts and values that contribute to changes at the individual, family, and community level. Beginning with indigenous knowledge and worldviews, the IHM sets the context for how indigenous people conceptualize holistic health (physical, spiritual, emotional, and mental) based on their ancestral teachings, which includes the natural environment and creation. The model is reflective of how to be a good relative and the connection to all life forces: creation, people, plants, and animals. These foundational teachings are the facilitators for illustrating how success can be measured based on community driven indicators that include cultural teachings, roles, and protocols.
23	FNHA Wellness Indicators https://www.fnha.ca/Documents/FNHA-Wellness-Indicators-Rebecca-Lee.pdf	Rebecca Lee (2015)	Canada	The Center Circle represents individual human beings. Wellness starts with individuals taking responsibilities for our own health and Wellness. The Second Circle illustrates the importance of Mental, Emotional, Spiritual and Physical facets of a healthy, well, and balanced life. Third Circle represents the overarching values that support and uphold wellness: Respect, Wisdom, Responsibility, and Relationships. The Fourth Circle depicts the people that surround us and the places

				from which we come: Nations, Family, Community, and Land are all critical components of our healthy experience as human beings. The Fifth Circle depicts the Social, Cultural, Economic and Environmental determinants of our health and well-being.  

Indigenous Peoples and Health Governance

#	Paper Title and Link	Authors (Year)	Country of Intervention	Abstract
1	Indigenous Governance: Questioning the Status and the Possibilities for Reconciliation with Canada's Commitment to Aboriginal and Treaty Rights https://fngovernance.org/wp-content/uploads/2020/09/kiera_ladner.pdf	Ladner, K.L. (2006)	Canada	No abstract available.
2	Improving Indigenous community governance through strengthening Indigenous and government organisational capacity	Tsey, K., McCalman, J., Bainbridge, R. & Brown, C. (2012)	Australia	No abstract available.

	https://www.aihw.gov.au/getmedia/04fa3771-33c4-448b-b82e-3dce26c4cd97/ctgc-rs10.pdf.aspx?inline=true			
3	Canadian Indigenous Governance Literature: A Review https://journals.sagepub.com/doi/10.1177/1177180112000800101	von der Porten, S. (2012)	Canada	This paper reviews contemporary concepts and practices in Indigenous governance. The purpose is threefold: to outline trends in and ways forward for Indigenous governance; to identify some common yet problematic approaches to Indigenous self-determination; and to discuss the different ways that Indigenous self-determination is defined. The paper serves as a literature review of Indigenous governance specifically in the Canadian context. The ideas discussed are framed within the concepts of democracy, critical Indigenous theory and governance.
4	How to decolonize democracy: indigenous governance innovation in Bolivia and Nunavut, Canada. https://bsj.pitt.edu/ojs/index.php/bsj/article/view/169	Rice, R. (2016)	Bolivia, Canada	This paper analyzes the successes, failures, and lessons learned from the innovative experiments in decolonization that are currently underway in Bolivia and Nunavut, Canada. Bolivia and Nunavut are the first large-scale tests of Indigenous governance in the Americas. In both cases, Indigenous peoples are a marginalized majority who have recently assumed power by way of democratic mechanisms. In Bolivia, the inclusion of direct, participatory, and communitarian elements into the democratic system, has dramatically improved representation for Indigenous peoples. In Nunavut, the Inuit have also opted to pursue self-determination through a public government system rather than

				through an Inuit-specific self-government arrangement. The Nunavut government seeks to incorporate Inuit values, beliefs, and worldviews into a Canadian system of government. In both cases, the conditions for success are far from ideal. Significant social, economic, and institutional problems continue to plague the new governments of Bolivia and Nunavut. Based on original research in Bolivia and Nunavut, the paper finds that important democratic gains have been made. I argue that the emergence of new mechanisms for Indigenous and popular participation has the potential to strengthen democracy by enhancing or stretching liberal democratic conceptions and expectations.
5	Multi-actor systems as entry points to capacity development. https://www.academia.edu/11478526/Multi_actor_systems_as_entry_points_to_capacity_development	Acquaye-Baddoo, N-A., Ekong, J., Mwesige, D., Nass, L., Neefjes, R., Ubels, J., Visser, P., Wangdi, K., & Were, T. (2010)	Ethiopia, Kenya, & Uganda	It is often assumed that capacity development starts from within individuals and organisations and then permeates into society. But capacity also comes about through interaction between actors. This suggests that a change in intervention logic and repertoire can boost effectiveness.
6	Strengthening Indigenous community	Hunt, J. & Smith, D.E.	Australia	This paper presents research which is currently underway into the state of Indigenous community governance in Australia. The Indigenous Community Governance Project starts from the

	governance: a step towards advancing reconciliation in Australia. https://core.ac.uk/download/pdf/162631492.pdf	(2005)		hypothesis that good governance of Indigenous communities is essential for effective self-determination and is a key ingredient to successful socio-economic development. It is also critically important to Indigenous people engaging successfully with governments at various levels. Currently there are many changes going on in the governance environment, but little is understood about what makes for culturally legitimate and effective indigenous governance and how to attain it. The Project, supported by the Centre for Aboriginal Economic Policy Research at ANU and Reconciliation Australia, has put together a team of researchers who are working with communities, their organisations and leaders, in order to understand how Indigenous governance operates at the local and regional levels. Preliminary work has highlighted a number of issues which will be the subject of more systematic research in coming months and years. Despite important local variations, it is apparent that all the participating community organisations are facing common systemic issues which are outlined.
7	Emergent Drivers for Building abnd Sustaining capacity in Australian Indigenous Communities https://link.springer	Abdullah, J., & Young, S. (2010)	USA	The perceived need for capacity building for Indigenous1 families and communities in Australia by policy-makers is based on the persistent negative indicators on all the relevant social, economic and health statistics. This results in the provision of 'help' to lift the capacities of Indigenous communities to overcome the conditions in which they live. We take little issue with capacity building per se in this chapter. Rather we wish to unpack how this 'help' is provided and with what results. This chapter will 'background' the debates about the deficits purported to be associated with

	.com/chapter/10.1057/9780230298057_5			Aboriginal people and communities (for that is how much of the capacity building policy and practice is constructed) without ignoring them, and 'foreground' the strengths, capabilities and resiliencies found in Aboriginal communities, as a way, not of denying the fragile state of First Nations Australian society, but of offering a picture that differs from that usually portrayed. As recently noted by Maddison (2009), this is the view that is almost always offered to a public which vacillates between interest and care, disinterest and accusatory blame. We provide an argument which, like Maddison's, is not about 'dysfunctional communities, welfare dependency, child abuse, alcohol or violence' (2009:xxvi), but recognises Aboriginal people as 'resourceful, creative and persistent' (2009:xxvi) in the face of the many challenges they face. We apply a well known framework from the Brotherhood of St Laurence to discuss three case studies of capacity building in Indigenous communities to tease out what we have found 'works' in policy and practice. We end by making suggestions for inclusion into policy and practice to enhance Indigenous peoples' and communities' own journeys of wellbeing.
8	Collaborative approaches to governance for water and Indigenous peoples: A case study from British Columbia, Canada	Von der Porten, S., & de Loë, R. C. (2013)	Canada	Indigenous peoples around the world hold views about identity, self-determination and nationhood that often are distinct from those of governments and others involved in environmental governance. Conflicts and tensions often result when these incompatible perspectives clash. This problem is evident in the context of collaborative approaches to environmental problem solving, which often are grounded in the assumption that Indigenous peoples simply are one of many stakeholders; this

	https://www.infona.pl/resource/bwmeta1.element.elsevier-48aeb2d4-6681-37e4-b619-2c4d391db8c1			perspective is fundamentally incompatible with the concept of Indigenous peoples as existing within self-determining nations. Using an empirical case of collaborative governance for water in the province of British Columbia, Canada, this paper explores the extent to which collaborative practices reflect Indigenous concerns and perspectives. In the cases examined, collaborative practices tended not to recognize or account for c…
9	Community capacity building – a review of the literature. https://researchnow.flinders.edu.au/en/publications/community-capacity-building-a-review-of-the-literature	Verity, F. (2007)	Australia	No abstract available.
10	Cultural and personal principles for Indigenous governance.	Phillips, G. (2010)	N/A	No abstract available.
11	Governance for sustainable development: strategic issues	Dodson, M. & Smith, D.E. (2003)	Australia	This Discussion Paper examines the concepts of ‘governance’, ‘good governance’ and ‘sustainable development’ in the context of Australian Indigenous communities and regions. It explores the hypothesis that there is vital link between governance and

	and principles for Indigenous Australian communities. https://www.researchgate.net/publication/237134933_Governance_for_sustainable_development_Strategic_issues_and_principles_for_Indigenous_Australian_communities			sustainable development. The first half of the paper defines the key concepts and reviews the existing barriers facing Indigenous communities and their organisations in securing sustainable socioeconomic development. It identifies the key ingredients of successful development and then those over which Indigenous Australians actually have some local control. On the premise that it is best to make a start in areas where local control can be exercised, building 'good governance' is identified as the key ingredient—the foundation stone—for building sustainable development in communities and regions. The second half of the paper then proposes a set of key ingredients and core principles which Indigenous communities might use to build more effective governance. These draw on the professional and field experience of the authors and other Australian research, the international findings of the Harvard Project in the USA, and the Gitxsan leader Neil Sterritt's applied research on governance with Canadian First Nations.
12	Governance, cultural appropriateness and accountability within the context of Indigenous self-determination. https://openresearch-	Martin, D.F. (2005)	Australia	No abstract available.

	repository.anu.edu.au/handle/1885/76660			
13	Leadership and capacity building for community and regional governance.	Dodson, M. (2002)	Australia	No abstract available.
14	Working differently to make a difference in Indigenous communities. Public Administration Today 14:5–13 https://search.informit.org/doi/10.3316/ielapa.200808944	Jarvie, W. (2008)	Australia	No abstract available.
15	Building capacity towards health leadership in remote Indigenous communities in	Laverack, G., Hill, K., Akenson, L. & Corrie, R. (2009)	Australia	This paper describes an established approach for building capacity used for the first time with Health Action Teams (HATs) in three remote indigenous communities in Cape York. A key purpose was to determine if the approach was an appropriate and practicable 'tool' in an Aboriginal context. This is not a research study but

	Cape York. https://healthbulletin.org.au/articles/building-capacity-towards-health-leadership-in-remote-indigenous-communities-in-cape-york/			rather the reflections on a project evaluation to collect and interpret information recorded during workshops to build and measure the capacity of the HATs using eight domains. The domains represent those aspects of the process of capacity building that allow the HATs to better organise and mobilize themselves towards gaining greater control. The analysis of each domain included a description and visual representation of capacity. There were similarities in the measurement of capacity between the three HATs in five domains. This was because each HAT was at an early stage of development and generally had a low capacity. Importantly, each HAT was able to develop a realistic strategy with which to move forward to build capacity with clear roles, responsibilities and timeframes. The key to building HAT capacity was the use of strategic planning based on the eight 'domains' and the use of an appropriate means of visual representation. This is discussed in detail in the paper and provides encouragement for an empirical study into the application of capacity building approaches.
16	Rethinking the Design of Indigenous Organisations: The Need for Strategic Engagement https://www.researchgate.net/publicat	Martin, D.F. (2003)	Australia	This paper argues that a fundamental issue confronting Australian indigenous groups and communities is how to develop the capacity to engage strategically with the general Australian society, in particular with its political and economic dimensions. 'Strategic engagement' refers to the processes through which indigenous individuals, groups and communities are able to interact with, contribute to, draw from—and of course potentially reject—the formal and informal institutions of the dominant Australian society in a considered and informed manner that

	ion/251774322_Rethinking_the_Design_of_Indigenous_Organisations_The_Need_for_Strategic_Engagement			provides them with real choices as to where to go, and how to get there. It refers to a process, not an outcome. This capacity for strategic engagement is dependent upon many factors, but effective governance mechanisms in particular are critical. Governance can be seen as the formal and informal structures and processes through which a group, community or society conducts and regulates both its internal affairs and its relations with others. This paper focuses on principles for effective governance within indigenous organisations. It argues that nowhere in Australia do indigenous people live in self-defining and self-reproducing worlds of meaning and practices; rather they inhabit complex and contested intercultural worlds. Therefore, if institutions for more effective governance are essential to strategic engagement, then they must draw not only from indigenous values and practices, but also from those of the general Australian society, and indeed from relevant international experience. It is argued that it is no longer defensible to resort to the mantra of 'cultural appropriateness', nor solely to traditions and customary practices in determining principles by which effective indigenous institutions should be established and should operate. Rather, the challenge is to develop distinctively indigenous institutions which nonetheless facilitate effective engagement rather than limiting it. This paper suggests a set of principles for this task.
17	Transition to governance: building capacity in an Indigenous	Mawson, F., Madgwick, M., Judd, J., &	Australia	This paper from the 2007 Australian Social Policy Conference outlines the issues and challenges faced by the Transition to Governance project, its partners and the Indigenous community members who are committed to establishing a new Aboriginal

	community https://apo.org.au/node/2730	Fergie, D. (2007)		community controlled health organisation. Historically the Indigenous community in outer eastern Melbourne was serviced by an Aboriginal Community Controlled Health Organisation (ACCHO). However, in 1998 following a review by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) the health service was de-funded and OATSIH approached Yarra Valley Community Health Service (YVCHS) to accept the auspice for the delivery of Indigenous heath services in the Shire of Yarra Ranges. The Indigenous community's response to the transmission of services to YVCHS was varied as the Indigenous community is in principle committed to aboriginal control of health services. The transmission of service delivery to an Indigenous specific team within a mainstream health organisation was a bold move and a new model of management for OATSIH. The auspice arrangement is an interim arrangement, subject to the development of an accountable aboriginal community controlled organisation. In 2004 a report was commissioned to investigate and propose models for the governance of the Indigenous health service. The preferred proposal was the transfer of Indigenous health services back to community control and subsequently the transition to governance project was established. This paper provides a case study of the journey by partners and Indigenous community members as they undertake the 'transmission of business' from Yarra Valley Community Health Service to a newly constituted Aboriginal Community Controlled Health Organisation.
18	Empowerment and change	McEwan, A.B., Tsey, K.,	Australia	The social organisation of work, management styles and social relationships in the workplace all matter for health. It is now well

	management in Aboriginal organisations: a case study	McCalman, J. & Travers, H.J. (2010)		recognised that people who have control over their work have better health and that stress in the workplace increases the level of disease. In the context of organisational change, the potential benefits of empowerment strategies are two-fold: a positive impact on the organisation's effectiveness and enhancements in staff health, wellbeing and sense of control. This case study describes the University of Queensland Empowerment Research Program's experience working with the Apunipima Cape York Health Council in a change management process. Participatory action research and empowerment strategies were utilised to facilitate shifts in work culture and group cohesion towards achieving Apunipima's vision of being an effective lead agency for Indigenous health reform in Cape York. As part of the project, staff morale and confidence were monitored using a pictorial tool, Change Curve, which outlined the phases of organisational change. The project findings indicated that organisational change did not follow a clear linear trajectory. In some ways the dynamics mapped over a period of 18 months mirror the type of struggles individuals commonly encounter as a part of personal growth and development. In this case, one of the factors which influenced the program's success was the willingness of executive employees to actively support and participate in the change management process.
19	First Nations Governance Project's Phase I Governance	First Nations Financial Management Board	Canada	No abstract available.

	Report. https://iog.ca/projects-initiatives/indigenous-governance/	& Institute of Governance (2018)		
20	Practising self-determination: Participation in planning and local governance in discrete indigenous settlements https://espace.library.uq.edu.au/view/UQ:158053	Moran, M.F. (2006)	Australia	The principle and policy of self-determination holds that Aboriginal people should have the right to pursue a lifestyle of their choosing and to have control over their interactions with the wider society. Self-determination policy has been in place at a federal level since the 1970's, yet after thirty years of implementation, there is considerable disarray and disagreement over its merits. This study investigated the transactions of decision-makers as they practised two of the main policy instruments of self-determination: participatory planning and self-governance. The research settings were Mapoon and Kowanyama, two discrete Indigenous settlements on the West Coast of Cape York Peninsula, in the state of Queensland, northern Australia. Three typologies for settlements, planning, and organisations were established, which gave the context for the study, as well as a basis from which to generalise findings. From the types of planning in practice, a participatory plan at Mapoon was singled out for further study since it specifically recreated the language of self-determination. The Mapoon Plan was found to be successful technically, but it fell short of its stated social development goals. Planning proved to be a highly politicised and idealised activity, brokered by external consultants. The complex interplay among knowledge, ideology

				and politics, as observed, could not be described in terms of two separate domains, but rather in terms of intercultural production across an interethnic field. The anthropological literature tended to treat Aboriginal polities as cultural isolates, situated within administrative vacuums. To progress the study, it became necessary to apply a functional and administrative rationality to what needed to be done in practice. Twenty case studies of decision-making forums were analysed in the main research setting of Kowanyama. Each involved the contemporary practice of self-determination, as local decision-makers engaged with the wider society. In the majority of cases, all six proposed factors were found to be necessary, but not sufficient, for success: (1) participation, (2) technical expertise, (3) negotiation, (4) institutional capacity, (5) focal driver, and (6) jurisdictional devolution. A typology of actors was established to define the different decision-makers involved. Of the 600 adults in Kowanyama, only 30 were found to be actively involved in decision-making. This was unexpectedly low given the quantity of government activity purporting to further Kowanyama's self-determination. Six determinants were found to influence the level of participation: efficacy in practice, jurisdictional devolution, representativeness, function, informality, language and motivation. In particular, form followed function, whereby the function of a decision-making forum decided the level of participation that was appropriate. Contrary to accounts in the anthropological literature, the study found a fledgling system of representation in Kowanyama, complete with informal 'extra-constitutional' checks and balances. Factions were a powerful aspect of Kowanyama

				society, but they did not monopolise politics. The local polity was better conceptualised in terms of its political pluralism, encompassing a complex array of balancing and competing interests. Significantly, constituents were beginning to exert local political influence over their leaders. The analysis found that notions of 'community control,' as promulgated in the community development literature, were not adequate to explain the intercultural production underway. The full spectrum of participation was relevant to the actors of governance, from political activism to ambivalent apathy. Community control was found in the absence of government interventions, imbedded within informal institutions and cultural norms. Yet, introduced political structures, including Councils, were no less a part of the local political arena. The notion of governance better encapsulated the array of decision-making activities and actors occurring across a broad range of institutional positions. The study documented multiple dilemmas and indeterminacies as actors practised self-determination in the interethnic field, especially the interplay between local and external ideologies and knowledge. All of the examples of political innovation in the contemporary history of governance in Kowanyama involved productive social contexts developing locally between leaders and trusted outsiders. The complexity of problems and their solutions were only revealed through practice, one step at a time. Successful initiatives in Kowanyama were to a degree inadvertent; it was not until the end that actors understood what they had done right or wrong. Significantly, political innovation occurred in practice, often without any active intervention by government. Ironically, one of the

				greatest obstacles limiting local capacity was the size of the task of administering the programs of self-determination. An accepted role for leaders and employees was radical action to manipulate the system and to create the institutional space to permit the subjects of self-determination to participate. The analysis suggested that the importance assigned to government policy, legislation, and structure has fallen out of balance with their actual practice. Rather than fixating on policy solutions to self-determination, policy-makers should be focusing more on creating an enabling framework for practice. The six success factors proven in the study give the basis for such a framework.
21	From oral history to leadership in the Aboriginal community: A five year journey with the Wagga Wagga Aboriginal Elders Group Incorporated https://eric.ed.gov/?id=EJ799036	Milliken, N., & Shea, S. (2007)	Australia	This paper aims to identify the links that show how the establishment of an Aboriginal Elders Group in the Wagga Wagga community has contributed to the social capital of the Wagga Wagga Aboriginal Community. The paper will highlight the key educational episodes: oral history program; incorporation of the Elders group; self governance of the group, and confirmation of identities of community members that show how social capital has accrued and community capacity building has occurred. It will also highlight the leadership role and the accumulation of community civil capital that has developed for members of the Aboriginal Elders group over the time that they have been together.
22	Being sorry is not enough: the sorry state of the evidence base for	Paul, C.L., Sanson-Fisher, R., Stewart,	Australia	Indigenous people worldwide experience worse health outcomes than other population groups on measures such as life expectancy, death rates, and years of life lost (i.e., premature deaths). The historical underpinnings of this trend can be seen in

	improving the health of indigenous populations https://pubmed.ncbi.nlm.nih.gov/20409504/	J., & Anderson, A.E. (2010)		the devastating effects of colonization on health outcomes for indigenous people, highlighting the urgency needed in providing effective health interventions. Differences in health policy and in social, economic, cultural, geographic, and institutional factors also contribute to disparities in health outcomes. To improve the health of indigenous populations, multiple strategies are needed to deal with the complexities of health inequity, taking into account all of these determinants.

Indigenous Peoples and Patient Intake and Navigation

#	Paper Title and Link	Authors (Year)	Country of Intervention	Abstract
1	Navigating the cancer journey: a review of patient navigator programs for Indigenous cancer patients https://onlinelibrary.wiley.com/doi/10.1111/j.1743-7563.2012.01532.x	Whop, L.J., Valery, P.C., Beesley, V.L., Moore, S.P., Lokuge, K., Jacka, C., & Garvey, G. (2012)	USA	Patient navigator programs have evolved to facilitate access to care and improve outcomes for Indigenous cancer patients. We reviewed the scientific literature on patient navigator programs in Indigenous people with cancer. We conducted a review of the published literature up to 13 April 2011. PubMed, MEDLINE and CINAHL databases were searched for original articles on Indigenous patient navigation programs. The review produced eight relevant articles covering two specific programs, the Native Sisters Program and the Walking Forward Program. Program descriptions, patient navigator's roles, cultural aspects and the impact of the programs were described. Patient navigators' roles in the programs varied, as did their qualifications, but importantly, all were Indigenous. Both programs aimed to increase participation in screening, remove barriers to treatment and decrease mortality. The Native Sisters Program documented an increase in adherence to breast screening among navigated American Indian participants, although there were substantial differences in the baseline screening adherence between navigated and non-navigated participants. The Walking Forward Program yielded on average 3 fewer days of treatment delays for navigated American Indians than for non-navigated American Indians. However, adjustments for socioeconomic characteristics and disease characteristics were not described. Although preliminary outcomes are seemingly positive, further rigorous evaluation of quantitative impacts are needed.
2	Patient Navigation:	Freeman,	USA	Poor people experience substantial barriers when seeking timely

	A Community Based Strategy to Reduce Cancer Disparities https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2527166/	H.P. (2006)		screening, diagnosis, and treatment of cancer. This was a major conclusion of the American Cancer Society (ACS) based on the findings of the ACS National Hearings on Cancer in the Poor in 1989. As national President of the Society that year, I had the privilege of chairing these hearings in seven American cities with testimony from poor people from all 50 states. The poor people who testified came from all racial and ethnic groups—whites, blacks, Hispanics, Asians, and Native Americans. The key findings of the hearings were as follows: 1) Poor people face substantial barriers in seeking screening, diagnosis, and treatment of cancer. 2) Poor people experience more pain, suffering, and death due to cancer because of late diagnosis and treatment. 3) Poor people make sacrifices in order to obtain care and often do not seek care because they cannot afford it. 4) Poor people often indicate that the educational system related to health care is frequently insensitive and even irrelevant to them. 5) Poor people often become fatalistic and give up hope when in need of health care. Based on these findings coupled with my personal experience in providing cancer care to poor black patients in Harlem, I established the nation's first Patient Navigation Program beginning in 1990 at Harlem Hospital Center in New York City.1 Since the introduction of Patient Navigation in 1990, hundreds of Patient Navigator programs of various varieties have been established throughout the nation. Of significance, too, is the fact that the Harlem Patient Navigator Program served as the model for the "Patient Navigator Outreach and Chronic Disease Prevention Act," which was signed into law by the President in June 2005.
3	Culturally Relevant "Navigator"Patient	Burhansstipanov, L.,	USA	No abstract available.

	Support The Native Sisters	Wound, D.B., Capelouto, N., Goldfarb, F., Harjo, L., Hatathlie, L., Vigil, G., & White, M. (1998)		
4	Walking Forward: A Program Designed to Lower Cancer Mortality Rates among American Indians in Western South Dakota https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2719825/	Kanekar, S. & Petereit, D. (2009)	USA	Walking Forward is a community-based participatory research program in western South Dakota funded by the National Cancer Institute (NCI). The primary goal of this initiative is to address the high and ominously increasing cancer mortality rates among American Indians by facilitating access to innovative clinical trials, behavioral and genetic research and tailored patient navigation. The critical outcomes include: an unprecedented accrual rate of 25 percent in clinical trials, including cancer treatment and cancer control trials; a significant reduction in the number of missed treatment days among navigated American Indian cancer patients undergoing radiation therapy; and most importantly, establishment of trusting partnerships with the American Indian communities as reflected in enrollment in a genetic study involving the ataxia telangiectasia mutated gene. The results indicate that the Walking Forward approach presents an effective strategy to overcome the barriers to cancer care in this underserved community.
5	American Indian and Alaska Native Cancer Patients'	Grimes, C., Dankovchi	USA	Lack of access to care, funding limitations, cultural, and social barriers are challenges specific to tribal communities that have led to adverse cancer outcomes among American Indians/Alaska

	Perceptions of a Culturally Specific Patient Navigator Program https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5313295/	k, J., Cahn, M., & Warren-Mears, V. (2018)		Natives (AI/AN). While the cancer navigator model has been shown to be effective in other underserved communities, it has not been widely implemented in Indian Country. We conducted in-depth interviews with 40 AI/AN patients at tribal clinics in Idaho and Oregon. We developed the survey instrument in partnership with community members to ensure a culturally appropriate semi-structured questionnaire. Questions explored barriers to accessing care, perceptions of the navigator program, satisfaction, and recommendations. AI/AN cancer patients reported physical, emotional, financial, and transportation barriers to care, but most did not feel there were any cultural barriers to receiving care. Navigator services most commonly used included decision making, referrals, transportation, scheduling appointments, and communication. Satisfaction with the program was high. Our study provides a template to develop a culturally appropriate survey instrument for use with an AI/AN population, which could be adapted for use with other indigenous patient populations. Although our sample was small, our qualitative analysis facilitated a deeper understanding of the barriers faced by this population and how a navigator program may best address them. The results reveal the strengths and weakness of this program, and provide baseline patient satisfaction numbers which will allow future patient navigator programs to better create evaluation benchmarks.
6	Lessons learned from a pilot study of an Indigenous patient navigator intervention in Queensland, Australia	Bernardes, C.M., Martin, J., Cole, P., Kitchener, T., Cowburn,	Australia	Indigenous patient navigator (IPN) programmes show promise in addressing barriers to cancer care and facilitation of patient self-efficacy. The purpose of this paper is to describe and reflect upon the experience of training an IPN and implementation of the intervention in the Australian context with Indigenous cancer patients. Randomised clinical trial might provide the best available evaluation measure of an intervention but caution should be taken

	https://pubmed.ncbi.nlm.nih.gov/28513056/	G., Garvey, G., Walpole, E., & Valery, P.C. (2018)		in the implementation process. Socio-cultural aspects and training can affect the conduct of this type of intervention. We report here five issues needing consideration prior to implementing such intervention. Specifically: (1) recognition of the collective bonds within Indigenous community and understanding by IPN of the degree of personal assistance perceived as not intrusive by the patient; (2) conduct ongoing evaluation of the different role of an IPN involved in this intervention care provider vs. researcher. (3) meaningful engagement develops from a trusting/collaborative relationship between research team and study site staff which may not occur in the study time frame; (4) existing skills as well as training provided may not translate in the IPN understanding and aligning with the study objectives/research values; (5) recruitment of participants requires innovative and highly flexible strategies to be successful.
7	Patient navigation for American Indians undergoing cancer treatment: utilization and impact on care delivery in a regional health care center https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3112306/	Guadagnolo, B.A., Boylan, A., Sargent, M., Koop, D., Brunette, D., Kanekar, S., Shortbull, V., Molloy, K., Petereit, D.G. (2011)	USA	Purpose To assess patient navigation (PN) utilization and its impact on treatment interruptions and clinical trial enrollment among American Indian (AI) cancer patients. Methods Between February 2004 and September 2009, 332 AI cancer patients received PN services throughout cancer treatment. The PN program provided culturally-competent navigators to assist patients with navigating cancer therapy, obtaining medications, insurance issues, communicating with medical providers, and travel and lodging logistics. Data on utilization and trial enrollment were prospectively collected. Data for a historical control group of 70 AI patients who did not receive PN services were used to compare treatment interruptions among those undergoing PN during curative radiation therapy (subgroup of 123 patients).

				Results The median number of contacts with a navigator was 12 (range, 1-119). The median time spent with the navigator at first contact was 40 minutes (range 10-250 min.) and 15 min for subsequent contacts. Patients treated with radiation therapy with curative intent who underwent PN had fewer days of treatment interruption (mean, 1.7 days; 95% CI, 1.1-2.2 days) than historical controls who did not receive PN services (mean, 4.9 days; 95% CI, 2.9-6.9 days). Of the 332 patients, 72 (22%; 95% CI, 17-26%) were enrolled on a clinical treatment trial or cancer control protocol. Conclusions PN was associated with fewer treatment interruptions and relatively high rates of clinical trial enrollment among AI cancer patients compared to national reports.
8	Coordinating First Nations health care: Policy and implementation challenges and opportunities https://summit.sfu.ca/item/13728	Nixon, L.M. (2013)	Canada	This study explores how First Nations-run health systems mitigate poor inter-jurisdictional coordination and health service fragmentation, particularly during patient hand-offs or movement. This study used a combination of case studies, qualitative interviews and literature review (especially project evaluations). This research leads to the following recommended policy options for improving First Nations health care fragmentation: improved information and client registries; standardizing referral, intake and discharge procedures; and, patient navigators.
9	Mentally healthy communities - aboriginal perspectives https://publications	Canadian Institute for Health Information (2009)	Canada	No abstract available. Summary: The purpose of the current collection of papers is to promote dialogue on what may contribute to mentally healthy communities, with a focus on Aboriginal Peoples' perspectives, recognizing the diversity of First Nations, Inuit and Métis groups.

	.gc.ca/site/eng/9.692752/publication.html?wbdisable=true			
10	Clinical indicators as measures of mental health nursing standards of practice in New Zealand https://pubmed.ncbi.nlm.nih.gov/15318902/	O'Brien, A.P., Boddy, J.M., Hardy, D.J., & O'Brien, A.J. (2004)	New Zealand	This paper discusses the utility of Consumer Notes Clinical Indicators (CNCI) as a means to monitor mental health nursing clinical practice against the Australian and New Zealand College of Mental Health Nurses' (ANZCMHN) Standards of Practice for mental health nursing in New Zealand. CNCI are statements describing pivotal mental health nursing behaviours for which evidence can be found in the nurses' case notes. This paper presents 25 valid and reliable CNCI that can be used to monitor mental health nursing practice against the ANZCMHN's Standards of Practice for mental health nursing in New Zealand. The bicultural clinical indicators were generated in focus groups of Maori and non-Maori mental health nurses, prioritized in a three-round reactive Delphi survey of expert mental health nurses and consumers, pilot tested, and applied in a national field study. This paper reports the development and validation of the CNCI, for which achievement is assessed by an audit of the nursing documentation in consumer case notes. The CNCI were tested in a national field study of 327 sets of consumer case notes at 11 District Health Board sites. The results of the national field study show wide variation in occurrence of individual indicators, particularly in the areas of informed consent, information about legal rights, and provision of culturally safe and recovery-focused care. We discuss the implications of using the CNCI to assess the professional accountability of mental health nurses to provide quality care. Recommendations are made regarding the application of the clinical indicators and future research required, determining appropriate benchmarks for quality practice. The

				CNCI could be adapted for application in other mental health nursing and other mental health professional clinical settings.
11	Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada https://campusmentalhealth.ca/wp-content/uploads/2018/03/Promoting-Indigenous-Mental-Health-Stewart.pdf	Stewart, S.L. (2008)	Canada	Objectives: This paper will present the findings from a qualitative study exploring the narratives of Indigenous counsellors in Native community. Design: The study employed a qualitative design. Semi-structured narrative interviews were used and analyzed through a narrative methodology. Methods: One Native community health agency participated and five individuals, who worked as counsellors with the agency's clients, were interviewed. Results: Four metathemes: community, cultural identity, holistic approach, and interdependence were identified as the main results. Further, a model for mental health and healing was created by the overlapping nature of these meta themes in practice. Conclusions: A health promoting counselling model for Indigenous clients could be based on cultural values and perspectives. However, employing these values and perspectives entails an understanding that a contemporary conception of Indigenous mental health contains two components: mental health as wellness, and mental health as a process of healing.
12	Cultural Connectedness and Its Relation to Mental Wellness for First Nations	Snowshoe, A., Crooks, C. V., Tremblay,	Canada	We explored the interrelationships among components of cultural connectedness (i.e., identity, traditions, and spirituality) and First Nations youth mental health using a brief version of the original Cultural Connectedness Scale. Participants included 290 First Nations youth (M age = 14.4) who were recruited from both urban

	Youth https://www.csmh.uwo.ca/docs/Snowshoe2017_Article_CulturalConnectednessAndItsRel.pdf	P. F., & Hinson, R. E. (2017).		and rural school settings in Saskatchewan and Southwestern Ontario. We performed a confirmatory factor analysis of the Cultural Connectedness Scale-Short Version (CCS-S) items to investigate the factor stability of the construct in our sample. We examined the relationships between the CCS-S subscales and self-efficacy, sense of self (present and future), school connectedness, and life satisfaction using hierarchical multiple linear regression analyses to establish the validity of the abbreviated measure. The results revealed that cultural connectedness, as measured by the 10-item CCS-S, had strong associations with the mental health indicators assessed and, in some cases, was associated with First Nations youth mental health above and beyond other social determinants of health. Our results extend findings from previous research on cultural connectedness by elucidating the meaning of its components and demonstrate the importance of culture for positive youth development.
13	Social and emotional wellbeing in Indigenous Australians: identifying promising interventions https://onlinelibrary.wiley.com/doi/epdf/10.1111/1753-6405.12083	Day, A., & Francisco, A. (2013)	Australia	Objective: To review the empirical evidence that exists to support the delivery of the range of psycho-social interventions that have been implemented to improve social and emotional wellbeing (SEWB) in Aboriginal and Torres Strait Islander individuals and communities. Methods: A systematic review of the available literature, with relevant evaluations classified using the Maryland Scientific Methods Scale. Results: Despite a substantial literature on topics relevant to SEWB being identified, only a small number of program evaluations have been published that meet the criteria for inclusion in a systematic review, making it impossible to articulate what

				might be considered evidence-based practice in this area. Examples of those programs with the strongest empirical support are outlined. Conclusions: The results are discussed in terms of the need to develop key indicators of improvement in SEWB, such that more robust evidence about program outcomes can be gathered. The diversity of the identified programs further suggests the need to develop a broader and over-arching framework from which to approach low levels of SEWB, drawing on the concepts of 'grief and loss' and 'healing' and how high levels of social disadvantage have an impact on service utilisation and outcomes. Implications: From a public health perspective, the pressing need to implement programs that have positive impacts on low levels of social and emotional well-being in Aboriginal and Torres Strait Islander communities in Australia seems clear.
14	Indigenous mental health 2035: future takers, future makers and transformational potential https://pubmed.ncbi.nlm.nih.gov/21878027/	Durie, M. (2011)	New Zealand	Objective: The aims were to review progress in Indigenous mental health over the past 25 years and to identify possible directions for the next 25 years. Method: Māori involvement in health and health care was used to illustrate key Indigenous developments since 1984. Challenges in the decades ahead were discussed in the context of demographic transitions, life course epidemiology, global trends, technological innovations and health leadership. Results: Progress was measured by a range of indicators including Māori-referenced life expectancy, Māori agendas for health, strengthened cultural identity, the dissemination of health knowledge, and Māori participation in the health sector. In contrast to being ready to respond to change (future takers), active

				planning for the future (future makers) was seen as a better way of achieving Indigenous aspirations. One option for health advancement currently being developed in New Zealand involved an integrated approach premised on intersectoral delivery and a focus on families. Conclusions: Indigenous health will be advanced by dedicated approaches to family wellbeing that avoid fragmentation, focus on positive strengths, and lead to positive outcomes for family members and the family as a whole.
15	First Nations women's mental health: results from an Ontario survey https://pubmed.ncbi.nlm.nih.gov/18493709/	MacMillan, H.L., Jamieson, E., Walsh, C.A., Wong, M.Y., Faries, E.J., McCue, H., MacMillan, A.B., Offord, D.D.; & Technical Advisory Committee of the Chiefs of Ontario.	Canada	The mental health of Canada's Aboriginal women has received little scholarly attention. This paper describes the mental health of First Nations women living on reserve in Ontario and compares these findings with results from the National Population Health Survey (NPHS). Reserve communities were randomly selected within urban, rural, remote and special access regions. Depression was measured by the Composite International Diagnostic Interview. Alcohol use and health services utilization questions were identical to those used in the NPHS. Compared with NPHS women, First Nations women reported significantly higher rates of depression (18% vs 9%) but significantly lower rates of alcohol use (55% vs 74% reported drinking in the last year), although significantly greater proportions reported having 5+ drinks on one occasion (43% vs 24%). Given the burden of suffering associated with depression and the twofold risk found here, it is important to examine risk and protective factors specific to First Nations women. The findings of a higher proportion of abstainers, but also a higher proportion of consumers of 5+ drinks among First Nations women relative to NPHS women indicate the need for a more careful investigation, based on community rather than clinical data, of patterns of alcohol use.

		(2008)		
16	Describing community needs: examples from the Circles of Care initiative https://pubmed.ncbi.nlm.nih.gov/15322974/	Novins, D.K., LeMaster, P.L., Jumper Thurman, P., & Plested, B. (2004)	USA	The assessment of community needs was one of the key foundations of the Circles of Care planning effort. Grantees identified a range of needs at the child, adolescent, family, programmatic, and community levels. This information, along with an emphasis on the importance of each community's history and culture, served as an important guide for each program as they developed their model systems of care.
17	First nations mental wellness continuum framework. https://www.sac-isc.gc.ca/eng/1576093687903/1576093725971	Health Canada (2015)	Canada	No abstract available.

Indigenous Peoples and Coordinated Discharge

#	Paper Title and Link	Authors (Year)	Country of Intervention	Abstract
1	Indigenous hospital experiences: a New Zealand case study https://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2011.04042.x	Denise Wilson, Pipi Barton (2012)	New Zealand	Aims and objectives. To explore Māori (Indigenous people of New Zealand) experiences of hospitalisation in surgical or medical settings and how these might influence length of stay. Background. Globally Indigenous peoples with histories of colonisation suffer health disparities compared with other groups. They experience higher levels of morbidity, premature mortality, lower life expectancies and differential access, use and quality of health services. In Indigenous communities' negative anecdotal accounts of hospital experiences indicate more research is needed about their hospital experiences. Design. A Māori (Indigenous) centered approach using case study methodology and three data sources: medical-surgical discharge data, interviews with Māori and a literature review. Method. Using statistical data from the New Zealand Health Information Service from 1989–2006, a retrospective interrupted time series design was used to examine length of stay for Māori patients in medical and surgical hospital settings. Semi-structured interviews with 11 participants identifying as Māori who had experienced hospitalisation in a medical or surgical setting were transcribed and thematically analysed. A structured review of the research literature on Indigenous hospital experiences was also analysed. These data were analysed individually, triangulated and interpreted. Results. Māori consistently have a shorter average length of stay

				than non-Māori using public hospitals in New Zealand. Marginalisation of Indigenous peoples in public hospitals was evident in both the interviews undertaken and the literature reviewed. Participants believed hospitals were not conducive to healing and negative experiences contributed to decisions to seek an early discharge. Conclusions. Given the disparities in Indigenous health status, health professionals can address negative hospitalisation experiences by attending to the quality of care delivered and nature of the hospital environment. Relevance to clinical practice. Nurses can play an important role improving health outcome disparities for Indigenous peoples linked to health service delivery, especially the delivery of culturally responsive and quality nursing care.
2	The Alice Springs Hospital Readmission Prevention Project (ASHRAPP): a randomised control trial https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5319097/	Gabrielle Diplock, James Ward, Simon Stewart, Paul Scuffham, Penny Stewart, Carole Reeve, Lea Davidson & Graeme	Australia	Background Hospitals are frequently faced with high levels of emergency department presentations and demand for inpatient care. An important contributing factor is the subset of patients with complex chronic diseases who have frequent and preventable exacerbations of their chronic diseases. Evidence suggests that some of these hospital readmissions can be prevented with appropriate transitional care. Whilst there is a growing body of evidence for transitional care processes in urban, non-indigenous settings, there is a paucity of information regarding rural and remote settings and, specifically, the indigenous context. Methods This randomised control trial compares a tailored, multidimensional

		Maguire (2017)		transitional care package to usual care. The objective is to evaluate the efficacy of the transitional care package for Indigenous and non-Indigenous Australian patients with chronic diseases at risk of recurrent readmission with the aim of reducing readmission rates and improving transition to primary care in a remote setting. Patients will be recruited from medical and surgical admissions to Alice Springs Hospital and will be followed for 12 months. The primary outcome measure will be the number of admissions to hospital with secondary outcomes including number of emergency department presentations, number of ICU admissions, days alive and out of hospital, time to primary care review post discharge and cost-effectiveness. Discussion Successful transition from hospital to home is important for patients with complex chronic diseases. Evidence suggests that a coordinated transitional care plan can result in a reduction in length of hospital stay and readmission rates for adults with complex medical needs. This will be the first study to evaluate a tailored multidimensional transitional care intervention to prevent readmission in Indigenous and non-Indigenous Australian residents of remote Australia who are frequently admitted to hospital. If demonstrated to be effective it will have implications for the care and management of Indigenous Australians throughout regional and remote Australia and in other remote, culturally and linguistically diverse populations and settings.
3	First Nations' hospital readmission ending in death: a potential sentinel indicator of inequity?	Josée Lavoie, Wanda Phillips-Beck, Kathi Avery Kinew,	Canada	In this study, we focused on readmissions for Ambulatory Care Sensitive Conditions (ACSC) ending in death, to capture those admissions and readmissions that might have been prevented if responsive primary healthcare was accessible. We propose this as a sentinel indicator of equity. We conducted analyses of Manitoba-based 30-day hospital readmission rates for ACSC which resulted in death, using data from 1986-2016 adjusted for age, sex, and socio-

	https://www.tandfonline.com/doi/full/10.1080/22423982.2020.1859824	Grace Kyoon-Achan & Alan Katz (2020)		economic status. Our findings show that, across Manitoba, overall rates of readmissions ending in death are slowly increasing, and increasing more dramatically among northern First Nations, larger First Nations not affiliated with Tribal Councils, and in the western region of the province. These regions have continuously been highlighted as disadvantaged in terms of access to care, suggesting that the time for action is overdue. Rising rates of readmissions for ACSC ending in death suggest that greater attention should be placed on access to responsive primary healthcare. These findings have broader implications for territorial healthcare systems which purchase acute care services from provinces south of them. As an indicator of quality, monitoring readmissions ending in death could provide territorial governments insights into the quality of care provided to their constituents by provincial authorities.
4	How Hospitals Reengineer Their Discharge Processes to Reduce Readmissions https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5102006/	Suzanne E. Mitchell, Jessica Martin, Sally Holmes, Carol van Deusen Lukas, Ramon Cancino, Michael Paasche-Orlow, Cindy Brach, and Brian Jack	USA	Background The Re-Engineered Discharge (RED) program is a hospital-based initiative shown to decrease hospital reutilization. We implemented the RED in 10 hospitals to study the implementation process. Design We recruited 10 hospitals from different regions of the United States to implement the RED and provided training for participating hospital leaders and implementation staff using the RED Toolkit as the basis of the curriculum followed by monthly telephone-based technical assistance for up to 1 year. Methods Two team members interviewed key informants from each hospital before RED implementation and then 1 year later. Interview data were analyzed according to common and comparative themes

		(2016)		identified across institutions. Readmission outcomes were collected on participating hospitals and compared pre- versus post-RED implementation. Results Key findings included (1) wide variability in the fidelity of the RED intervention; (2) engaged leadership and multidisciplinary implementation teams were keys to success; (3) common challenges included obtaining timely follow-up appointments, transmitting discharge summaries to outpatient clinicians, and leveraging information technology. Eight out of 10 hospitals reported improvement in 30-day readmission rates after RED implementation. Conclusions A supportive hospital culture is essential for successful RED implementation. A flexible implementation strategy can be used to implement RED and reduce readmissions.
5	The outcome of critically ill Indigenous patients. https://onlinelibrary.wiley.com/doi/abs/10.5694/j.1326-5377.2006.tb00341.x	Kwok Ming Ho, Judith Finn, Geoffrey J Dobb, Steven A R Webb (2006)	Australia	Objective: To investigate the short-term outcome of critically ill Indigenous patients. Design and participants: Retrospective cohort study using de-identified audit data from a tertiary intensive care unit (ICU) in Western Australia for the 11-year period 1 January 1993 to 31 December 2003. Main outcome measures: Hospital mortality (crude, and adjusted for severity of illness). Results: Of 16 757 ICU patients, 1076 (6.4%) were identified as Indigenous. The Indigenous patients were younger and more commonly had chronic liver and renal diseases. Indigenous people represented 3.2% of the population of Western Australia in 2001, but represented 3.1% and 9.5% of all elective and emergency ICU

				admissions, respectively. Diagnosis of sepsis, pneumonia, trauma, and cardiopulmonary arrest were common among critically ill Indigenous patients. Following emergency admission, the crude hospital mortality for Indigenous patients was higher (22.7% v 19.2%; crude odds ratio, 1.24; 95% CI, 1.04–1.47) than for non-Indigenous patients. The crude hospital mortality of critically ill Indigenous patients was lower than that predicted by the APACHE II prognostic model and was similar to that of non-Indigenous patients after adjusting for severity of illness and chronic health status. Conclusions: The pattern of critical illness affecting Indigenous Australians in Western Australia was different from that affecting non-Indigenous patients. The crude hospital mortality was high, but similar to that of non-Indigenous Australians after adjusting for severity of illness and chronic health status.
6	Trauma-related admissions to intensive care units in Australia: the influence of Indigenous status on outcomes https://pubmed.ncbi.nlm.nih.gov/30644562/	Fraser Magee, Anthony Wilson, Michael J Bailey, David Pilcher, Paul J Secombe, Paul Young, Rinaldo Bellomo (2018)	Australia	Objectives To investigate the admission characteristics and hospital outcomes for Indigenous and non-Indigenous patients admitted to intensive units (ICUs) after major trauma. Design, setting Retrospective analysis of Australian and New Zealand Intensive Care Society (ANZICS) Adult Patient Database data from 92 Australian ICUs for the 6-year period, 2010–2015. Participants Patients older than 17 years of age admitted to public hospital ICUs with a primary diagnosis of trauma. Main outcome measures ICU and overall hospital lengths of stay, hospital discharge

				destination, and ICU and overall hospital mortality rates for Indigenous and non-Indigenous patients. Results 23 804 people were admitted to Australian public hospital ICUs after major trauma; 1754 (7.4%) were Indigenous Australians. The population-standardised incidence of admissions was consistently higher for Indigenous Australians than for non-Indigenous Australians (847 per million v 251 per million population; incidence ratio, 3.37; 95% CI, 3.19–3.57). Overall hospital mortality rates were similar for Indigenous and non-Indigenous patients (adjusted odds ratio [aOR], 1.04; 95% CI, 0.82–1.31). Indigenous patients were more likely than non-Indigenous patients to be discharged to another hospital (non-Indigenous v Indigenous: aOR, 0.84; 95% CI, 0.72–0.96) less likely to be discharged home (non-Indigenous v Indigenous: aOR, 1.17; 95% CI, 1.04–1.31). Conclusion The population rate of trauma-related ICU admissions was substantially higher for Indigenous than non-Indigenous patients, but hospital mortality rates after ICU admission were similar. Indigenous patients were more likely to be discharged to a another hospital and less likely to be discharged home than non-Indigenous patients.
7	Quasi-experimental evaluation of the effectiveness of a large-scale readmission reduction program	Grace Y. Jenq; Margaret M. Doyle; Beverly M. Belton; et al (2016)	USA	Importance: Feasibility, effectiveness, and sustainability of large-scale readmission reduction efforts are uncertain. The Greater New Haven Coalition for Safe Transitions and Readmission Reductions was funded by the Center for Medicare & Medicaid Services (CMS) to reduce readmissions among all discharged Medicare fee-for-service (FFS) patients.

	https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2513451			Objective: To evaluate whether overall Medicare FFS readmissions were reduced through an intervention applied to high-risk discharge patients. Design, Setting, and Participants: This quasi-experimental evaluation took place at an urban academic medical center. Target discharge patients were older than 64 years with Medicare FFS insurance, residing in nearby zip codes, and discharged alive to home or facility and not against medical advice or to hospice; control discharge patients were older than 54 years with the same zip codes and discharge disposition but without Medicare FFS insurance if older than 64 years. High-risk target discharge patients were selectively enrolled in the program. Interventions: Personalized transitional care, including education, medication reconciliation, follow-up telephone calls, and linkage to community resources. Measurements: We measured the 30-day unplanned same-hospital readmission rates in the baseline period (May 1, 2011, through April 30, 2012) and intervention period (October 1, 2012, through May 31, 2014). Results: We enrolled 10 621 (58.3%) of 18 223 target discharge patients (73.9% of discharge patients screened as high risk) and included all target discharge patients in the analysis. The mean (SD) age of the target discharge patients was 79.7 (8.8) years. The adjusted readmission rate decreased from 21.5% to 19.5% in the target population and from 21.1% to 21.0% in the control population, a relative reduction of 9.3%. The number needed to treat to avoid 1 readmission was 50. In a difference-in-differences analysis using a logistic regression model, the odds of readmission in the target

				population decreased significantly more than that of the control population in the intervention period (odds ratio, 0.90; 95% CI, 0.83-0.99; P = .03). In a comparative interrupted time series analysis of the difference in monthly adjusted admission rates, the target population decreased an absolute −3.09 (95% CI, −6.47 to 0.29; P = .07) relative to the control population, a similar but nonsignificant effect. Conclusions and Relevance: This large-scale readmission reduction program reduced readmissions by 9.3% among the full population targeted by the CMS despite being delivered only to high-risk patients. However, it did not achieve the goal reduction set by the CMS.
8	Review of successful hospital readmission reduction strategies and the role of health information exchange https://www.sciencedirect.com/science/article/abs/pii/S1386505617301612?via%3Dihub	Kash BA, Baek J, Davis E, Champagne-Langabeer T, Langabeer II (2017)	USA	Context The United States has invested substantially in technologies that enable health information exchange (HIE), which in turn can be deployed to reduce avoidable hospital readmission rates in many communities. With avoidable hospital readmissions as the primary focus, this study profiles successful hospital readmission rate reduction initiatives that integrate HIE as a strategy. We hypothesized that the use of HIE is associated with decreased hospital readmissions beyond other observed population health benefits. Results of this systematic review are used to describe and profile successful readmission reduction programs that integrate HIE as a tool. Methods A systematic review of literature provided an understanding of the use of HIE as a strategy to reduce hospital readmission rates. We conducted a review of 4,862 citations written in English about readmission reduction strategies from January 2006 to September

				2016 in the MEDLINE-PubMed database. Of these, 106 studies reported 30-day readmission rates as an outcome and only 13 articles reported using HIE. Results Only a very small number (12%) of hospitals incorporated HIE as a primary tool for evidence-based readmission reduction initiatives. Information exchange between providers has been suggested to play a key role in reducing avoidable readmission rates, yet there is not currently evidence supporting current HIE-enabled readmission initiatives. Most successful readmission reduction programs demonstrate collaboration with primary care providers to augment transitions of care to existing care management functions without additional staff while using effective information exchange capabilities. Conclusions This research confirms there is very little integration of HIE into health systems readmissions initiatives. There is a great opportunity to achieve population health targets using the HIE infrastructure. Hospitals should consider partnering with primary care clinics to implement multifaceted transitions of care programs to significantly reduce 30-day readmission rates.
9	Long term outcomes for Aboriginal and Torres Strait Islander Australians after hospital intensive	Mitchell, W. G., Deane, A., Brown, A., Bihari, S., Wong, H., Ramadoss,	Australia	Objectives: To assess long term outcomes for Aboriginal and Torres Strait Islander (Indigenous) Australians admitted non-electively to intensive care units (ICUs). Design: Data linkage cohort study; analysis of ICU patient data (Australian and New Zealand Intensive Care Society Adult Patient Database), prospectively collected during 2007–2016.

	care https://onlinelibrary.wiley.com/doi/full/10.5694/mja2.50649	R., & Finnis, M. (2020)		Setting: All four university-affiliated level 3 ICUs in South Australia. Main outcomes: Mortality (in-hospital, and 12 months and 8 years after admission to ICU), by Indigenous status. Results: 2035 of 39 784 non-elective index ICU admissions (5.1%) were of Indigenous Australians, including 1461 of 37 661 patients with South Australian residential postcodes. The median age of Indigenous patients (45 years; IQR, 34–57 years) was lower than for non-Indigenous ICU patients (64 years; IQR, 47–76 years). For patients with South Australian postcodes, unadjusted mortality at discharge and 12 months and 8 years after admission was lower for Indigenous patients; after adjusting for age, sex, diabetes, severity of illness, and diagnostic group, mortality was similar for both groups at discharge (adjusted odds ratio [aOR], 0.95; 95% CI, 0.81–1.10), but greater for Indigenous patients at 12 months (aOR, 1.14; 95% CI, 1.03–1.26) and 8 years (adjusted hazard ratio, 1.23; 95% CI, 1.13–1.35). The number of potential years of life lost was greater for Indigenous patients (median, 24.0; IQR, 15.8–31.8 v 12.5; IQR, 0–22.3), but, referenced to respective population life expectancies, relative survival at 8 years was similar (proportions: Indigenous, 0.78; 95% CI, 0.75–0.80; non-Indigenous, 0.77; 95% CI, 0.76–0.78). Conclusions: Adjusted long term mortality and median number of potential life years lost are higher for Indigenous than non-Indigenous patients after intensive care in hospital. These differences reflect underlying population survival patterns rather than the effects of ICU admission.
1	Preventing 30-day	Leppin,	Not	Importance: Reducing early (<30 days) hospital readmissions is a

0	hospital readmissions: a systematic review and meta-analysis of randomized trials. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1868538	Aaron L., Michael R. Gionfriddo, Maya Kessler, Juan Pablo Brito (2014)	Reported	policy priority aimed at improving health care quality. The cumulative complexity model conceptualizes patient context. It predicts that highly supportive discharge interventions will enhance patient capacity to enact burdensome self-care and avoid readmissions. Objective: To synthesize the evidence of the efficacy of interventions to reduce early hospital readmissions and identify intervention features—including their impact on treatment burden and on patients' capacity to enact postdischarge self-care—that might explain their varying effects. Data Sources: We searched PubMed, Ovid MEDLINE, Ovid EMBASE, EBSCO CINAHL, and Scopus (1990 until April 1, 2013), contacted experts, and reviewed bibliographies. Study Selection: Randomized trials that assessed the effect of interventions on all-cause or unplanned readmissions within 30 days of discharge in adult patients hospitalized for a medical or surgical cause for more than 24 hours and discharged to home. Data Extraction and Synthesis: Reviewer pairs extracted trial characteristics and used an activity-based coding strategy to characterize the interventions; fidelity was confirmed with authors. Blinded to trial outcomes, reviewers noted the extent to which interventions placed additional work on patients after discharge or supported their capacity for self-care in accordance with the cumulative complexity model. Main Outcomes and Measures: Relative risk of all-cause or unplanned readmission with or without out-of-hospital deaths at 30 days postdischarge.

				Results: In 42 trials, the tested interventions prevented early readmissions (pooled random-effects relative risk, 0.82 [95% CI, 0.73-0.91]; P < .001; I2 = 31%), a finding that was consistent across patient subgroups. Trials published before 2002 reported interventions that were 1.6 times more effective than those tested later (interaction P = .01). In exploratory subgroup analyses, interventions with many components (interaction P = .001), involving more individuals in care delivery (interaction P = .05), and supporting patient capacity for self-care (interaction P = .04) were 1.4, 1.3, and 1.3 times more effective than other interventions, respectively. A post hoc regression model showed incremental value in providing comprehensive, postdischarge support to patients and caregivers. Conclusions and Relevance: Tested interventions are effective at reducing readmissions, but more effective interventions are complex and support patient capacity for self-care. Interventions tested more recently are less effective.
11	Implementation of the Re-Engineered Discharge (RED) toolkit to decrease all-cause readmission rates at a rural community hospital https://journals.lww.com/qmhcjournal/Abstract/2014/070	Adams, C. J., Stephens, K., Whiteman, K., Kersteen, H., & Katruska, J. (2014)	USA	Overview: National hospital readmission rates average 19%. One in 5 Medicare patients are readmitted within 30 days of discharge each year, resulting in $17.5 billion in additional costs. Objective/Purpose: The aim of this quality improvement project was to use the methodology outlined by Joint Commission Resources-Hospital Engagement Network and Project Re-Engineered Discharge (Project RED) to redesign the discharge process, reduce hospital 30-day all-cause readmission rates, and improve patient/family involvement in the discharge process.

	00/Implementation_of_the_Re_Engineered_Discharge.5.aspx			Method: The methodology of the Joint Commission Resources-Hospital Engagement Network and the Agency for Healthcare Research and Quality Project RED toolkit, the After Hospital Care Plan, and a patient discharge questionnaire were used to incorporate best discharge practices into patient care and evaluate the outcomes of the project. Monthly readmission rates and patient/family involvement in the discharge process were examined for 336 patients discharged from a dedicated 30-bed medical-surgical unit in a rural community hospital over a 4-month period. Results: During the 4-month project, readmissions were reduced by 32% (rate 7.12); the overall monthly reduction from baseline was 27%, with a 44% reduction from baseline during the previous 6 months. The patient and family perception of their discharge process was positive.
12	Culturally safe and sustainable solution for Closing the Gap - registered patients discharging from a tertiary public hospital. https://pubmed.ncbi.nlm.nih.gov/32192571/	Mitchell, Scott, Hayley Michael, Stephanie Highden-Smith, Vivian Bryce, Sean Grugan, Hua Bing Yong, Sonia Renouf, Tanya	Australia	This case study describes the development, implementation and review of a sustainable and culturally sensitive procedure for a hospital-funded discharge medicine subsidy for Aboriginal and Torres Strait Islander patients registered with the Closing the Gap (CTG) program discharged from a public hospital. A 7-day fully subsidised medication supply was approved to be offered to Aboriginal and Torres Strait Islander patients admitted under cardiac care teams, including cardiology and cardiothoracic surgery patients. Patients were offered the option of a 7-day supply free of cost to them or a full Pharmaceutical Benefits Scheme (PBS) supply if preferred. A general practitioner (GP) appointment was organised within 7 days of discharge to ensure patients received ongoing supply of their medications as well as timely clinical review after discharge. Over a 34-month period from September 2015 to June 2018, 535 Aboriginal

		Kitchener, and William YS Wang. (2020)		and Torres Strait Islander patients were admitted to the hospital under cardiac care teams. Of these patients, 296 received a subsidised discharge medication supply with a total cost of A$6314.56 to the hospital over the trial period, with a mean cost of A$21.26 per discharge. The provision of subsidised medications through the CTG program has improved the continuity of care for Aboriginal and Torres Strait Islander patients. The culturally sensitive approach is well received and has allowed smooth transition back to the community. This site-specific and state-based funding model was found to be financially sustainable at a public hospital. The CTG PBS program is not applicable to discharge prescriptions from public hospitals. As such, patients are required to either leave the hospital with no medicines or leave the hospital with medicines for which they have to pay full PBS price. This creates a huge financial barrier to the care for CTG-registered patients in the acute care setting. A sustainable solution to the problem was found via a state-funded model while providing a supportive team to ensure GP follow-up and continuity of care after discharge. If similar approvals are granted and supported at other public hospital sites, practitioners will be afforded one less barrier to provide patient-centred care for Aboriginal and Torres Strait Islander patients.
13	Health information system linkage and coordination are critical for increasing access to secondary prevention in Aboriginal health: a qualitative study	DiGiacomo, Michelle, Patricia Davidson, Katherine Taylor, Julie Smith, Lyn Dimer, Mohammed	Australia	Background: Aboriginal Australians have low rates of participation in cardiac rehabilitation (CR), despite having high rates of cardiovascular disease. Barriers to CR participation reflect multiple patient-related issues. However, an examination of the broader context of health service delivery design and implementation is needed. Aims: To identify health professionals' perspectives of systems related barriers to implementation of the National Health and Medical Research Council (NHMRC) guidelines Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and

	https://pubmed.ncbi.nlm.nih.gov/20359409/	Ali, Marianne Wood, Timothy Leahy, and Sandra Thompson (2010)		Torres Strait Islander Peoples. Method: Semi-structured interviews were conducted with health professionals involved in CR within mainstream and Aboriginal Community Controlled Health Services in Western Australia (WA). Thirty-eight health professionals from 17 services (ten rural, seven metropolitan) listed in the WA Directory of CR services and seven Aboriginal Medical Services in WA were interviewed. Results: Respondents reported barriers encountered in health information management and the impact of access to CR services for Aboriginal people. Crucial issues identified by participants were: poor communication across the health care sector and between providers, inconsistent and insufficient data collection processes (particularly relating to Aboriginal ethnicity identification), and challenges resulting from multiple clinical information systems and incompatible technologies. Conclusions: This study has demonstrated that inadequate information systems and communication strategies, particularly those representing the interface between primary and secondary care, contribute to the low participation rates of Aboriginal Australians in CR. Although these challenges are shared by non-Aboriginal Australians, the needs are greater for Aboriginal Australians and innovative solutions are required.

Indigenous Peoples and Mental Health

#	Paper Title and Link	Authors (Year)	Country of Intervention	Relevant Indicators identified
1	Cultural Connectedness and Its Relation to Mental Wellness for First Nations Youth. https://www.csmh.uwo.ca/docs/Snowshoe2017_Article_CulturalConnectednessAndItsRel.pdf	Angela Snowshoe, Claire V. Crooks, Paul. F. Tremblay & Riley E. Hinson (2017)	Canada	The mental health of youth is one of the most urgent concerns affecting many First Nations communities across Canada. Of the myriad forces that influence youth mental health, the most fundamental are the social contexts in which youth are embedded. The results revealed that cultural connectedness, as measured by the 10-item CCS-S, had strong associations with the mental health indicators assessed and, in some cases, was associated with First Nations youth mental health above and beyond other social determinants of health.
2	Social and emotional wellbeing in Indigenous Australians: identifying promising interventions. [Review] https://onlinelibrary.wiley.com/doi/epdf/10.1111/1753-6405.12083	Andrew Day, Ashlen Francisco (2013)	Australia	From a public health perspective, the pressing need to implement programs that have positive impacts on low levels of social and emotional well-being in Aboriginal and Torres Strait Islander communities in Australia seems clear. Personal wellbeing for Indigenous peoples is understood as contingent upon social influences, such as the level of social support that is available or the context in which emotional states arise. It is regarded as a culturally appropriate construct in that it reflects the holistic philosophy that many Aboriginal and Torres Strait Islander people have towards health and encapsulates the wide range of experiences that have the potential to adversely affect an individual's wellbeing. Many of these experiences are familiar to those who identify as from Aboriginal and Torres Strait Islander cultural backgrounds. They include: environmental deprivation; emotional, physical and sexual abuse; emotional and physical neglect; stress; social exclusion; grief and trauma; removal from

				family; substance abuse; family breakdowns; cultural disconnection; racism; discrimination; domestic violence; and social disadvantage. Despite there being several articles published on topics relevant to social and emotional well being identified, only a small number of program evaluations have been published that meet the criteria for inclusion in a systematic review, making it impossible to articulate what might be considered evidence-based practice in this area. There is a significant need to develop key indicators of improvement in SEWB, such that more robust evidence about program outcomes can be gathered. One way of supporting future evaluations may be to return to the question of defining what relevant SEWB outcomes might be, perhaps using grief and loss as a guiding framework. This may allow for the identification of shorter-term markers of improvements in SEWB

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<td>(such as improvement in dysphoric or traumatic symptoms, sense of well-being, social participation and engagement) that can be routinely used by evaluators.

<table>
<tr><th>Item #</th><th>Standardized loadings</th></tr>
<tr><td>Identity (4 items)</td><td></td></tr>
<tr><td>4. I plan on trying to find out more about my [Aboriginal/FNMI] culture, such as its history, traditions, and customs[a]</td><td>.735</td></tr>
<tr><td>6. I have spent time trying to find out more about being [Aboriginal/FNMI], such as its history, traditions and customs[b]</td><td>.744</td></tr>
<tr><td>7. I have a strong sense of belonging to my [Aboriginal/FNMI] community or Nation[b]</td><td>.762</td></tr>
<tr><td>8. I feel a strong attachment towards my [Aboriginal/FNMI] community or Nation[b]</td><td>.741</td></tr>
<tr><td>Traditions (3 items)</td><td></td></tr>
<tr><td>3. I use tobacco for guidance[a]</td><td>.666</td></tr>
<tr><td>5. I have a traditional person, Elder or Clan Mother who I talk to[a]</td><td>.603</td></tr>
<tr><td>10. How often does someone in your family or someone you are close with use sage, sweetgrass, or cedar in any way or form[c]</td><td>.535</td></tr>
<tr><td>Spirituality (3 items)</td><td></td></tr>
<tr><td>1. I know my cultural/spirit name[a]</td><td>.418</td></tr>
<tr><td>2. In certain situations, I believe things like animals and rocks have a spirit like [Aboriginal/FNMI] people[a]</td><td>.695</td></tr>
<tr><td>9. The eagle feather has a lot of meaning to me[b]</td><td>.681</td></tr>
</table>
FNMI = First Nations, Métis, and/or Inuit
[a] No or yes response format
[b] Strongly disagree, disagree, do not agree or disagree, agree, strongly agree response format
[c] Never, once/twice in the past year, every month, every week, every day response format</td>
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<td>3</td>
<td>Indigenous mental health 2035: future takers, future makers and transformational potential. [Review]</td>
<td>Mason Durie (2011)</td>
<td>New Zealand</td>
<td>Mental wellness is supported by culture, language, Elders, families, and creation, and is necessary for healthy individual, community and family life. First Nations embrace the achievement of whole health — physical, mental, emotional, spiritual, social, and economic well-being — through a coordinated, comprehensive approach that respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of</td>
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	https://journals.sagepub.com/doi/abs/10.3109/10398562.2011.583058			knowing. Indicators included: Māori-referenced life expectancy, Māori agendas for health, strengthened cultural identity, the dissemination of health knowledge, and Māori participation in the health sector.
4	First Nations women's mental health: results from an Ontario survey. https://link.springer.com/article/10.1007/s00737-008-0004-y	Harriet L. MacMillan, Ellen Jamieson, Christine A. Walsh, Maria Y.-Y. Wong, Emily J. Faries, Harvey McCue, Angus B. MacMillan, David (Dan) R. Offord & with The Technical Advisory Committee of the Chiefs of Ontario (2008)	Canada	Mental wellness is a balance of the mental, physical, spiritual, and emotional. This balance is enriched as individuals have: purpose in their daily lives whether it is through education, employment, care giving activities, or cultural ways of being and doing; hope for their future and those of their families that is grounded in a sense of identity, unique indigenous values, and having a belief in spirit; a sense of belonging and connectedness within their families, to community, and to culture; and finally a sense of meaning and an understanding of how their lives and those of their families and communities are part of creation and a rich history. Indicators measured: Depression (Composite International Diagnostic Interview), Alcohol use and health services utilization. Not indicators derived from Indigenous community.
5	Culturally specific process measures	Anthony P. O'Brien,	New Zealand and	In New Zealand the need for culturally appropriate and safe mental health care is widely recognized, especially in light of the

	to improve mental health clinical practice: indigenous focus. https://journals.sagepub.com/doi/10.1080/00048670701449211?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed	Julie M. Boddy, Derrylea J. Hardy (2007)	Australia	disproportionate number of indigenous Mâori diagnosed with mental illness in New Zealand. This paper described standards of practice for mental health nursing dedicated to Indigenous communities. The focus was on designing nursing practices that are grounded in cultural humility and safety by respect and awareness of the cultural values, sacred knowledge, language, and practices of First Nations communities that are essential determinants of individual, family, and community health and wellness. Given the way Indigenous Australians interact culturally, incorporating a belief in kinship, story telling, community and spirituality, the development of process indicators that support personal interaction in clinical practice is essential to ensure that there has been an attempt to engage the patient and their family at a cultural and clinical level. Further information is also needed on how Indigenous people deal with emotional crises individually and collectively as part of their kinship structure.
6	Describing community needs: examples from the Circles of Care initiative. https://files.eric.ed.gov/fulltext/EJ683985.pdf	Novins, Douglas; LeMaster, Pamela; Thurman, Pamela Jumper; Plested, Barbara (2004)	USA	Mental health indicators/needs described by community members: - Tenuous sense of connectedness "...[Community members] feel tenuously connected to the Native American community – especially if they are unable to document their tribal affiliations. They also are keenly aware of being outside the majority culture – yet unable to embrace their Native heritage due to lack of understanding of cultural practices and loss of their Native language." - Historical trauma and internalized oppression - Population growth - Percentage of population under 22 - Growth of gaming - Traditional resources, extended kinship networks, and

				community organizations such as churches, recreational and educational programs - Number of speakers of their AI/AN languages - Number of networks of traditional healers - High school graduation rates - Unemployment and poverty rates - Geographic isolation of communities - Transportation options - high arrest, accident, and substance abuse rates for both adults and adolescents - Suicide and related-behaviors as well as juvenile delinquency - rates of domestic violence and child abuse and neglect, as well as consequent foster care placements - Rates of teenage pregnancy, fetal alcohol syndrome, infant mortality - Rates of alcohol abuse, depression, domestic violence - Number of single parent families
7	A challenge to the cross-cultural validity of the SF-36 health survey: factor structure in Maori, Pacific and New Zealand European ethnic groups. https://www.sciencedirect.com/scienc	Kate M Scotta, Diana Sarfatia, Martin I Tobiasa, Stephen J Haslettb (2000)	New Zealand	The scales are: Physical Functioning (PF), Role Physical (RP) (the impact of physical health on performance of everyday role); Bodily Pain (BP); General Health (GH); Vitality (VT); Social Functioning (SF); Role Emotional (RE) (the impact of emotional health on role performance); and Mental Health (MH). The SF-36 was constructed to represent two dimensions of health: physical health and mental health. This did not crossover into the Maori population. Traditional Māori views of health do not recognise the separation of mental and physical health. One of the models used to describe Māori health is Whare Tapa Whā, which outlines four basic concepts: te taha tinana (a bodily or physical health component),

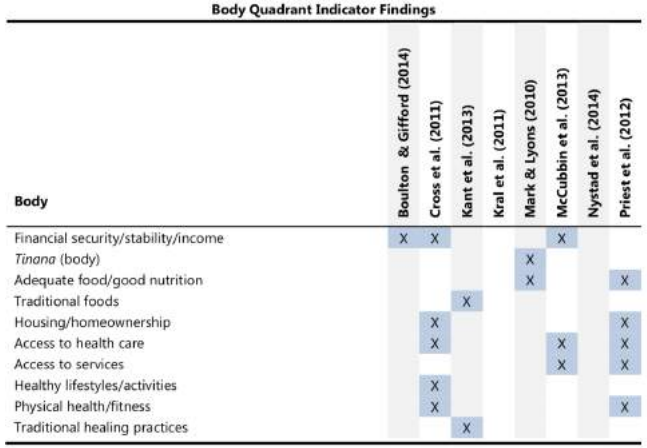
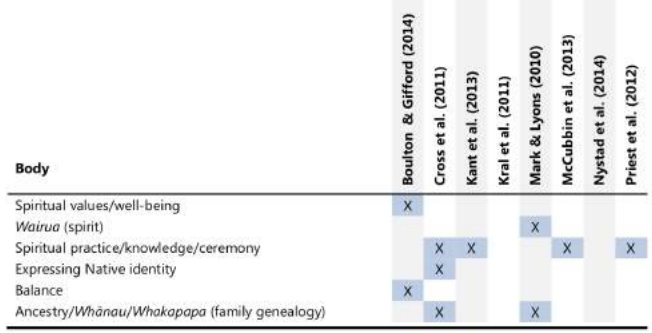
	e/article/abs/pii/S0277953600000836			te taha hinengaro (a psychological or mental health component), te taha wairua (a spiritual component) and te taha whānau (a family or social health component). More recently, two other elements have been added to this model: te taha tūroa (a component relating health to the integrity of the environment) and te taha rangitira (recognising the importance of Māori language to the health of the people). Notions of mind-body dualism are rejected. Te taha hinengaro and te taha tinana are inseparable aspects of growth, development and functioning. Te taha whānau, in particular, reflects the concept that health is not so much the property of the individual, but of the extended family.
8	Strength-based well-being indicators for Indigenous children and families: A literature review of Indigenous communities' identified well-being indicators https://coloradosph.cuanschutz.edu/docs/librariesprovider205/journal_files/vol23/23_3_2016_206_rountree.pdf?sfvrsn=8dd1e0b9_2	Rountree, Jennifer; Smith, Addie (2016)	USA	 The four quadrants that make up this conceptual model for wellbeing are context (family, culture, community, environment, history), mind (cognition, emotion, identity), body (physical needs and genetic makeup, practical needs—including financial needs), and spirit (spiritual practices and teachings, dreams, stories.)

Table 1
Context Indicator Findings

Context	Boulton & Gifford (2014)	Cross et al. (2011)	Kant et al. (2013)	Kral et al. (2011)	Mark & Lyons (2010)	McCubbin et al. (2013)	Nystad et al. (2014)	Priest et al. (2012)
Support (family, friends, community)/interdependence	X							X
Connection to land					X		X	X
Community involvement/participation/contribution	X	X				X		
Family commitment						X		
Kinship/elders/community connection/ties			X	X			X	X
Life cycle events/traditional activities/practices				X		X	X	X
Healthy relationships		X		X				
Safety		X						X
Connecting with resources		X						
Access to cultural sites			X					

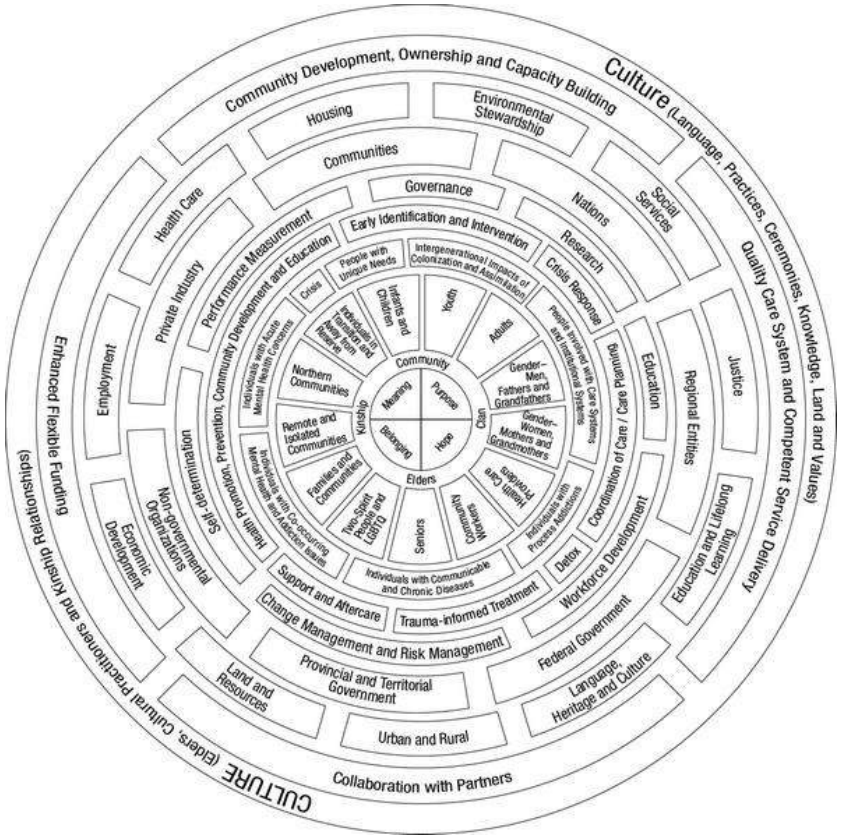
Table 2
Mind Quadrant Indicator Findings

Mind	Boulton & Gifford (2014)	Cross et al. (2011)	Kant et al. (2013)	Kral et al. (2011)	Mark & Lyons (2010)	McCubbin et al. (2013)	Nystad et al. (2014)	Priest et al. (2012)
Cultural identity/sense of belonging to cultural group	X	X	X					X
Ethnic pride							X	X
Self-esteem								X
Happiness	X							X
Focus/determination		X						
Hope/looking forward/optimism	X							
Hinengaro (mind)					X			
Educational enrollment/achievement		X						
Resilience						X		X
Speaks Native language						X	X	
Cultural teachings/knowledge		X						X
Coping skills		X						
Personal qualities/capacities		X						X
Employment/employability		X						

				Table 3 **Body Quadrant Indicator Findings**  **Table 4** **Spirit Quadrant Indicator Findings** 
9	Mental health issues among indigenous communities and the role of traditional medicine. [Review]	Paolo Cianconi, Cokorda Bagus Jaya Lesmana, Antonio	Global	This review confirms the impact of societal changes, environmental threats and exploitation of natural resources on the mental health of indigenous populations. First Nation languages, culture, and teachings are tied to the past, the present, and the future. First Nations individuals, families, and communities have a wealth of knowledge from which to draw to know how to live in balance with others and the environment, to care for themselves

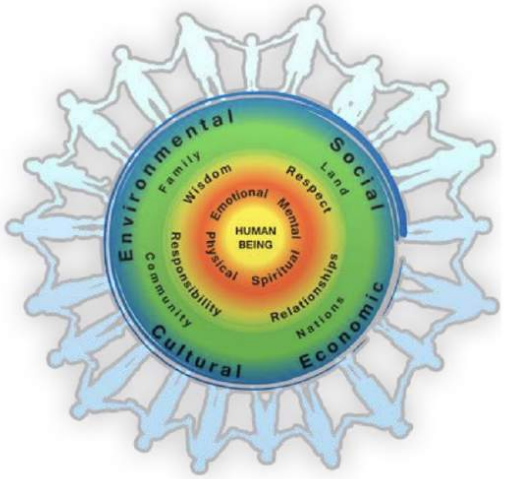
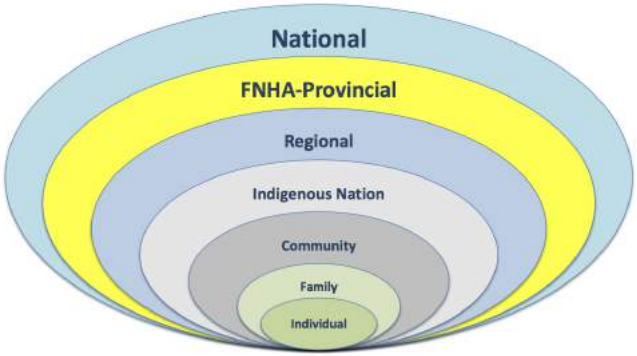
	https://journals.sagepub.com/doi/abs/10.1177/0020764019840060?journalCode=ispa	Ventriglio (2019)		and others, and to restore balance when it is lost. Overall, the mental health of these populations is poorly studied and described.
10	Mental health indicators among pregnant Aboriginal women in Canada: results from the Maternity Experiences Survey. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6126563/	Nelson, Chantal; Lawford, Karen M.; Otterman, Victoria; Darling, Elizabeth K. (2018)	Canada	Common predictors of PPD including anxiety, experiencing stressful life events during pregnancy, having low levels of social support, and a previous history of depression were consistent among non-Aboriginal women. However, with the exception of the number of stressful events among First Nations off reserve, these were not associated with PPD among Aboriginal women. This information can be used to further increase awareness of mental health indicators among Aboriginal women.
11	Rural American Indian and Alaska Native veterans' telemental health: A model of culturally centered care. https://pubmed.ncbi.nlm.nih.gov/28805411/	Goss, Cynthia W. Richardson, W. J. “Buck” Dailey, Nancy Bair, Byron Nagamoto	USA	4 main components: mental health care, technology, care coordination, and cultural facilitation. There is a need to make improvements to care made by addressing barriers such as system transference, provider-patient trust, and videoconferencing. The care model leverages strengths within Native communities, such as social cohesion and spirituality. Future steps include selection of appropriate performance indicators for larger systematic evaluation.

		, Herbert Manson, Spero M. Shore, Jay H. (2017)		
12	A community-led design for an Indigenous Model of Mental Health Care for Indigenous people with depressive disorders. https://onlinelibrary.wiley.com/doi/10.1111/1753-6405.13115	Brennan-Olsen, S., N. S. Gill, G. Beccaria, S. Kisely, L. Hides, S. Kondalsamy-Chennakesavan, G. Nicholson, and M. Toombs. (2021)	Australia	The most common themes from the focus groups included Indigenous autonomy, wellbeing and identity. The three most common themes from the Elder interviews included culture retention and connection to Country, cultural spiritual beliefs embedded in the mental health system, and autonomy over funding decisions.
13	First nations mental wellness continuum framework. https://www.sac-isc.gc.ca/eng/1576093687903/15760	Health Canada and Assembly of First Nations (2015)	Canada	The First Nations Mental Wellness Continuum (the Continuum) is a complex model, rooted in culture and composed of several layers and elements foundational to supporting First Nations mental wellness. Embedded within the model are the key themes that emerged through dialogue with partners as well as the social determinants of health that are critical to supporting and maintaining wellness. The Continuum must be supported by a number of partners at several levels.

	93725971			 A full spectrum of culturally competent supports and services is necessary to support mental wellness. This continuum includes: Health Promotion, Prevention, Community Development, and Education; Early Identification and Intervention; Crisis Response; Coordination of Care and Care Planning; Detox; Trauma-Informed Treatment; Support and Aftercare. During regional discussion sessions, the National Gathering, the federal discussion, and the National Validation and Implementation Session, several key themes emerged that have shaped the Framework and the Continuum. These themes are: Culture as

				Foundation, Community Development, Ownership, and Capacity Building, Quality Care System and Competent Service Delivery, Collaboration with Partners, and Enhanced Flexible Funding.
14	Aboriginal mental health-What works best. https://www.sfu.ca/content/dam/sfu/carmha/resources/aboriginal-mental-health-what-works-best/Aboriginal%20Mental%20Health%20-%20What%20Works%20Best%20-July%202001.pdf	Smye, V., & Mussell, B. (2001)	Canada	The traditions, values and health belief systems of First Nations people are poorly understood by many providers and often are not respected or considered. Aboriginal knowledge tends to be devalued and marginalized. There is a lack of timely, coordinated treatment and support for individuals with alcohol and substance use issues (in particular, across agencies and communities) as well as for those people with serious mental illness who require immediate intensive care. A lack of funding for travel to external treatment facilities also has been a barrier to care. Although there is some follow-up provided for individuals returning from treatment centres outside of the community, there are few rehabilitation programs. Individuals often find themselves returning to the same set of circumstances that precipitated and/or perpetuated the problem. Housing is considered to be one of the most pressing social issues affecting mental health. Youth without safe homes and elders requiring varying levels of supervised living and care have been identified as priority concerns. Safe housing for women also has been identified as an important issue in several communities. Although the hospital sometimes serves the latter function, many women continue to express the need for refuge for themselves and their children to prevent further abuse/assault. Regardless of the variations in the acculturation histories and health beliefs of First Nations people across Canada, many hold to the view that health refers to a person's whole being. The notion of health captures aspects of physical, mental, emotional and especially spiritual being. Equally important, it captures the context

				in which the individual and community lives, that is, both the physical and social environment. In illness terms, the First Nations people believe that illness is the outcome of a lack of balance or harmony in one or more of the physical, mental, emotional or spiritual aspects of life.
15	The First Nations health authority: A transformation in healthcare for BC First Nations. In Healthcare management forum https://journals.sagepub.com/doi/10.1177/0840470415600131?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed	Gallagher, J., Mendez, J. K., & Kehoe, T. (2015)	Canada	The Center Circle represents individual human beings. Wellness starts with individuals taking responsibilities for our own health and Wellness. The Second Circle illustrates the importance of Mental, Emotional, Spiritual and Physical facets of a healthy, well, and balanced life. Third Circle represents the overarching values that support and uphold wellness: Respect, Wisdom, Responsibility, and Relationships. The Fourth Circle depicts the people that surround us and the places from which we come: Nations, Family, Community, and Land are all critical components of our healthy experience as human beings. The Fifth Circle depicts the Social, Cultural, Economic and Environmental determinants of our health and well-being.

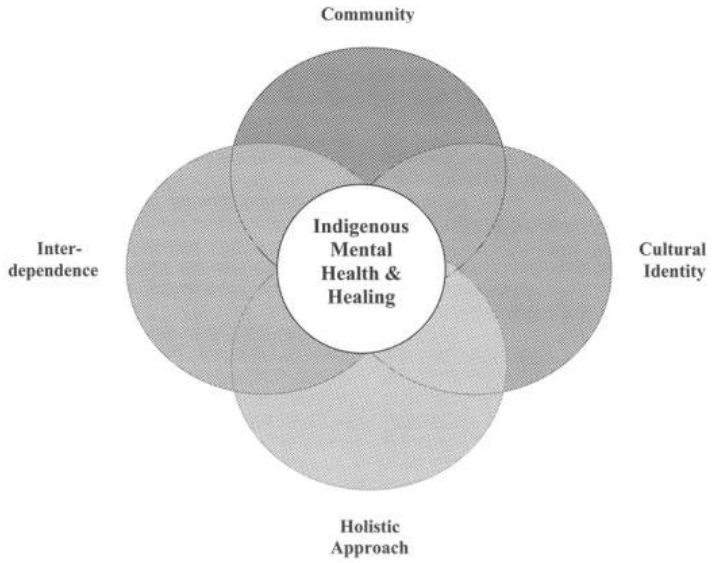
				 
16	Mentally Healthy Communities: Aboriginal Perspectives (Ottawa, Ont.: CIHI, 2009).	Canadian Institute for Health Information (2009)	Canada	There are views, beliefs and guiding principles—rooted in traditional cultures and continuing to evolve—that many First Nations and Inuit individuals, families and communities share. Many First Nations and Inuit partners have taught us that the concepts of balance and holism are central to their understanding of mental wellness. According to this

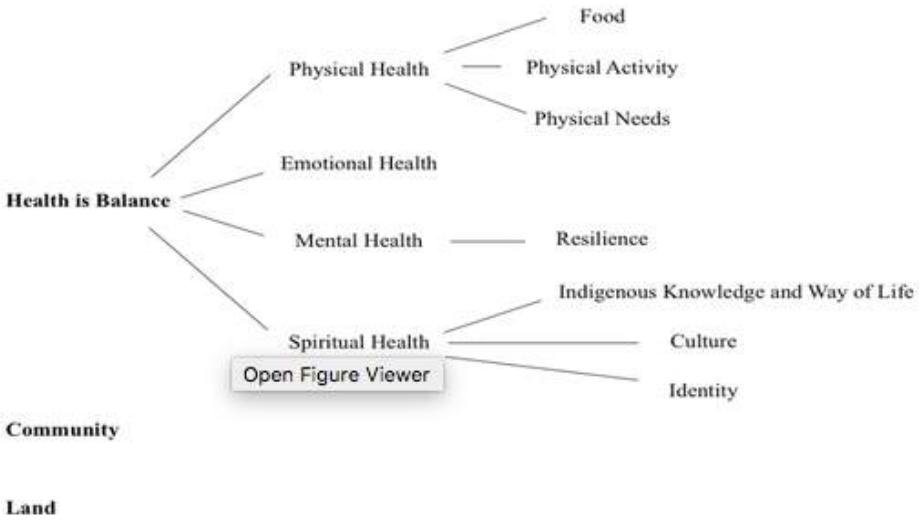
				understanding, balance of the four dimensions of life—the physical, mental, spiritual and emotional—is generally viewed as the basis of wellness. Holism refers to “awareness of and sensitivity to the interconnectedness of all things: of people and nature; of people, their kin and communities; and within each person, the interconnectedness of body, mind, heart and spirit.” The fundamental concept of the inherent interconnectedness of individuals, families and communities implies that individual, family and community wellness must also be understood as essentially interwoven. In this way, mental wellness is viewed as closely linked to one’s relationship with others, the land, and animals. In the words of Inuit elder Mariano Aupilaarjuk, “The living person and the land are actually tied up together because without one the other doesn’t survive and vice versa . . . The land is so important for us to survive and live on; that’s why we treat it as part of ourselves.” For First Nations communities, it is also important to take a strengths-based approach to mental wellness. Wellness is not only the absence of illness, but also a positive expression of well-being and strength that is present in individuals, families, and communities. A powerful illustration of this is provided by Inuit, who know World Suicide Prevention Day as Embrace Life Day in Nunavut, Celebrate Life Day in Nunatsiavut and Live Life Day in Nunavik.
17	Clinical indicators as measures of mental health nursing standards of practice in New Zealand. International	Anthony P O'Brien, Julie M Boddy, Derrylea J Hardy, Anthony J	Australia	Quality of care has become an increasingly important issue in healthcare over the past decade in New Zealand. The objective of the study was to develop bicultural clinical indicators to measure achievement of the new standards of practice for mental health nursing in New Zealand specific to Indigenous populations. The development of clinical indicators needed to ensure that clinical indicators are culturally appropriate and valid for Maori tangata

	Journal of Mental Health Nursing, 13(2), 78-88. https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1440-0979.2004.00322.x?sid=nlm%3Apubmed	O'Brien (2004)		whaiora and their whanau -(family), and for Maori nurses. The development of clinically and culturally valid generic and Maori-specific clinical indicators for New Zealand mental health nursing standards of practice, is a significant advancement for the ability of the mental health service to monitor the quality of service delivery. The potential application of the CNCI to the wider health sector is significant as they also have widespread relevance to generic mental health practice and could be utilised in this capacity. These indicators are listed below. 

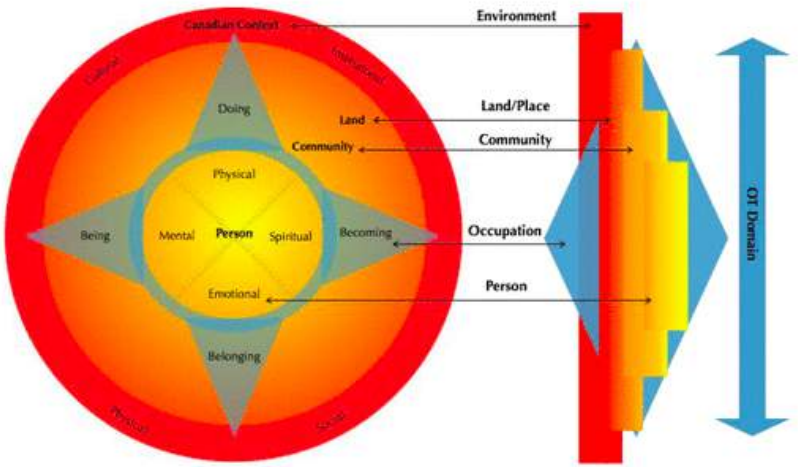
CNCI		Site range	Mean
1[1]	Tangata whaiora are given a choice of whether they want their cultural issues addressed	16.7–72.4	34.3
18[1]	If tangata whaiora has identified specific cultural issues, then access to relevant cultural support is provided for ALL issues	33.3–100.0	72.0
23[1]	The nurse supports tangata whaiora decision to utilize rongoa (traditional medicine/remedy)	0–100.0	77.8
25[1]	If a deficit in the provision of culturally safe practice has been identified, then there is evidence of change	0–100.0	22.0
2[2]	The nurse has sought informed consent of tangata whaiora	3.4–83.3	43.2
3[2]	Tangata whaiora has been informed of their legal rights	6.9–63.3	29.2
6[2]	Goals are set and reviewed in partnership with tangata whaiora	33.3–93.5	69.7
8[3]	There is a documented nursing assessment	20.0–100.0	69.4
9[3]	There is a completed nursing care plan	30.0–90.3	65.7
24[3]	Where restrictions are placed on tangata whaiora freedom, there is evidence in the case notes of regular nursing review	62.5–100.0	89.9

CNCI		n	No.	Mean
1[1]	Tangata whaiora are given a choice of whether they want their cultural issues addressed	111	324	34.3
18[1]	If tangata whaiora has identified specific cultural issues, then access to relevant cultural support is provided for ALL issues	54	75	72.0
19[1]	Maori cultural assessment for Maori tangata whaiora has been conducted	19	83	22.9
20[1]	Maori mental health nurses and/or cultural advisors have been consulted regarding care of Maori tangata whaiora and/or whanau (family)	55	85	64.7
23[1]	The nurse supports tangata whaiora decision to utilize rongoa (traditional medicine/remedy)	14	18	77.8
25[1]	If a deficit in the provision of culturally safe practice has been identified, then there is evidence of change	11	44	25.0
2[2]	The nurse has sought informed consent of tangata whaiora	140	324	43.2
3[2]	Tangata whaiora has been informed of their legal rights.	94	322	29.2
4[2]	Consultation about treatment has taken place with whanau and/or significant others	213	324	65.7
5[2]	Tangata whaiora has been informed of support services	264	323	81.7
6[2]	Goals are set and reviewed in partnership with tangata whaiora	226	324	69.8
7[2]	Tangata whaiora has been given the opportunity to provide feedback on nursing care	234	324	72.2
21[3]	Maori tangata whaiora has been asked if they would like a Maori mental health nurse as their advocate	20	88	22.7
22[3]	The mental health nurse has observed and supported Maori tikanga/kawa (protocols and procedure)	36	82	43.9
8[4]	There is a documented nursing assessment	225	324	69.4
9[4]	There is a completed nursing care plan	215	327	65.7
10[4]	There is a rationale for nursing care	272	327	83.2
24[4]	Where restrictions are placed on tangata whaiora freedom, there is evidence in the case notes of regular nursing review	124	138	89.9
12[4]	There is a relapse prevention programme based on the principles of recovery	60	324	18.5
13[4]	Available health and social resources have been used to support tangata whaiora in the community	258	327	78.9
14[4]	Nurses collaborate with significant others in providing wellness education	95	325	29.2
15[4]	The nurse has provided mental health promotion that focuses on tangata whaiora strengths and wellness	157	327	48.0
16[4]	The nurse has provided a health promotion intervention that reflects relevant personal issues.	178	327	54.4
17[6]	There is a partnership between the nurse and the multidisciplinary team	224	326	68.7

18	Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. https://www.tandfonline.com/doi/abs/10.1080/14635240.2008.10708129	Suzanne L. Stewart (2008)	Canada	This paper presented the findings from a qualitative study exploring the narratives of Indigenous counsellors from Indigenous communities on the topic of mental health and mental health indicators. A health promoting counselling model for Indigenous clients could be based on cultural values and perspectives. However, employing these values and perspectives entails an understanding that a contemporary conception of Indigenous mental health contains two components: mental health as wellness, and mental health as a process of healing. Four metathemes: community, cultural identity, holistic approach, and interdependence were identified as the main results. Further, a model for mental health and healing was created by the overlapping nature of these meta themes in practice. **FIGURE 1: Model of Indigenous Mental Health and Healing** 

19	Indigenous perspectives on health: Integration with a Canadian model of practice. Canadian journal of occupational therapy, 86(3), 220-231. https://journals.sagepub.com/doi/abs/10.1177/0008417419832284	Fijal, Dominique, and Brenda L. Beagan (2019)	Canada	Effectively integrating Indigenous perspectives may be an important first step in a longer journey toward engaging more respectfully with Indigenous perspectives on health and wellness. The Canadian TRC included health care in its calls to action to engage all Canadians in a process of reconciliation between Indigenous and non-Indigenous peoples. The current reality that long-standing Indigenous perspectives on health and wellness are not incorporated in mainstream health care is just one of the reasons Indigenous peoples in Canada experience poorer health status than the Canadian average. In the literature reviewed by this article, the overarching themes identified were balance, community, and land. Balance involves physical, emotional, mental, and spiritual components. Indigenous knowledge, culture, and identity were considered as part of the spiritual domain though interconnected with community and relationship to the land.  **Figure 1.** Themes: Interpretive analysis of literature on Indigenous views of health.

				These four components of health apply to health issues involving individuals, families, and communities as well as the environment. Specific to mental health, components of mental health and wellness identified in the literature included making “good choices,” regularly and safely accessing and connecting with the land, and being self-sufficient. Personal outlook on situations, such as taking personal responsibility, having a positive attitude, and helping oneself, was identified as improving mental health. Some examples of activities identified as contributing to mental health were mental games, abstaining from drugs and alcohol, and participating in continuing education. Resilience, on an individual level and a community level, was also identified as important to mental health. At the individual level, resilience (the ability to come through hardship) is enhanced by having strong coping and problem-solving skills, a strong attitude of accepting change, and the capacity to deal with past, present, and future challenges. Being embedded in a family, community, and culture that embodies preparedness, adaptability, and resilience, as well as collective capacity to deal with challenges, promotes healing from the wounds of racism and colonialism. A deep connection to and respect for nature and the land were described as foundational to adaptability. At the community level, connection to traditional territory and knowledge of interconnections with land and other species may strengthen resilience. The reimagined model of wellness brings these aspects of Indigenous wellbeing and health into focus.

				 **Figure 2.** An integrated Canadian Model of Occupational Performance and Engagement (ICMOP-E).
20	Indigenous Australians' understandings regarding mental health and disorders. Australian & New Zealand Journal of Psychiatry, 41(6), 467-478. https://journals.sagepub.com/doi/10.1080/00048670701332953	Ypinazar, V. A., Margolis, S. A., Haswell-Elkins, M., & Tsey, K. (2007)	Australia	The purpose of the present paper was to determine what is currently documented about Indigenous Australians' understandings of mental health and mental disorders through a meta-synthesis of peer-reviewed qualitative empirical research. An overarching theme emerged from the synthesis: the dynamic interconnectedness between the multi-factorial components of life circumstances. Reciprocal translations and synthesis regarding Indigenous understandings of mental health and illness resulted in five themes: (i) culture and spirituality; (ii) family and community kinships; (iii) historical, social and economic factors; (iv) fear and education; and (v) loss. The application of a meta-synthesis to these qualitative studies provided a deeper insight into Indigenous people's understandings of mental health and illness. The importance of understanding Indigenous descriptions and perceptions of mental health issues is crucial to enable two-way understandings between Indigenous people's constructs of

				wellness and Western biomedical diagnostic labels and treatment pathways for mental disorders and mental health problems. The specific factors identified as components of Indigenous mental health and wellness are below. *Table 2. Key concepts and themes derived from reciprocal translation of original studies* **Vicary and Bishop [32]** / **Vicary and Westerman [15]** / **Emden et al. [11]** / **McLennan and Khavarpour [34]** / **O'Brien [33]** Culture Spirituality: Importance of country; Influence of spirituality; Culture: 'powerful determinant' of perceptions of mental health; Cultural identity / Mechanism of interpretation: cultural reasons sought for ill health; Treatment dependent on cultural interpretation / Mismatch between traditional and Western understandings of health and illness / Importance of identity Sacred sites / Loss of cultural identity; Lack of respect; Importance of Aboriginal identity; Individual (mainstream) versus the community Kinship: Diminished traditional roles / Family and community tensions / Basis of identity Sense of belonging / Traditional kinship roles; Role of elders; Importance of family; Lack of role models within community Lack of support in community Social Historical Economic: Impact on wellness – employment, substance abuse, family violence, dispossession, Stolen Generation, financial problems, housing / Grief and anger over past injustices; Racism; Low self-esteem; Stolen generation; Grief due to loss of family members; Social and emotional stress; Overcrowding; Effects of alcohol misuse / Intergenerational impact of colonial domination; Social oppression and racism; Impact of alcohol and drugs; Domestic violence and other abuse; Grief Fear Education: Stigma therefore need for education; Lack of awareness of mental health issues; Lack of culturally appropriate mental health promotion; Mental illness as 'culturally alien'; Fear of treatment outcomes / Fear of Western mental health system: reluctance to seek help; Stigma and shame attached to mental illness; Need for education to improve skills and knowledge; 'Depression' seen as a character of individual therefore cannot be treated by medication / Relevant and accessible education required; Lack of knowledge regarding medication / Understanding of mental health 'medically simplistic and naïve' *Table 2. Continued* **Vicary and Bishop [32]** / ***Vicary and Westerman [15]*** / **Emden et al. [11]** / **McLennan and Khavarpour [34]** / **O'Brien [33]** Loss: Loss of traditional role as family provider for men; Loss of culture more keenly felt by men: loss of identity; Loss of control of society, politically and spiritually (men) / 'Longing for country' / Loss of family members through suicide, overdose, ill health and other; Loss through stolen generation: inability to locate family members; Loss of connection with land; Loss of sense of belonging; Loss of meaning in life / This study highlights the importance of identity, kinship, culture, spirituality and land in achieving well-being. Loss of any aspect of these factors therefore impacts on well-being and mental health / Loss of cultural and Koori identity; Loss of respect for elders and traditional rules and cultural values (especially by youth); Loss of community support; Loss of 'tribal continuity and togetherness'; Loss of family life Teenagers 'lost'; Loss through stolen generations
21	Rethinking resilience from indigenous perspectives. The Canadian Journal	Kirmayer, L. J., Dandeneau, S., Marshall,	Canada	The notions of resilience that have emerged in developmental psychology and psychiatry in recent years require systematic rethinking to address the distinctive cultures, geographic and social settings, and histories of adversity of indigenous peoples. In Canada, the overriding social realities of indigenous peoples

	of Psychiatry, 56(2), 84-91. https://journals.sagepub.com/doi/10.1177/070674371105600203	E., Phillips, M. K., & Williamson, K. J. (2011)		include their historical rootedness to a specific place (with traditional lands, communities, and transactions with the environment) and the profound displacements caused by colonization and subsequent loss of autonomy, political oppression, and bureaucratic control. These constructs are expressed through specific stories and metaphors grounded in local culture and language; however, they can be framed more generally in terms of processes that include: regulating emotion and supporting adaptation through relational, ecocentric, and cosmocentric concepts of self and personhood; revisioning collective history in ways that valorize collective identity; revitalizing language and culture as resources for narrative self-fashioning, social positioning, and healing; and renewing individual and collective agency through political activism, empowerment, and reconciliation. Each of these sources of resilience can be understood in dynamic terms as emerging from interactions between individuals, their communities, and the larger regional, national, and global systems that locate and sustain indigenous agency and identity. This social–ecological view of resilience has important implications for mental health promotion, policy, and clinical practice.
22	Aboriginal and Western Conceptions of Mental Health and Illness. Pimatisiwin, 9(1), 65.	Vukic, A., Gregory, D., Martin-Misener, R., & Etowa, J. (2011)	Canada	This article states that in order to address Mi'kmaq youth mental health, research and initiatives to improve this area of healthcare must be conducted with an awareness of how Western and Traditional systems of health and healing operate: in isolation of each other; in parallel directions; and in collaboration with each other. Indigenous youth can benefit from the knowledge and wisdom of both understandings of mental health and illness.

Indigenous Peoples and Aging Well

#	Paper Title and Link	Authors (Year)	Country of Intervention	Abstract
1	Aging and health: An examination of differences between older Aboriginal and non-Aboriginal people. Canadian Journal on Aging https://pubmed.ncbi.nlm.nih.gov/20731890/	Kathi Wilson, Mark W. Rosenberg, Sylvia Abonyi, Robert Lovelace (2010)	Canada	"The Aboriginal population in Canada, much younger than the general population, has experienced a trend towards aging over the past decade. Using data from the 2001 Aboriginal Peoples Survey (APS) and the 2000/2001 Canadian Community Health Survey (CCHS), this article examines differences in health status and the determinants of health and health care use between the 55-and-older Aboriginal population and non-Aboriginal population. The results show that the older Aboriginal population is unhealthier than the non-Aboriginal population across all age groups; differences in health status, however, appear to converge as age increases. Among those aged 55 to 64, 7 percent of the Aboriginal population report three or more chronic conditions compared with 2 per cent of the non-Aboriginal population. Yet, among those aged 75 and older, 51 per cent of the Aboriginal population report three or more chronic conditions in comparison with 23 percent of the non-Aboriginal population."
2	Expanding the Circle of Knowledge: Reconceptualizing Successful Aging Among North American Older Indigenous Peoples https://pubmed.ncb	Jessica E. Pace, Amanda Grenier (2017)	North America	"Objectives: Indigenous older peoples' voices and experiences remain largely absent in the dominant models and critical scholarship on aging and late life. This article examines the relevance of the model of successful aging for Indigenous peoples in North America. Method: This article presents the results of a review of the published conceptual literature on successful aging among Indigenous peoples. Our intent was to explore the current state of the field of successful aging among Indigenous peoples and suggest dimensions that may be more reflective of Indigenous voices and experiences that leads to a more inclusive model of successful aging. Results: Based on our review, we suggest four dimensions that may

	i.nlm.nih.gov/27729385/			broaden understandings of successful aging to be more inclusive of Indigenous older people: health and wellness, empowerment and resilience, engagement and behavior, and connectedness. Discussion: Our review suggests that Indigenous peoples' voices and experiences are beginning to be included in academic literature on successful aging. However, we suggest that understandings of successful aging be broadened based on our summative findings and a process of community involvement. Such processes can lead to the development of models that are more inclusive to a wide range of older people, including Indigenous older peoples."
3	Meanings of memory: Understanding aging and dementia in First Nations communities on Manitoulin Island, Ontario https://macsphere.mcmaster.ca/handle/11375/13464	Jessica E Pace (2013)	Canada	"This thesis reports results from my PhD research investigating experiences of aging and dementia among First Nations seniors on Manitoulin Island, Ontario. Dementia has been identified as a growing problem in Aboriginal communities by researchers and Aboriginal stakeholders. However, little research has documented First Nations peoples' explanatory models of dementia or aging. In this thesis I explore Manitoulin Island First Nations people's knowledge, attitudes, beliefs and behaviours related to healthy aging and dementia. I present data that documents explanatory models of successful aging and dementia, issues surrounding help-seeking and treatment, and practices relating to care-giving. This research uses an ethnographic approach following a community-based participatory action research design. In-depth, semi-structured interviews were carried out with seniors, people with dementia, informal family caregivers, health care providers, and traditional healers in seven First Nations communities on Manitoulin Island. Focus groups were carried out with nurses and personal support workers. A total of 59 participants were involved in this research. Participant observation was used to enrich interview data. A hermeneutic phenomenological approach was used to interpret participants' lived experiences of aging and dementia. This research demonstrates that First Nations seniors strive to remain healthy and

				engaged in life as they age. However, it also demonstrates that dementia is a growing problem in First Nations communities. Although First Nations people are generally accepting of memory loss in old age as a natural occurrence, a conflicting perception of dementia as pathological was also present. This research demonstrates that changes to culture and ways of life are perceived to have a significant impact on First Nations peoples' ability to age successfully and on the emergence of dementia as a growing health concern. I conclude that improving access to culturally safe supports and services is needed to ensure that people can better cope with the challenges of aging and dementia."
4	Grannies, elders, and friends: Aging Aboriginal women in Toronto. https://pubmed.ncbi.nlm.nih.gov/25026198/	Cyndy Baskin & Caitlin J. Davey (2014)	Canada	"Based on a research project in Toronto, Canada, this article highlights the strengths and resiliency of 12 female Aboriginal Elders and seniors as they age together. For these women, being actively involved in their families and the Aboriginal community gives them a solid grounding in who they are, what their roles are and how they contribute to the whole. Of particular significance is the support and friendship the women offer each other through their commonalities, activities, and sense of humor."
5	The Importance of Optimism in Maintaining Healthy Aging in Rural Alaska https://pubmed.ncbi.nlm.nih.gov/25026198/	Jordan P. Lewis (2013)	USA	"Many Alaska Native Elders attended government-run boarding schools as children, were forbidden to speak their native language, and were forced to abandon their traditional subsistence lifestyle, yet they maintained an optimistic outlook on life and continued to age well. The Explanatory Model Interview Protocol was adapted to interview a purposive sample of Alaska Native Elders (n = 26) and grounded theory was used to develop a model of successful aging for Alaska Native Elders in Bristol Bay, Alaska. The theme of optimism was significant in the findings and was also found in each of the elements of successful aging, which were spirituality, emotional well-being, community engagement, and physical health. These four elements served as the foundation of the Model of Successful Aging. The Elders believed they

				were able to age successfully because they continued to be optimistic despite the challenges they faced (and are currently facing) in their communities."
6	Empowerment and wellness of Aboriginal Elders https://ourspace.uregina.ca/handle/10294/13203	Elisabeth Rachel Brass (2004)	Canada	"The purpose of this study is to explore how Elders of a particular First Nation have experienced empowerment in their roles as Elders and how their experiences have affected them in terms of health and wellness. In this qualitative study, the information regarding health and wellness was gathered by asking seven Elders who are members of a Saskatchewan First Nation about their experiences and how their experiences are connected with empowerment. Grounded theory methods were utilised to analyse the interview data, which grounds the theory in the Elders' worlds to facilitate understanding of the experiences of empowerment, health, and wellness for this particular group of aboriginal Elders. Results of data analysis suggest there is a four-stage process theory that explains the Elders' experiences of empowerment and how Elders' experiences affect the Elders in terms of health and wellness. The Aboriginal Wellness Empowerment ProcessTheory suggests that the Elders have retained traditional aboriginal cultural constructs, which are the foundation for the Elders' strength and direction in empowering themselves to maintain community wellness, restore traditional values in the community, and restore traditional perceptions of Elders and Elder roles. There is also a subsidiary theme of individual wellness that interacts with the stages of the process in the matrix. The stages are interactive and interconnected and the Elders simultaneously move through the stages to continue to empower themselves and maintain community wellness."
7	"If you've got everything, it's good enough": Perspectives on successful aging in	Peter Collings (2001)	Canada	"Structured interviews with 38 Inuit in the community of Holman were conducted to examineInuit definitions of successful and unsuccessful aging. Qualitative analysis of the interview data suggests that (1) contrary to much of the literature about culture change in the Canadian North, there appear to be no perceivable differences in the ways Inuit of

	a Canadian Inuit community. https://link.springer.com/article/10.1023/A:1010698200870			different age cohorts view aging and elderhood;(2) a successful old age is not one necessarily characterized by individual good health, but rather by the ability of the individual to successfully manage declining health; and (3)for Inuit, the most important determinants of successful elderhood are not material but ideological. That is, an individual's attitudes in late life, and in particular their willingness to transmit their accumulated wisdom and knowledge to their juniors, are the critical determinants of whether an elder is viewed as having a successful old age."
8	Keeping busy: a Yup'ik/Cup'ik perspective on health and aging https://pubmed.ncbi.nlm.nih.gov/17451133/	Scarlett E. Hopkins, Pat Kwachka, Cécile Lardon &Gerald V. Mohatt (2007)	USA	"Objectives. Knowledge of cultural beliefs about health and how they influence life choices and intervention is essential in forming health policy and health promotion programs to meet the growing needs of aging minority populations. This study explores cultural beliefs and practices of health and well-being of Yup`ik/Cup`ik women in two rural villages in southwestern Alaska. Study Design. Exploratory, descriptive qualitative study. Methods. Interviews were conducted with 15 mid-life and older women to address two key research questions: 1) How do Yup'ik/Cup'ik women define health and wellbeing; and 2) What environmental, social, and cultural factors contribute to healthy aging? Results. The women in this study define health aging within the framework of subsistence living-keeping busy, walking, eating subsistence foods, and respect for elders. These beliefs and practices promote a strong, active body and mind, vital components to healthy aging. Conclusions. While many health beliefs and practices appear very different from those currently in research on aging, many commonalities and similarities emerge-concern for family, importance of physical activity and healthy diet. A significant finding of this study is that traditional Yup`ik/ Cup`ik ways of living parallel that of current research findings on what constitutes healthy aging in mainstream populations."

9	Successful aging through the eyes of Alaska Native Elders: What it means to be an Elder in Bristol Bay, Alaska https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3945528/	Jordan P. Lewis (2011)	USA	"Purpose: Alaska Natives (ANs) view aging from a holistic perspective, which is not typical of the existing successful aging literature. One of the challenges of conducting research with cultural groups (e.g., ANs) is the lack of data, or research, on culture and aging and its impact on how we view successful aging. This research explores successful aging from an AN perspective or what it means to reach "Eldership" in rural Alaskan communities, which is an area of successful aging where there is very little research. Design and Methods: Data were gathered from 26 elders aged 61–93 years in 6 Bristol Bay communities in Southwest Alaska. An Explanatory Model approach was used and adapted to gain a sense of the beliefs about aging and establish an indigenous understanding of successful aging or what it means to attain "Eldership." Results: Rather than establishing a definition of successful aging for AN Elders, this study highlights the four elements of "Eldership" or what AN Elders believe are important characteristics to becoming a respected elder. The four elements of "Eldership" are emotional well-being, community engagement, spirituality, and physical health, which are the characteristics of ANs who have reached "Eldership" and become a respected Elder in their community. Implications: This research seeks to inform studies on indigenous aging that prioritizes the perspectives of elders to affect positively on the delivery of health care services in rural Alaska."
10	Aging, health, and the indigenous people of North America. https://link.springer.com/article/10.1007/s10823-010-9130-x	Lori L. Jervis (2010)	North America	"Although the articles for this special issue on Native North American elders cover a diverse array of topics, approaches, and geographical areas, this issue was motivated by a single desire: to gather together in one venue a collection of varied disciplinary approaches to contemporary social and cultural research with older American Indian, Alaska Native, and First Nations people. These Native elders constitute a relatively small, but rapidly growing, population (John 1996). The importance of elders to Native communities, however, belies these small numbers. Elders have traditionally been leaders, keepers of

				history and cultural knowledge, and socializers of the younger generation (Red Horse 1983; Red Horse 1980; Weibel-Orlando 1989). In many communities, these roles continue, although they may be challenged in the face of contemporary pressures. Despite elders' symbolic and practical importance in many tribal communities, current empirical research with this group remains limited. Indeed, there are many important elder-related topics that have received scant research attention, although they are of keen interest to communities themselves. This special issue is one step toward rectifying that discrepancy."
11	Prioritizing Indigenous Elders' Knowledge for Intergenerational Well-being https://www.cambridge.org/core/journals/canadian-journal-on-aging-la-revue-canadienne-du-vieillissement/article/prioritizing-indigenous-elders-knowledge-for-intergenerational-wellbeing/5CE1EB144FEF00F8F670FCE52F208E0B	Gladys Rowe, Silvia Straka, Michael Hart, Ann Callahan, Don Robinson, Garry Robson (2019)	Canada	"Canada's Truth and Reconciliation Commission Final Report (2015) highlighted the necessity of Indigenous self-determination in addressing the legacy of residential schools, yet Indigenous aging research remains dominated by Settlers. This Indigenist study by a Cree/Settler research team asked Indigenous Elders what is needed to support the wellness of the older adults in their communities. Elders shared that the healing of older survivors comes from reconnecting to the cultural knowledges that residential schools sought to eradicate. In resuming their traditional roles as transmitters of knowledge, older adults not only support their own healing, but also that of their whole communities. This understanding of the profoundly inter relational nature of Indigenous communities means that older adults' wellness depends on first reclaiming their cultural identity and then on their roles as intergenerational transmitters of knowledge."
1	Indigenous Older	L Brooks-	Canada	"Active aging and successful aging have become the common

2	Adults' Perspectives on Aging Well in an Urban Community in Canada https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6229756/	Cleator, A Giles (2018)		frameworks for aging well in order to address seniors' health and social needs. They identify what it means to "age well" and guide the development of communities that support seniors to do this; however, these frameworks have been critiqued for their Western perspective that does not take into account the experiences and perspectives of older adults from diverse non-Western cultural backgrounds, including Indigenous older adults. Using community-based participatory research, semi-structured interviews, focus groups, and Photovoice was conducted to explore aging well from the perspectives of Indigenous seniors in an urban community in Canada. The findings show how Indigenous older adults define aging well and explore some of the enablers and barriers to aging well, which can be used to further develop key frameworks related to aging and guide urban communities in supporting the aging Indigenous population."
13	The future of successful aging in Alaska https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3753159/	Jordan Lewis (2013)	USA	"Background: There is a paucity of research on Alaska Natives and their views on whether or not they believe they will age successfully in their home and community. There is limited understanding of aging experiences across generations. Objective: This research explores the concept of successful aging from an urban Alaska Native perspective and explores whether or not they believe they will achieve a healthy older age. Design: A cultural consensus model (CCM) approach was used to gain a sense of the cultural understandings of aging among young Alaska Natives aged 50 years and younger. Results: Research findings indicate that aging successfully is making the conscious decision to live a clean and healthy life, abstaining from drugs and alcohol, but some of Alaska Natives do not feel they will age well due to lifestyle factors. Alaska Natives see the inability to age well as primarily due to the decrease in physical activity, lack of availability of subsistence foods and activities, and the difficulty of living a balanced

				life in urban settings. Conclusions: This research seeks to inform future studies on successful aging that incorporates the experiences and wisdom of Alaska Natives in hopes of developing an awareness of the importance of practicing a healthy lifestyle and developing guidelines to assist others to age well.”
14	Aging in Indigenous Canada. Aging People, Aging Places: Experiences, Opportunities, and Challenges of Growing Older in Canada https://www.jstor.org/stable/j.ctv1h0p58s	Maxwell Hartt, Samantha Biglieri, Mark W. Rosenberg, Sarah E. Nelson (2021)	Canada	“How well do the places where we live support the wellbeing of older adults? The Canadian population is growing older and is reshaping the nation's economic, social and cultural future. However, the built and social environments of many communities, neighbourhoods and cities have not been designed to help Canadians age well. Bringing together academic research, practitioner reflections and personal narratives from older adults across Canada, this cutting-edge text provides a rare spotlight on the local implications of aging in Canadian society.”
15	The Role of the Social Engagement in the Definition of Successful Ageing among Alaska Native Elders in Bristol Bay, Alaska https://journals.sag	Jordan Lewis (2014)	USA	“This article explores the role of social engagement (family and community support) in Alaska Native (AN) Elders’ definitions of successful ageing, why social engagement is important to the health and well-being of AN Elders. In terms of methods, each tribal council nominated AN Elders, ranging in age from 61 to 93 years old, resulting in a purposive sample of 25. Interviews consisted of open- and closed-ended questions, ranging from 45 to 90 minutes. Content analysis was used to find recurring themes and infer meaning from the data and understand the ageing process in rural Alaska. The Elders discussed the importance of family and community, not only as a source of support

	epub.com/doi/abs/10.1177/0971333614549143			but also as part of their culture and identity. Family support provided them with meaningful roles in their family, which contributed to their well-being, optimism and generative behaviours. Community support involved Elders' inclusion in community events and activities and feeling they were supported and meaningfully engaged by their community. The themes in this study highlight the importance of social engagement for AN Elders. This study suggests that perhaps more focus should be placed on social engagement of AN Elders to ensure successful ageing and not just physical and mental health conditions. This Indigenous psychology perspective on positive ageing may serve as a point of dialogue with future First Nations studies of generativity in old age globally."
16	Indigenous Peoples Experiences with Aging: A systematic literature review https://cjds.uwaterloo.ca/index.php/cjds/article/download/674/929#:~:text=A%20Canadian%20study%20found%20seven,et%20al.%2C%202010).	Sean Hillier, Hamza Al-Shamma a (2018)	Canada	"Indigenous Peoples in Canada are a non-homogenous group consisting of First Nations, Metis, and Inuit Peoples representing the original settlers of a given land or a geographical area (Parrott, 2018). Based on geographical location, there are unique names used to describe a given subset or group of Indigenous Peoples around the world. Despite their proximity, they originate from different nations, tribes, and communities and remain distinct in their spoken language, history, and way of life. Although there has been a notable growth in the literature on Indigenous Peoples, relatively little is published about their understanding of healthy aging. Similarly, there is a dearth of literature about the specific needs and wishes of Indigenous Peoples in Canada to facilitate a healthy aging process."
17	Aboriginal Experiences of	Shawnda Lanting,	Canada	"Examining the role of culture and cultural perceptions of aging and dementia in the

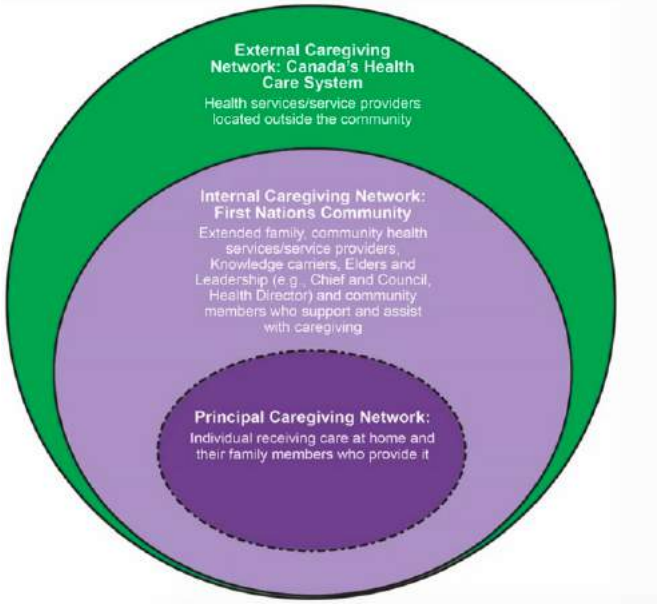
	Aging and Dementia in a Context of Sociocultural Change: Qualitative Analysis of Key Informant Group Interviews with Aboriginal Seniors https://pubmed.ncbi.nlm.nih.gov/21287400/	Margaret Crossley, Debra Morgan, Allison Cammer (2011)		recognition, diagnosis, and treatment of age-related cognitive impairment remains an understudied area of clinical neuropsychology. This paper describes a qualitative study based on a series of key informant group interviews with an Aboriginal Grandmothers Group in the province of Saskatchewan. Thematic analysis was employed in an exploration of Aboriginal perceptions of normal aging and dementia and an investigation of issues related to the development of culturally appropriate assessment techniques. Three related themes were identified that highlighted Aboriginal experiences of aging, caregiving, and dementia within the healthcare system: (1) cognitive and behavioural changes were perceived as a normal expectation of the aging process and a circular conception of the lifespan was identified, with aging seen as going back "back to the baby stage", (2) a "big change in culture" was linked by Grandmothers to Aboriginal health, illness (including dementia), and changes in the normal aging process, and (3) the importance of culturally grounded healthcare both related to review of assessment tools, but also within the context of a more general discussion of experiences with the healthcare system. Themes of sociocultural changes leading to lifestyle changes and disruption of the family unit and community caregiving practices, and viewing memory loss and behavioural changes as a normal part of the aging process were consistent with previous work with ethnic minorities. This research points to the need to understand Aboriginal perceptions of aging and dementia in informing appropriate assessment and treatment of age related cognitive impairment and dementia in Aboriginal seniors."
18	Alaska Native Elders' Perspectives on	Lauren A. Brooks-Cleator&	USA	"Physical activity is widely considered to be a significant contributing factor to how "successfully" one ages. There are, however, certain groups whose voices have not been widely heard in discussions around

	Physical Activity and Successful Aging https://www.cambridge.org/core/journals/canadian-journal-on-aging-la-revue-canadienne-du-vieillissement/article/alaska-native-elders-perspectives-on-physical-activity-and-successful-aging/F63F7CCF28ABB53A8B77EE006B4428E4	Jordan P. Lewis (2019)		physical activity and aging, particularly those from diverse cultural backgrounds. In this research, we explored how Alaska Native Elders perceive the role of physical activity as they age and its contribution to successful aging. Based on semi-structured interviews with 41 Elders, the results show that engaging in physical activity was not just seen as a personal responsibility to maintain health and age successfully, but also as a way to resist Western society's dominant view of older adults as deteriorating and declining by being physically active regardless of age; to improve or maintain their physical, mental, emotional, and spiritual health; and/or to enable them to continue participating in subsistence activities that are rooted in their culture and traditional roles as Elders."
19	The Koori Growing Old Well Study: investigating aging and dementia in urban Aboriginal Australians https://pubmed.ncbi.nlm.nih.gov/24507414/	Kylie Radford, Holly A. Mack, Hamish Robertson, Brian Draper, Simon Chalkley, Gail	Australia	"Dementia is an emerging health priority in Australian Aboriginal communities, but substantial gaps remain in our understanding of this issue, particularly for the large urban section of the population. In remote Aboriginal communities, high prevalence rates of dementia at relatively young ages have been reported. The current study is investigating aging, cognitive decline, and dementia in older urban/regional Aboriginal Australians. We partnered with five Aboriginal communities across the eastern Australian state of New South Wales, to undertake a census of all Aboriginal men and women aged 60 years and over residing in these communities. This was followed by a survey of the health, well-being, and life history of all consenting participants.

		Daylight, Robert Cumming, Hayley Bennett, Lisa Jackson Pulver, Gerald A. Broe (2014)		Participants were also screened using three cognitive instruments. Those scoring below designated cut-offs, and a 20% random sample of those scoring above (i.e. "normal" range), completed a contact person interview (with a nominated family member) and medical assessment (blind to initial screening results), which formed the basis of "gold standard" clinical consensus determinations of cognitive impairment and dementia. This paper details our protocol for a population-based study in collaboration with local Aboriginal community organizations. The study will provide the first available prevalence rates for dementia and cognitive impairment in a representative sample of urban Aboriginal people, across city and rural communities, where the majority of Aboriginal Australians live. It will also contribute to improved assessment of dementia and cognitive impairment and to the understanding of social determinants of successful aging, of international significance."
20	Ageing, Cognition and Dementia in Australian Aboriginal and Torres Strait Islander Peoples: A Life Cycle Approach http://www.dementiaresearch.org.au/images/dcrc/output-files/260-ipwd1_monograph.pdf	Arkles, R., Jackson Pulver, L., Robertson, H., Draper, B., Chalkley, S., & Broe, A (2010)	Australia	"Dementia is emerging as a global phenomenon, although it is predominantly defined in the literature as a, 'Western diagnostic category'. There is general acceptance that 'Culture', namely, values, practices and beliefs, play an important role in understanding dementia, from uncovering risk factors for the disease, in particular, the interplay of environmental and genetic factors (Burchard, Ziv et al. 2003), to influencing what has been described as, "help-seeking behaviours", across different populations (Dilworth-Anderson and Gibson 2002). In Aboriginal communities, both in Australia and other comparative societies, what we know about the nature and extent of dementia, and of its sub-types, is still in its infancy, as is knowledge about the experiences, perceptions and meaning of dementia for Aboriginal people, the causes of, and risk factors for cognitive decline, and the need for and provision of dementia services (Pollitt 1997; Jervis and Manson 2002; LoGiudice, Smith et al. 2006). This Report is a review of

				the literature to-date on dementia in Aboriginal and Torres Strait Islander Australians. We reviewed the research in comparable Indigenous communities internationally as well as dementia research in non-Indigenous populations, both nationally and internationally, to illuminate cognitive development, growth and decline across the life-cycle and its application to the 'brain health' of Indigenous Australians. The Review was conducted over a three year period between late 2006 and 2009."

Indigenous Peoples and Palliative Care

#	Paper Title and Link	Authors (Year)	Country of Intervention	Relevant Key Points
1	"If you understand you cope better with it": the role of education in building palliative care capacity in four First Nations communities in Canada. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6983-y	Prince, Holly, Shevaun Nadin, Maxine Crow, Luanne Maki, Lori Monture, Jeroline Smith, and Mary Lou Kelley. (2019)	Canada	First Nations people have long-standing cultural practices surrounding the end of life. Death is seen as sacred and a natural part of the life cycle, and care and support are provided by family and communities. There are long-standing traditions for preparing for death and established social processes for supporting community members through dying, loss, grief and bereavement. Connection to the land (the home land or home community) is especially important for people who are dying.  Specific targets identified by the Indigenous communities: ● a lack of knowledge around services that are available in the community

				• lack of knowledge surrounding palliative care as a whole • lack of trained providers from the community • Band leadership (Chief and council members, health directors and band managers who supervise staff)
2	Provision of comprehensive, culturally competent palliative care in the Qikiqtaaluk region of Nunavut: Health care providers' perspectives. https://www.cfp.ca/content/65/4/e163.long	Vincent, Daniel, Jill Rice, Jessica Chan, and Pamela Grassau. (2019)	Canada	Interviews with the participating health care providers in the Qikiqtaaluk region of Nunavut revealed 5 complex and interwoven themes that influence the provision of comprehensive, culturally competent palliative care services to Indigenous patients: • respecting Inuit culture, end-of-life care planning, and the role of family; • recognizing the importance of the Northern community (sense of home); • being aware of the limited health care resources; • recognizing the critical role of medical interpreters; • and improving the quality of palliative care programs and resources, as well as health care provider training in palliative care and Inuit end-of-life care.
3	Bereaved Families' Perspectives of End-of-Life Care. Towards a Bicultural Whare Tapa Wha Older person's Palliative Care Model. https://link.springer.com/article/10.100	Moeke-Maxwell, Tess, Aileen Collier, Janine Wiles, Lisa Williams, Stella Black, and Merryn	New Zealand	Palliative care for Indigeous populations are profoundly relationship-oriented and must uphold the older person's mana (authority, status, spiritual power) across four critical health domains. However, poor health care on one level impacts on all four domains by affecting (reducing) mana (status). • Whānau (social/family), • Hinengaro (emotional/mental), • Wairua (spiritual) and • Tinana (physical) health domains.

	7/s10823-020-09397-6	Gott. (2020)		
4	Understanding Indigenous Australians' experiences of cancer care: stakeholders' views on what to measure and how to measure it. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3780-8	Green, Monica, Kate Anderson, Kalinda Griffiths, Gail Garvey, and Joan Cunningham. (2018)	Australia	Several aspects of cancer care were identified as critical in shaping Indigenous patients' experiences. Key themes included: ● feeling safe in the system; ● the importance of Indigenous staff; ● ameliorating barriers to care; ● the role of family and friends; ● effective communication and education; ● and coordination of care and transition between services. Those participants affected by carers' wellbeing and palliative care strongly advocated for the importance of these topics. Participants expressed support for a face-to-face interview with a trusted person as the most appropriate means of collecting cancer care experience information.

<table>
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<td>5</td>
<td>Key features of palliative care service delivery to Indigenous peoples in Australia, New Zealand, Canada and the United States: a comprehensive review. [Review]

https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-018-0325-1</td>
<td>Shahid, S., Taylor, E. V., Cheetham, S., Woods, J. A., Aoun, S. M., & Thompson, S. C. (2018)</td>
<td>Australia, New Zealand, Canada, & USA</td>
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<tr><th colspan="2">Needs</th></tr>
<tr><td rowspan="3">Collaboration</td><td>Community Engagement</td></tr>
<tr><td>Family Engagement</td></tr>
<tr><td>Health Care Provider Collaboration</td></tr>
<tr><td rowspan="7">Service Delivery</td><td>Funding</td></tr>
<tr><td>Communication</td></tr>
<tr><td>Policy Change</td></tr>
<tr><td>Staff</td></tr>
<tr><td>Built Environment</td></tr>
<tr><td>Service Delivery, Provision of Care, Capacity of Care</td></tr>
<tr><td>Cultural & Spiritual</td></tr>
<tr><td rowspan="2">Education & Training</td><td>Training for Health Care Providers</td></tr>
<tr><td>Education for Patient, Family and Community</td></tr>
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Main findings from Indigenous communities and preferences and needs shared and communicated by community members:

Strong preference for living with family and within the community at end-of-life and during the dying process
Families should be at the centre of any decision-making process
Better communication, commitment around end-of-life care at the policy level, staff capacity building, and improved physical environment and access to services were identified as key service delivery needs
More education and training for both the Indigenous communities and the health care staff in palliative care was identified repeatedly
Community and/or gathering of extended family members was regarded as significant and as part of the palliative

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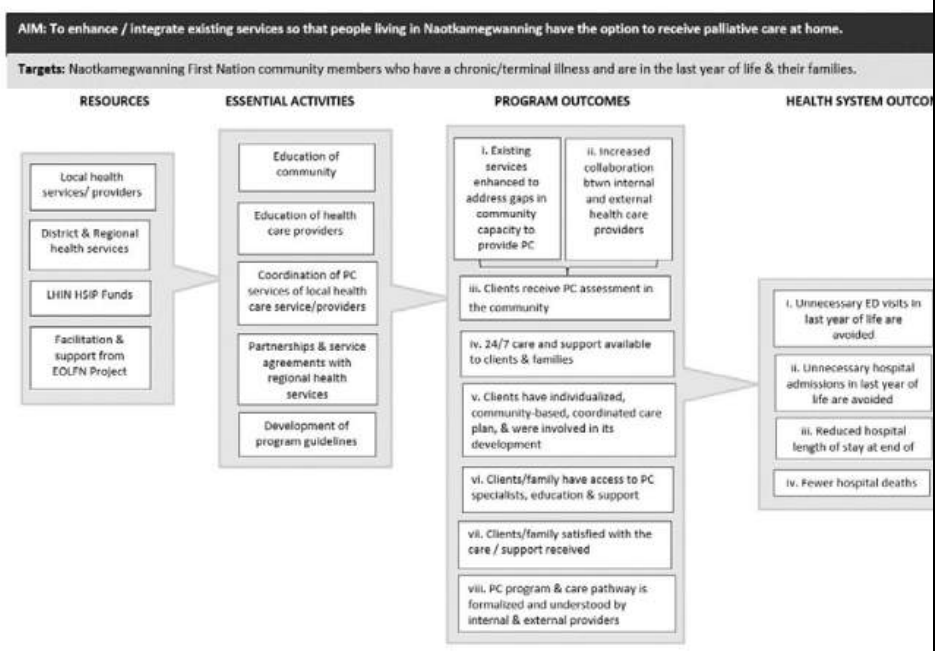
				 care process Key preferences identified are: ● family and community involvement; ● dying at home; ● provision for cultural and spiritual ceremonies within service settings; ● open and honest communication from health professionals; ● respectful treatment by HSPs, ● and availability of Indigenous staff. Indigenous people expressed a strong preference to spend time with families and communities at end-of-life. Families are pivotal to the wellbeing of dying Indigenous patients.

6	Wiisokotaatiwin: development and evaluation of a community-based palliative care program in Naotkamegwanning First Nation. https://www.rrh.org.au/journal/article/4317	Nadin, S., Crow, M., Prince, H., & Kelley, M. L. (2018)	Canada	 Several essential activities were vital for the delivery of culturally competent and high quality palliative care for Indigenous patients: ● comprehensive education of community members and healthcare providers; ● effective coordination of palliative care services and providers; development and implementation of partnerships and service agreements with provincial and territorial health services; ● and evidence-based development of program guidelines with input and direction from Indigenous leadership. Their palliative care program included several key components that were identified as important by the Indigenous community: ● palliative care assessment that was provided within the community;

				• 24/7 access to care and support for patients and their families; • access to individualized, community-based coordinated care planning that is developed in collaboration with patients and families The palliative care program, including the pathway to palliative care specialists, as well as culturally competent education and support, was formalized and well understood by all internal and external providers and healthcare delivery networks. The program delivery and the indicators used to measure program outcomes were: • number of unnecessary ED visits in the last year of life, • unnecessary hospital admissions in last year of life, • reduced length of hospital stay at end-of-life, • number of in-hospital deaths.
7	Priorities and challenges for a palliative approach to care for rural indigenous populations: A scoping review. [Review] https://onlinelibrary.wiley.com/doi/10.1111/hsc.12469	Caxaj, C. S., Schill, K., & Janke, R. (2018)	Canada	Priorities included: • family connections throughout the dying process; • building local capacity for palliative care to provide more relevant and culturally appropriate care; • flexibility and multi-sectoral partnerships to address the complexity of day-to-day needs for patients/families. These findings point to several areas for change and action that can improve the relevance, access and comprehensiveness of palliative care programming for rural Indigenous communities in Canada and elsewhere. Taking into account the diversity and unique strengths of each Indigenous community will be vital in developing sustainable and meaningful change.

8	Cultural understanding in the provision of supportive and palliative care: perspectives in relation to an indigenous population. https://spcare.bmj.com/content/3/1/61	Grace Johnston, Adele Vukic and Skylan Parker (2013)	Canada & USA	**Table 2** Themes emerging from a review of literature and discussion with informants on culturally competent supportive and palliativ care for the Mi'kmaq **Theme** — **Description** Historic context of colonisation — It is critically important to recognise the role of colonialism in shaping policy and its impact on what services are available Canada's First Nation peoples. Unlike other parts of the country, there has been no land surrender in Nova Scotia. Jurisdictional issues — Continuity of care may be lost as individuals require care outside their community and move between provincial and feder services. Cultural understanding — Values: lack of alignment between values implicit in Western medicine and those of the Mi'kmaq culture can be problema Using a holistic health approach can act as a bridge for understanding indigenous values such as the interconnectedness the physical, social and spiritual dimensions of self and the impact this has on health decisions. Rather than being univers and unchanging, values differ, often subtly, by family and individual as well as from community to community. Language: acknowledging culture as a part of an individual's healing process is vital to understanding health choices and preferences. The integration of spirit as a part of healing occurs through the inseparable interrelationships among self, fan and community. Different world views, language and cultural contexts reflect the divide that needs to be bridged to attain cultural competency in the care of indigenous peoples at end of life. Complexity is inherent in gaining a deep understandi of language. The main themes identified by the Indigenous population were the acknowledgement and recognition of the ongoing impacts of colonisation; as well as jurisdictional issues and cultural understanding. They are all interconnected and grounded in the historic Mi'kmaq context of colonialism. Jurisdictional issues experienced by the Mi'kmaq affect access, continuity and appropriateness of care. Cultural concepts were associated with worldview, spirituality, the role of family and community relationships and communication norms, and thereby with the alignment of values and language in the provision of care. Three Mi'kmaq concepts were noted as significant to the provision of palliative care for Indigenous peoples: apiksiktatulti (a Mi 'kmaq term used to describe when a person is thought to be dying, family and friends go to the bedside to partake in this act of mutually being present with each other which may include forgiveness or reconciliation. This has the intent of ensuring that the dying person will go to the spirit world without any burden while also preparing all involved for the inevitable), nemu'ltus (A commonly used Mi'kmaq saying which translates to 'I'll see you.' It is mostly used as a form of goodbye, but is also used when someone is dying. The implication here is that death is not final, and is not so much its own period but a

				continuation of the realities that there are many levels of existence), and salite (Mi'kmaq feast after a person leaves this world.) A lack of alignment between values implicit in Western medicine and those of the Mi'kmaq culture can be problematic. Using a holistic health approach can act as a bridge for understanding indigenous values such as the interconnectedness of the physical, social and spiritual dimensions of self and the impact this has on health decisions. Rather than being universal and unchanging, values differ, often subtly, by family and individual as well as from community to community. Acknowledging culture as a part of an individual's healing process is vital to understanding health choices and preferences. The integration of spirit as a part of healing occurs through the inseparable interrelationships among self, family and community. Complexity is inherent in gaining a deep understanding of language. Different world views, language and cultural contexts reflect the divide that needs to be bridged to attain cultural competency in the care of indigenous peoples at end of life. Key recommendations for non-Indigenous healthcare providers were also summarized:

				Table 3 Recommendations for non-indigenous care providing supportive and palliative care **I. The systems: learn history of indigenous people and relevance to healthcare today** (A) Be aware and adapt to the impact of the historic context of colonialism. — Even though practices may differ today, pain from the past reverberates and retains a resonanc that must be recognised. Colonialism shaped political relationships and resources and led to discrimination and injustices including lack of respect and unequal access to care. (B) Recognise the gaps and issues in the provision of indigenous health services. — While not a main focus of this paper, addressing health system problems is essential for the provision of culturally competent supportive and palliative care. The need to lobby to improve access, quality, comprehensiveness and continuity of care is apparent. **II. The individual: gain insight into the views of the person** (A) Make an effort to get to know the individual. — Cultural needs must be considered on an individual basis, not according to cultural assumptior biases. Individuals are unique, even within their cultures. Dignity is individually determined. Providers should take every opportunity to build a relationship with the patient/client to enable them provide competent care. Cultural knowledge and awareness is one step in the continuum providing quality care. (B) Treat each situation as unique and case-specific. — A great opportunity for attaining cultural understanding is remembering that even specialised healthcare providers can expand their awareness of other cultures and learn from those they se Biomedical values are not always reconcilable with other cultural values. Sensitivity should be g to individual's previous experience with the medical system and models for achieving health. (C) Recognise the value placed on trust and respect. — Sincerity is recognised as an emotional strength. Focused communication, including listening ar noting responses, strengthens a relationship built on trust and respect. If trust is given to caregivers by a Mi'kmaw as a way of respecting their role, the trust should be protected, never abused or disregarded. (D) Be aware of non-verbal communication and cues for discussion. — Minimal eye contact may not indicate discomfort. Care providers can share information to encourage discussion rather than directly asking personal, intrusive questions. (E) Consider the role of religious beliefs and spirituality. — Spirituality, in particular feelings toward life, death and afterlife, hold varying degrees of importance. When traditional views of going to the spirit world are identified, providers should recognise that death is viewed as a transition from one state to another and not with the sam finality as other worldviews concerning death. Spiritual and religious beliefs play an important in framing processes and choices relating to values enacted at this time.
9	What are the priorities for developing culturally appropriate palliative and end-of-life care for older people? The views of healthcare staff working in New Zealand. https://onlinelibrary	Gary Bellamy, Merryn Gott (2012)	New Zealand	The findings demonstrated that participants viewed the involvement of family as fundamental to the provision of palliative care ● Enabling family members to provide 'hands-on' care ● The role of family in decision-making was fundamental to the delivery of and satisfaction with care ● Need to be cognisant of individual preferences both within and across cultures as a fundamental aspect of palliative care provision ● The role of family in 'hands-on' palliative care and decision-making requires care staff to relinquish their role as 'expert provider' ● Counter to the prioritisation of autonomy in Western health-care, collective decision-making was favoured

	.wiley.com/doi/10.1111/j.1365-2524.2012.01083.x			• Providing families with the requisite knowledge and skills to give care to older family members was important. Whilst assumptions are sometimes made about preferences for end-of-life care based on cultural values alone, these data suggest that care preferences need to be ascertained by working with family members on an individual basis and in a manner that respects their involvement in palliative care provision.
10	Understanding death and dying in select first nations communities in northern Manitoba: issues of culture and remote service delivery in palliative care. https://www.tandfonline.com/doi/pdf/10.3402/ijch.v63.32708	Kenneth E. Hotson, Sharon M. MacDonald & Bruce D. Martin (2016)	Canada	The majority of Indigenous people and health care providers interviewed reported that Indigenous people living in remote communities would prefer to die at home. The issues surrounding palliative care provision in remote Indigenous communities are cultural and geographic. Culturally sensitive care requires that patients have access to family support and traditional services if requested. Geographic isolation requires that: patient-specific care plans be created for use in the remote community; effective lines of communication are established between remote health care providers and urban specialists; health care providers and family care-givers be properly trained to fill their respective roles; and appropriate guidelines and resources are available in the community to support this type of care.

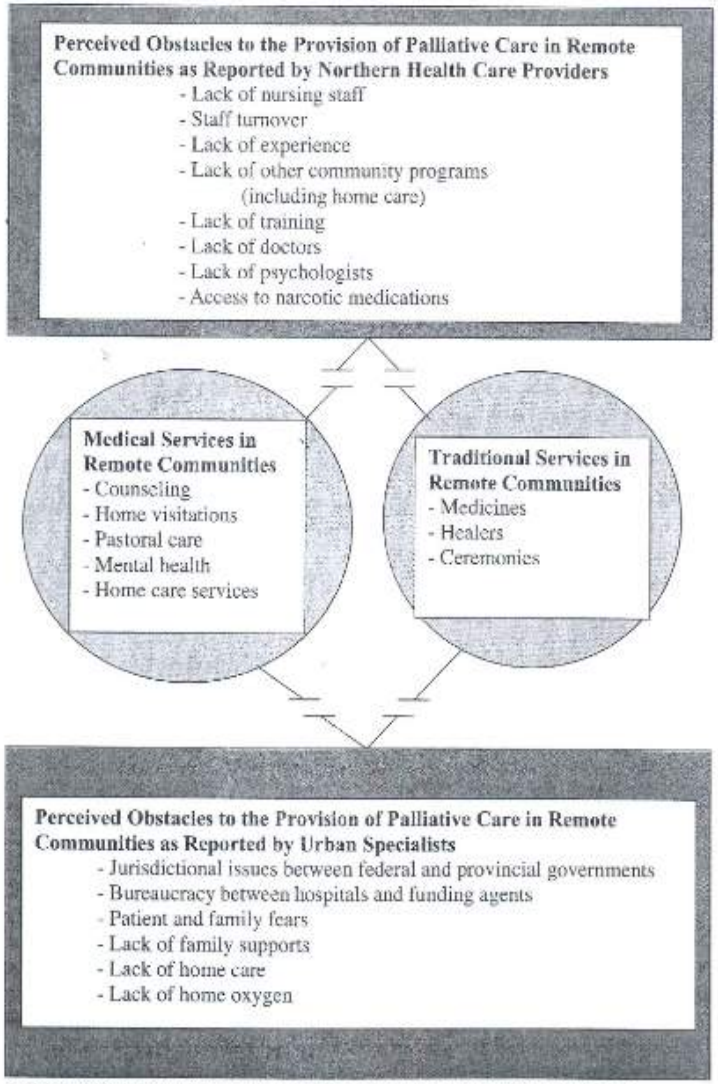


Figure 2. Summary of remote community services, and potential obstacles to palliative care.

11	Developing palliative care programs in Indigenous communities using participatory action research: a Canadian application of the public health approach to palliative care https://apm.amegroups.com/article/view/19273/19351	Kelley ML, Prince H, Nadin S, Brazil K, Crow M, Hanson G, Maki L, Monture L, Mushquash CJ, O'Brien V, Smith J. (2018)	Canada	This research focused on four diverse First Nations communities located in Ontario and Manitoba. First Nations communities have well-established culturally-based social processes for supporting their community members experiencing dying, loss, grief and bereavement. However, communities do not have formalized local palliative care programs and have limited access to medical services, especially pain and symptom management. While there is diversity between and within First Nations communities, there are common themes pertaining to end of life. Communities view death as a natural part of the life cycle and care is provided by family and community. For most First Nations people, the dying experience is sacred and needs to be prepared for according to their beliefs. There are established traditions for providing psychological and spiritual support, and long standing social processes for supporting people experiencing dying, loss, grief and bereavement. Further, connection to the land is important, especially to the traditional territories where people grew up and have familial connections. Details of these points are further exemplified in the below figures:

Table 4 Community assessment data illustrating the importance of dying at home

Key informant sample group[†]	Illustrative quote
Community member	*"I think about my uncle right now and he had cancer and, he just kept going and going, and going because I th his hope was that he would be at home to die, and he didn't go into the hospital for a very long time in the end maybe a week eh, and then he died. He struggled every day to stay home because he wanted to really be at ho to die, but it was just that last week he had to go in, and that's where he died, but to me and even, in this time his death, I really believe that it was a very hard thing for him to go there and be in that environment, to leave th world because I think his hope was he would be at home to leave the world."*
	"One of the things that there is such a great need in the community for end-of-life care and it brings a commun together. Not being able to have that love on at home because of barriers can really pull family, not only the fam the community apart. That's why it's so important to bring them home where they belong."
Elder/knowledge carrier	*"You hear everyone say well they passed away at home in their bed, and that just makes you feel so good ... th was nice, they, it happened the way they wanted it, but some of us don't have that choice, we're taken away to soon."*
Internal First Nations health care provider	*"There are people that are very sick in our community and we want to help them, and we know that is their wis stay at home for as long as possible and that is what we want to do."*

[†], community member: a member of one of the participating First Nations communities, including community leadership, family caregi internal health care providers (a member of the community who also provides health services in the community); elder/knowledge ca a member of the community having status as being knowledgeable either due to age or immersion into the traditional cultural prac of the community; internal First Nations health care provider: community member who also provides health services within one of the First Nations community partners.

Table 5 Summary of community assessment results related to challenges and barriers to community PC

PC resources & supports
Lack of PC services in the community and lack of access to external PC specialists
Lack of support services for families & lack of respite care
Lack of grief supports for families, internal health providers and the community at large
Lack of medical equipment (hospital beds, wheelchairs, pain pumps, oxygen)
Lack of transportation to transport seriously ill community members to medical appointments
Lack of access to medication for pain and symptom management; problems with the safe storage of medications
Inadequate housing and lack of assistive devices (e.g., houses lack proper door width, grab bars, and bathing equipment)
Knowledge, skills & cultural safety
Community members' personal fears around death and dying were identified as barriers
Community members lack knowledge in PC. The identified education needs focused mostly on the medical aspects of death and dy (e.g., illness specific information, care techniques, and what to expect at the end of life) as well as training in advance care planning
External health care providers lack knowledge of how to provide culturally safe care to First Nations people
Service, policy & jurisdictional barriers
Lack of communication/coordination between internal and external service providers
Jurisdictional issues related to First Nations health policy and inadequate budgets for delivering quality programing 24/7 in the

				Table 6 Community assessment data illustrating the need for community-based PC Key informant sample group† — Illustrative quote Community member — *"Having a palliative care program allows for that community to bring their loved one's home, to die wh they were born…Certainly in an aboriginal community that is the one thing that is key, to be born on th territory and to pass away on the territory. Having a palliative care program helps them to feel comfort leaving the hospital."* (community facilitator) Internal First Nations health care provider — *"If the community members themselves, staff and family can keep care of their loved one, then they ca come home. If the care that they require is too great for the staff that's here and, or the family then the usually have to stay in the hospital or in Kenora. Sometimes people stay in Kenora at family or friends there, for more service."* *"Oh, I have a friend, her mother passed away in the hospital and she told me that her mom was trying come home, but the doctors wouldn't let her come home. And, my friend said that they wished she co of, like had the power to bring her home."* †, community member: a member of one of the participating First Nations communities, including community leadership, family caregiv internal health care providers (a member of the community who also provides health services in the community); internal first nat health care provider: community member who also provides health services within one of the four First Nations community partners.
12	Cultural safety strategies for rural Indigenous palliative care: a scoping review https://bmcpalliatcare.biomedcentral.com/articles/10.1186/s12904-019-0404-y	Kaela Schill, Susana Caxaj (2019)	Canada	Culturally safe strategies invite decolonization of care through awareness of colonialism, racism, and discrimination. They invite commitment to building partnerships, power sharing, and decision-making in the delivery of care. The following themes were extracted from the literature: symbolic or small gestures; anticipating barriers to care; defer to client, family and community; shared decision-making; active patient and family involvement; respectful, clear, and culturally appropriate communication; community ownership of services; empower cultural identity, knowledge, and traditions; and, policy. Culturally competent practices can improve Indigenous palliative care services; however, they do not result in decolonized care. Strategies include: symbolic or small gestures; anticipating barriers to access; deferring to the client, family, and community members; and, collective decision making and family involvement. Culturally safe approaches contribute to institutional or organizational change and decolonized care. Strategies include: involvement of patient and family in service planning; reflection about individual and systemic racism; community ownership of services and;

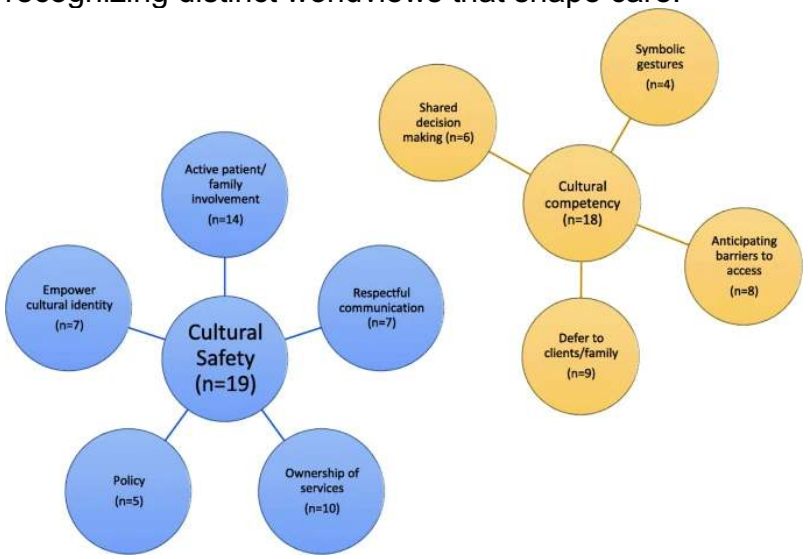
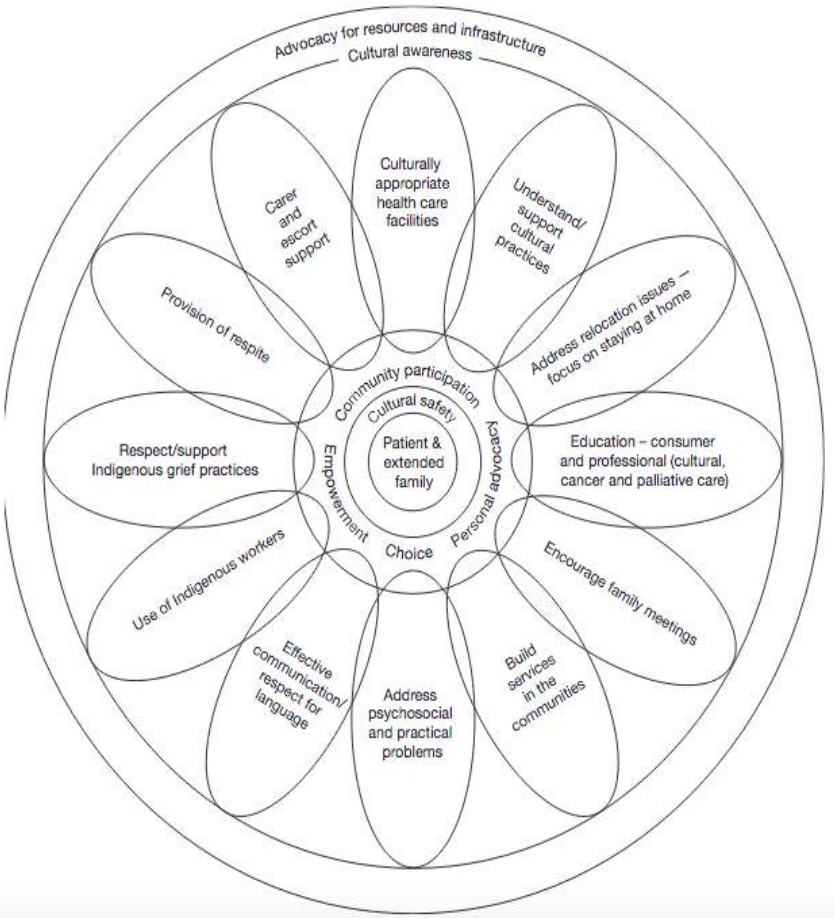
				recognizing distinct worldviews that shape care. 
13	The living model: an Australian model for Aboriginal palliative care service delivery with international implications https://journals.sagepub.com/doi/abs/10.1177/082585971002600112	McGrath, Pam	Australia	There are many practical obstacles related to palliative care service provision to Indigenous people in rural and remote areas. These are associated with equipment, power, transport, distance, and telephone access. The study found that there is a serious lack of local, culturally appropriate palliative care services. The findings provide a clear articulation of the wish of Indigenous people from rural and remote areas to die at home, connected to land and family. The model for palliative care that was developed by this study team was created to address the many challenges faced by Indigenous people in rural and remote areas, and has at its core the notion of the patient within the context of the extended family. The model is intended to serve as a practical representation of factors for use in healthcare provision and advocacy work. It is comprised of 12 interlocking ovals that outline key processes in the provision of effective palliative care.

				Figure 1 / **Living Model: A Model for Indigenous Palliative Care** 
14	Insights from the Northern Territory on factors that facilitate effective palliative care for	Phillips, E.L. and McGrath, P.D	Australia	The findings show that successful outcomes are derived from factors associated with palliative care philosophy and practice and from more specific factors, including the provision of pragmatic support to overcome practical problems, and community visits by health professionals. Factors specific to

	Aboriginal peoples https://www.publish.csiro.au/AH/AH090636			cultural respect are important, including familiarity and continuity of health care providers, cultural respect for grieving practices, provision of comfort food and bush tucker, development of culturally appropriate built environments, use of traditional healers and respect for spiritual practices.