INDIGENOUS PRIMARY HEALTH CARE COUNCIL

A Wholistic and Strength-based Approach for Measuring Health and Wellness:

Considerations for Public Health Indicators

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INTRODUCTION

Measuring health equity is a critical step to promote opportunities for all people - regardless of their social background - to live healthy longer lives, and to monitor progress in health and intersectoral strategies (Ansari et al., 2008). Despite this progress, there are important measurement gaps in existing public health frameworks, including wholistic, strength-based measures that promote health and wellness for First Nation, Inuit, and Métis (FNIM) individuals and communities[1]. Public health core competencies for Canada are being updated and will include even more focus on these skills.

Achieving the shared goal of healthy, vibrant FNIM communities requires a shift away from conventional population health data *about* FNIM to data that illuminates the strengths and perspectives of wellness *within* FNIM communities (National Collaborating Centre for FNIM Health 2021). Strength-based Indigenous models of health and wellbeing are virtually non-existent within public health and medical research (Bryant et al., 2021, O'Keefe et al., 2022; O'Keefe 2023). This paper offers an important starting point to fill this void and provides a background of Indigenous conceptualizations of health and wellness and important strength-based determinants of health that need to be recognized, measured, and actioned to ensure healthy FNIM communities.

BACKGROUND

FNIM Perspectives on Health and Wellness

Wellness can be seen as both an individual perception and a relational phenomenon. An abundance of evidence points to how important it is to shift the paradigm from sickness to wellness and from deficits to strengths (Kendell 2016, Geddes, Chretien, 2010, First Nations Centre, 2007, Thiessen, 2020, Anderson 2006, Kendall, 2016, Heggie 2018, First Nations Authority, 2018). Despite the impacts of historical and present-day colonialism, FNIM communities have maintained their cultural knowledge in their ways of living, in their language, and in their strength and resilience.

FNIM communities conceptualize health as a multifaceted construct that incorporates physical, mental, emotional, spiritual, social, ecological, and economic wellbeing. First Nation, Inuit, and Métis also have distinct traditions. There is not one single "Indigenous" concept of health, which is very important for public health practitioners to recognize in their practice.

The concept of wholistic health and wellness is not easy to assess using conventional measurement tools and traditional data sets (Chretien, 2010). Too often, indicators of health and wellness measure the absence of something negative, rather than the presence of something positive. A wellness indicator is a measure of how *well a*

[1] Communities refer to First Nations on territory, Métis settlements, Inuit lands, as well as FNIM organizations (IPHCOs, MNO offices, OFIFCs, ONWA chapters, Inuit associations, etc.).

person or community is doing (Geddes, 2015). Some communities are redesigning indicators using the concept of reframing – with community engagement, each objective is taken and transformed into a wellness indicator using the question "What would success look like in this area?" (Geddes).

Despite its importance, measures of culture are missing in most data sets. As a result, there is an enormous need for general data in this area, including language use, participation in cultural activities, eating traditional foods, being out on the land, etc. Others are stressing the importance of the concept of Two-Eyed Seeing (Cultural Safety Attribute Working Group. September 2019, Kendall 2016). For example, the First Nation Health Authority (FNHA), in partnership with the B.C. Ministry of Health, recently created a strength-based measurement approach to wellness and resilience using a Two-Eyed Seeing[2] approach. **This work resulted in a set of 22 indicators that will be monitored for 10 years.** The indicators include measures of healthy, self-determining nations and communities, healthy systems and healthy children and families and are measured from both the western and Indigenous lens (FNHA PHO, 2021). The renewed set of indicators will bring together knowledge to support and inform policy, initiatives, and approaches. This project has been used as an exemplar in the creation of population health indicators and greatly informed the work being presented.

Health Equity and Determinants of Health

Over the past two decades, there has been an emergence of academic literature documenting the influence of social determinants on the wellness of FNIM and what has become evident is that the physical, emotional, mental, and spiritual dimensions of health among Indigenous peoples are distinctly and differentially influenced by a broad range of environments, circumstances, and relationships (Carson et al., 2007; Fisher et al., 2019; George et al., 2019; Wypych- Ślusarska et al., 2019). Indigenous individuals, families, communities, and nations experiencing inequities in the social determinants of health are more likely to carry an additional burden of ill health as well as be restricted from access to resources that might ameliorate these concerns (Loppie & Wien 2022).

Underlying proximal and intermediate determinants of health are the continued effects of colonialism, often considered to be the most important foundational or *distal* determinant of health for FNIM communities (Krieger, 2008; Richmond & Ross, 2009). Over the last several years there have been provincial, national, and international initiatives such as the Royal Commission on Aboriginal Peoples (Canadian Institute for Health Information [CIHI], 2004), the Truth and Reconciliation Commission (TRC) of Canada (TRC, 2015a), and the United Nations Declaration on the Rights of FNIM Peoples (UNDRIP) (United Nations, 2018), which confirm these

[2] Two-Eyed Seeing – "learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing…and learning to use both eyes together, for the benefit of all" Championed by Elder Albert Marshall (Mi'kmaw Nation).

assertions and repeat the necessity of Indigenous self-determination and equity as being critical to health and wellbeing.

Strength-Based Determinants of Health

Research reporting negative FNIM health statistics has dominated over the past decade and although focus on the SDOH have highlighted glaring health inequities this has drawn attention away from the strengths and resilience of FNIM communities. Focusing on deficits is a top-down approach to solving problems and often results in portraying FNIM as the problem without understanding the layers of context.

SDOH in an Indigenous context include unique *structural determinants*, such as history, political climate, economics, and social contexts. These determinants are premised on the importance of relationships, interconnectivity, and community (Reading, 2015). Deficit narratives in healthcare are reproduced through practices and policies that ignore Indigenous strengths and reproduce structural inequalities (Rountree & Smith 2016). When strengths are recognized, it is possible to strengthen capacities and address challenges, while still recognizing the structural factors impacting Indigenous peoples' health (Kenney 2022).

A strengths-based approach challenges these negative stereotypes and supports a broader appreciation of cultural diversity of FNIM culture and knowledge. This approach 'harnesses the energy and ingenuity' of FNIM communities (Foley and Schubert 2013) and privileges Indigenous ways of knowing, being and doing (Martin 2003). Ultimately it shifts the focus from problems and deficits to inherent strengths (Geia et al 2011). Most health indicators currently available are problematic within FNIM communities for a variety of reasons including:

- key drivers of health and wellbeing are excluded (e.g. strength-based determinants of health)
- a comprehensive definition of health and wellbeing from an FNIM perspective is not used
- data is either fragmented or unavailable
- there is a lack of FNIM identifiers
- indicators are developed without Indigenous consultation

Indigenous populations in Canada have significant cultural, traditional, and healing practices. These practices convey core cultural values and perspectives distinct to particular communities; however, they often share an understanding of health as arising from a state of balance and equilibrium between the physical, mental, spiritual and emotional aspects of the person (McCormick, 2008; Browne et al., 2016; TRC, 2015). This interconnected view of health and well-being draws attention to the importance of interpersonal relationships, social networks, and relationship to the environment.

Traditional healing practices convey key values for FNIM communities, as well as strengthens connections within the family and community, and between individuals and the environment. These are often framed in terms of teachings of the Medicine

Wheel, which aligns experience in terms of the different directions, each of which correspond to major dimensions of health and well-being: physical, mental, emotional, and spiritual. Each of these dimensions of health and well-being is associated with sources of strength and resilience including family and community relationships, spirituality, and connection to the land and the environment (Brant, 2006; Henderson et al., 2007).

Wholistic, Strength-Based Population Health Indicators

Most current indicators are risk-focused and aligned with deficit-based models that draw from Western definitions of health that may be harmful to FNIM communities in terms of stigmatization and the continuation of negative stereotypes (King et al., 2019; Bryant et al., 2021).

More specifically, deficit-based measures focused on disease and illness do not reflect the Indigenous conceptualization of wellbeing, which is not based on a medical model but rather a wholistic model and is grounded in balance and harmony (Rountree & Smith 2016). Recognizing that many of these are integral to current health care and public health service delivery, they play an important role but there is also room to consider any unintended harms as well as approaches that can be adapted alongside.

Indigenous ways of knowing considers wellness to occur when balance and harmony exists in relationships. Whereas the Western framework is a linear model based on cause and effect. Indigenous-based interventions do not target symptoms or causes, but rather focus on returning the individual or system (family, community, organization, etc.) back into balance (Limb, Hodge, & Panos, 2008).

Health status indicators measure aspects of the health of a population. Examples include life expectancy, disability, or chronic disease rates. They measure what is wrong with a person.

Health determinant indicators measure things that influence health. Examples include diet, smoking, water quality, income, and access to health services. FNIM also consider language, culture, and spirituality to be health determinants.

Strength-based determinants focus on identifying and supporting the strengths, motivations, ways of thinking and behaving, as well as the protective factors—within the person or the environment—that support people in their journeys toward well-being.

Key to this approach is empowerment by focusing on inherent strengths, including both internal and external resources, rather than problems to be overcome. In the context of FNIM communities, problems to be overcome often are the result of centuries of violent and oppressive policies and practices and may represent political and structural issues that children and families cannot solve on their own (Roundtree & Smith 2016). We need to recognize that if the focus is solely on pathology and deficits that this is what will be found. Strengths-based measurement is not simply the inverse of deficit measurement (FNIGC 2020). While low scores on an indicator of pathology often can be taken as a measure of better health, a strengths-based

approach should result in an understanding of the origins, processes, and outcomes of health and wellbeing.

The most meaningful and useful indicators, stresses Geddes (2015), are those generated and approved by the community. Ideally, indicators are simple, easy, and clear to understand, track, and report on, to be most useful (Geddes, 2015). In addition to having the qualities of being valid and reliable (described in the above section), indicators also need to be specific, measurable, relevant, and cost-effective to collect (Assembly of First Nations Health & Social Secretariat, 2006, as cited in Geddes, 2015).

The Thunderbird Partnership Foundation, in partnership with Health Canada, has developed an Indigenous, knowledge-based wellness assessment. This framework identifies valuing cultural competency, cultural safety, and Indigenous knowledge as a priority for action and highlights the importance of whole health (physical, mental, emotional, spiritual, social, and economic well-being) through a comprehensive and coordinated approach that respects, values, and utilizes First Nations cultural knowledge, methodologies, languages, and ways of knowing (Assembly of FN & Health Canada, 2015). Important components have been identified that are not seen in the Public Health Agency's definition, including environmental stewardship, justice, heritage, and housing.

> *"Culture must not only guide work, it must also be understood as an important social determinant of health" (Yukon Health and Social Services 2016).*

Development of FNIM Population Health Indicators

To advance FNIM self-determination in the health system, it is essential for FNIM narratives and knowledge to thrive in population health data and reporting. The indicators selected for this work are wellness-focused; have a wholistic, strength-based approach; and focus on population health.

Five promising practices promoted by Stelkia et al. (2023) were used to guide the development of FNIM wholistic, strength-based indicators to ensure they:

1. Are culturally relevant and centre on health and wellness.
2. Honour Indigenous ways of knowing and being.
3. Involve respectful relationships and meaningful engagement with FNIM communities.
4. Incorporate Indigenous leadership and self-determination – Nothing about us, without us.
5. Fully embrace a strength-based approach and contextualize indicators within historical, sociopolitical contexts.

This can be done in concert with approaches public health teams will use in creating any indicators, such as SMART (specific, measurable, achievable, relevant, and time-bound).

Indicator Sources

Leveraging the existing work of FHNA on strength-based measurement of wellness and resilience, IPHCC developed wholistic, strength-based population health indicators that align with the Public Health Ontario population health indicators. The current PHO indicators were reviewed with specific domains and/or indicators identified where opportunity existed to develop or reframe using a wholistic, strength-based lens. Several PHO indicators were reworded using this lens, while other indicators were created anew to incorporate FNIM perspectives.

Principles for Indicator Selection

The following table outlines three domains[3] of specific population health considerations with coinciding indicators, definitions, and proposed data collection modality. The domains include:

1. Culture as Care[4] – Overarching Approach towards Wholistic Health and Wellbeing
2. Supportive Systems – Environment, Economy, and Health Systems
3. Healthy, Vibrant Communities – Emotional, Mental, Physical, and Spiritual Wellbeing

Culture as Care – Overarching Approach towards Wholistic Health and Wellbeing Culture refers to connection to land, holding language, importance of ceremony, access to traditional foods and medicines. Wholistic care refers to balance between the mental, physical, emotional, and spiritual elements of self. The indicators within this domain look at the role of culture and how it positively contributes to the health of FNIM communities.
Supportive Systems – Environment, Economy, and Health Systems Colonialism dismantled intrinsic and time-honoured Indigenous supportive systems and replaced them with systems grounded in social exclusion and discrimination (FNHA), resulting in inequities and poor health outcomes that perpetuate today. The indicators within this domain focus on addressing the distal determinants of health (i.e., colonialism, anti-Indigenous racism). A paradigm shift can occur through mandatory cultural safety education and training and the creation of an inclusive public health system designed for all, including FNIM (culturally appropriate). The result is an environment in which FNIM communities restore self-determination and equity to reclaim control over their own health and wellness journeys.
Healthy, Vibrant Communities – Emotional, Mental, Physical, and Spiritual Wellbeing

[3] Domains relate to First Nations Population Health & Wellness Agenda themes.

[4] Culture plays a significant role in the health and wellbeing of FNIM Peoples, yet measurement to its existence, implementation, and impact is nonexistent.

Healthy and vibrant communities should be determined by the community and is evidenced by the joy in daily life with genuine social interaction, with people coming together, celebrating, laughing, and sharing their stories and lives with each other.

The indicators within this domain encompass traditional knowledge, traditional healing practices, and self-determination as a fulcrum to restoring balance at the individual, familial, and community levels. To accomplish this requires the promotion and delivery of high-quality care through the community-endorsed Model of Wholistic Health and Wellbeing (MWHW). The model is rooted in a population needs-based approach to health system planning and delivery for FNIM.

While many of the indicators have a more deficit-based approach, First Nation and Inuit Health and Wellness indicators have information that is publicly available. Additional include:

- Association of Public Health Epidemiologists in Ontario
- Canadian Community Health Survey
- Chronic Disease and Injury Indicator Framework

Wholistic, Strength-Based Population Health Indicators

DOMAIN	CURRENT PHO CATEGORY/INDICATOR	REFRAMED/NEW INDICATOR	DEFINITION	DATA SOURCE
Culture as Care – Overarching Approach towards Wholistic Health and Wellbeing	Social Environment – None	Proportion of communities reporting ability to exercise self-determination over health	Communities who have led/co-created and delivered public health programming.	PHU self-reflection and community survey[5]
	Social Environment – None	Proportion of communities reporting connection to land and ceremony	Connection to ancestors, traditional ceremonies and medicines, traditional wellness practitioners, a link to identity, language, FNIM culture, knowledge, and stories.	Community survey
	Social Environment – None	Proportion of households who have access to traditional foods	Measuring food security incorporating an FNIM lens that is inclusive of access to fish, wild game, berries, etc.	Community survey
	Child Health – None	Proportion of children accessing cultural-based early childhood development programming	Opportunities for children to enhance a sense of self-identity and belonging through connection to culture (i.e., Indigenous HBHC which includes language, traditional teachings, dance, story telling, arts and crafts etc.).	Community survey
DOMAIN	**CURRENT PHO CATEGORY/INDICATOR**	**REFRAMED/NEW INDICATOR**	**DEFINITION**	**DATA SOURCE**
Supportive Systems – Environment,	Built Environment – None	# of communities impacted by evacuations due to fire, flooding, or other seasonal occurrences	Communities evacuated, supporting activities linked to evacuations (relocation, host	Community survey

[5] Mutual reflection will aim to assess how all partners view the collaboration and co-design process.

Economy and Health Systems			communities, physical, mental, emotional and spiritual care), or those on standby for evacuations.	
	Social Environment – Food security	Proportion of households who can afford to eat a balanced meal	Measuring food security according to financial affordability and geography.	Community survey
	Social Environment - % without high school diploma	Proportion of students who complete high school within 8 years (FNHA)	A student of any age including those completing a General Education Diploma.	Census
	Social Environment – housing affordability	Proportion of individuals with acceptable (adequate, suitable, affordable, not overcrowded) housing.	Acceptable housing is permanent or at minimum semi-permanent housing with access to all essential amenities (hydro, clean water, heat, sewer) and is in good repair (no internal leaks, windows intact, etc.) and a dedicated room for sleeping and is not overcrowded in the space.	Community survey
	Social Environment - None	Proportion of individuals who were offered culturally appropriate services.	Cultural appropriate care means that FNIM have access to programs and services that designed to meet their wholistic health needs. This includes offering access and referrals to FNIM services where available and client preferred.	Community survey

	Social Environment - None	Proportion of individuals who felt culturally safe and respected when accessing public health programming. Proportion of individuals who experienced feeling trust and respect when accessing programming. Proportion of individuals who felt their cultural identity and teachings are valued by public health.	Measuring cultural safety and humility by incorporating FNIM beliefs, and practices into public health domains. Cultural safety refers to care that is free of discrimination and anti-FNIM racism.	Community survey
	Social Environment - None	Number of FNIM public health practitioners. Number of FNIM representatives on the PHU board of governance.	Measuring FNIM public health workforce participation through self-identification, including all roles inclusive of leadership and decision-making roles.	Staff survey
DOMAIN	**CURRENT PHO CATEGORY/INDICATOR**	**REFRAMED/NEW INDICATOR**	**DEFINITION**	**DATA SOURCE**
Healthy, Vibrant Communities – Emotional, Mental, Physical, and Spiritual Wellbeing	Child Health – Children with Dental Caries from Kindergarten to Grade 2	Proportion of children from kindergarten to grade 2, who are cavity-free	FNIM children who are cavity-free between kindergarten and grade 2	Oral Health Information Support System (?)
	Child Health – None	Proportion of children aged 2-11 with a healthy/moderate body mass index	FNIM children aged 2-11 years who have a healthy/moderate BMI	

	Injury & Substance Use – Emergency Visits for Intentional Self-Harm	Rate of youth/young adults (age 15-24) who attempt suicide	Rate of FNIM per 10,000 population who attempted suicide	National Ambulatory Care Reporting System
	Injury & Substance Use – Mortality from Injuries Due to Intentional Self Harm	Rate of youth/young adults (age 15-24) complete suicide	Rate of FNIM per 10,000 population completing suicide	National Ambulatory Care Reporting System
	Chronic Disease & Mental Health – Overall Self-Perceived Mental Health	Proportion of individuals who felt balanced physically, emotionally, mentally, and spiritually.	Measure FNIM wellbeing through a wholistic lens (physical, mental, emotional, spiritual aspects of care).	Community survey
	Health Behaviours – Self Reported Adult Physical Activity During Leisure Time	Proportion of individuals meeting the recommended physical activity guidelines.	Measure FNIM physical activity across the lifespan to include seniors, adults, children, and youth.	Community survey
	Health Behaviours – Self Reported Current Adult Smoking (daily and occasional)	Proportion who smokes commercial tobacco for recreational use.	Differentiate between using tobacco for recreational smoking versus for ceremony or other traditional use.	Community survey

Data Sources and Quality of Data

The calculation of many indicators necessitates accurate population estimates to have appropriate denominators. Serious concerns have been raised about the quality of existing data reflecting FNIM population counts, attributable populations and health status (Rotondi 2017; Anderson 2006; Smylie 2018; 2015). The absence of appropriate ethnic identification on health records, which is maintained by the lack of opportunity to self-identify, contributes to the ongoing oversight of non-registered FNIM, particularly in urban communities (National Collaborating Centre for FNIM Health 2021).

Often the only source of FNIM-specific health information is periodic surveys, which rely on self-reported health status, only occur every few years, and have insufficient sampling. These factors contribute to their inadequacy in serving as the bases for regional or community level planning and surveillance (Anderson 2006; Smylie 2015). Technically, the most feasible way of obtaining FNIM-specific data, is by linking the Indian Register with health care databases.

It is important to note that such databases generate data that is reflective of federal priorities, categorized by externally imposed political definitions of who "Aboriginal" people are, and allows for a coverage of less than 60%.

In addition, use of Census data provides an inaccurate depiction of the Indigenous population as they are grossly underestimated for the following reasons:

1. Due to a history of mistrust, many Indigenous people are hesitant to participate in a government data collection tool.
2. Census questionnaires are available in English and French with only reference materials available in Indigenous languages. However, requests to access must be made online or phone, limiting access to those without access to these services.
3. Statistics Canada does not collect data from the following groups:
    a. Those residing on territory (reserves)
    b. Those experiencing homelessness or unhoused (overrepresentation among FNIM)
    c. Those within correctional settings (overrepresentation among FNIM).
4. Indigenous self-identification question is only asked on the long-form census which only goes to 25% of Canadian households.

Key improvements are immediately required that include Indigenous self-identification and the right to be counted (Smylie 2015). One strategy for consideration that will provide more accurate data is use of respondent-driven sampling to reach and include Indigenous people more effectively. Community-driven data collection approaches have shown effectiveness in reaching Indigenous peoples commonly excluded, unidentifiable or underrepresented in health information systems. Until this is done, using the usual data sources will undercount Indigenous populations up to 40%.

The IPHCC has started this process however this will take time and until fully implemented all measures will be under counted. Many of the indicators suggested requires new data. Public health and health care systems can commit to collecting strength-based data and ensure that multiple data sources are prioritized. We cannot continue to rely on the usual data sources that mask and ignore the strengths within FNIM communities and the opportunities for improvement. This is a significant issue and must be prioritized along with additional data collection to ensure measurement will lead to action and ultimately improved health and wellbeing.

Equity Stratifications

Data should be stratified (when appropriate) to identify health disparities on all standard and PHU specific measures. These health disparities are important to identify, however they need to be recognized to be part of the continuing impact of colonization and systemic racism aimed at Indigenous people and not seen as an individual problem (Richmond 2016; Mitchel 2019). An equity stratifier is a characteristic such as a demographic, social, economic or geographic variable that can identify population subgroups for measuring differences in health and health care that may be considered unfair or unjust. Inequities between subpopulations can be identified by disaggregating health indicators using equity stratifiers (CIHI 2018; 2022).

Analyses and Interpretation of Data

When analysing, interpreting and presenting the indicator data, it is important to ensure that there is a fine balance of pulling out the details you need by disaggregating but not at a level that will cause harm via loss of confidentiality or presenting inaccurate trends/data. Inaccurate trends/data can lead to mistakes, including for decisions and programs changed based on the data.

Equity Stratifications

Data should be stratified (separated out by groups) when appropriate to identify health disparities on all standard and PHU specific measures. These health disparities are important to identify, however they need to be recognized to be part of the continuing impact of colonization and systemic racism aimed at Indigenous people and not seen as an individual problem (Richmond 2016; Mitchel 2019). An equity stratifier is a characteristic such as a demographic, social, economic or geographic variable that can identify population subgroups for measuring differences in health

and health care that may be considered unfair. Inequities between subpopulations can be identified by disaggregating (separating) health indicators using equity stratifiers (CIHI 2018; 2022).

Privacy/Confidentiality

Although equity stratification is important, it is also very important to balance with maintaining the privacy/confidentiality of those that could be identified when presenting low levels of data. For example, if you present community-specific indicator data stratified by both age and gender, it may be possible for those in the community to identify the individual(s) that small number represents. Data should not be disaggregated if it could cause a risk to making individuals identifiable in the data.

Statistical Significance

Small sample sizes should be considered when trying to interpret the results and identify trends. Small numbers can make it more difficult to identify true trends from random fluctuations, and to have confidence in if what is being captured is the true picture. Ensure that data is aggregated to a level that ensures there is enough 'power' to include testing for statistical significance (where appropriate) and reduces the influence of random observations. Some jurisdictions use a threshold of anything less than 5 is not reported (and represented with the symbol "*" or as "<5").

Conclusion and Key Findings

Key findings include:

- Indicators must include metrics that reflect wholistic health, wellness and cultural safety from an Indigenous perspective. Meaningful indicators have been developed and should be incorporated into PHU measurement.
- The population counts significantly underestimate Indigenous populations – especially in urban areas. For meaningful denominators and comparisons this must be fixed through self-identification and community-driven data collection methods to ensure everyone is counted. Recognizing that this will improve over time if the appropriate strategy is implemented.
- Implementation across Ontario and all PHUs is important.
- Equity stratifications are important to identify health disparities between Indigenous communities and others however additional measures should be included that reflect strength-based determinants of health.

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Appendix: Technical Specifications

From Rountree and Smith - Having a *sense of belonging or identity and active participation* was described as engagement of community members, being part of a place and having a greater purpose and contributing to the community.

Good rationale for indicator selections – from Strength-based Approaches to FNIM Research and the Development of Well-Being Indicators First Nations Information Governance Centre, Strengths-Based Approaches to FNIM Research and the Development of Well-Being Indicators, (Ottawa: 2020). 36 pages. Published in June 2020. Ottawa, Ontario.

Culture and Spirituality - The importance of access to traditional knowledge and culture, spirituality, activities, modes of healing and teaching, kinship roles and structures, and land-based ways of knowing and being is strongly emphasized in much of the literature on mental wellness in an FNIM context (Rountree & Smith, 2016).

- Culture is a source of identity but also of many forms of knowledge, values, and practices. These may contribute to individual and collective self-esteem and to having a large repertoire of ways to solve life problems or challenges (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011; Wexler, 2014).
- An important dimension of culture concerns ceremonial activities that are sacred and convey teachings of core values. For many FNIM people and communities, sacred and ceremonial aspects of cultural teachings are crucial to their strength and sense of well-being, connectedness, and meaning in life.
- Family and Community - Many FNIM people report that family and community ties are important sources of their strength and resilience (Walsh, 2015). Values associated with family and connectedness informed by traditional knowledge may also influence resilience (Boss, 2006)
- Connection to land and environment - In many First Nations contexts, the health of individuals cannot be understood as separate from the health of the environment. This poses challenges to conventional mental health research that tends to view individuals in isolation or as in transactions with the environment that are characterized mainly by mastery and exploitation.