Marginalized and Underrepresented Groups: Indigenous Peoples

The global population of Indigenous Peoples is over 476 million, representing a diversity of geographic locations, cultural identities and practices, languages, and socioeconomic and political dynamics (ILO 2020). The United States Agency for International Development (USAID) follows the United Nations' (UN's) approach to identifying, rather than defining, Indigenous Peoples based on factors and considerations related to their self-identification as "Indigenous," as well as recognition by other groups as distinct inheritors and practitioners of unique cultures and ways of relating to people and the planet (USAID 2018). See USAID's Policy on Promoting the Rights of Indigenous Peoples for the Agency's seven criteria for identifying Indigenous Peoples (USAID 2020). According to the UN, "Indigenous Peoples are inheritors and practitioners of unique cultures and ways of relating to people and the environment" and "they have retained social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live" (United Nations n.d.). The United Nations Permanent Forum on Indigenous Issues (UNPFII) highlights that Indigenous Peoples reside in nations with varying levels of infrastructure and are situated across multiple socioeconomic circumstances, including those struggling to fulfill basic human needs (UNPFII 2023). Despite this diversity, Indigenous Peoples around the world share common challenges related to the protection and realization of their rights, including the right to enjoy the highest attainable standard of mental health.

Intersectionality and Indigenous Youth Identities

The social, cultural, economic, and political factors that increase Indigenous Peoples' structural vulnerability to mental health conditions differentially affect individuals, groups, and populations in local Indigenous communities through their intersectional identities (UN Partnership on the Rights of Persons with Disabilities and UN Women 2022). In other words, Indigenous youth are not a homogenous group—they have a range of different layers of multiple identities, including some that are unique to each community. These include conceptions of self, living systems, spiritual beliefs and practices, ways of being, gender categories, and connections to culture, language, community, and land. Gender categories among Indigenous youth may be non-binary and/or non-conforming to non-Indigenous gender norms, and genders could include lesbian, gay, bisexual, questioning, and two-spirit (LGBTQ2+) or other sexual identities, some of which may link to specific social, cultural, and spiritual roles in Indigenous society. Additional identity markers may include age, race, religion, disability, national origin, migration status, and others.

Social determinants of mental health are the non-medical factors that influence mental health conditions. They are the conditions and life circumstances that people are born into and live within. They are the wider set of forces and systems shaping the conditions of daily life.

The below box presents an example of how Indigenous

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youth with several marginalized and underrepresented identities are likely to face multiple forms of discrimination and more mental health inequities (Roy et al. 2020).

Intersectional identities and mental health inequities

Findings from the 2019 Youth19 Rangatahi Smart Survey in New Zealand show that youth who are both Maori, Pacific or Rainbow, and have disabilities or chronic conditions face greater mental health inequities than youth with only one of these overlapping identities. They also experience double the rate of mental health inequities compared to the majority of youth who are Pakeha non-Rainbow or Pakeha young people without a disability or chronic condition. Yet, having many aspects of identity could also offer a sense of belonging and pride when connecting with youth with similar identities through support networks (Roy et al. 2021).

MHPSS Needs among Indigenous Peoples and Indigenous Youth

MHPSS needs among Indigenous communities are inextricably linked to the need to address the contextual and historical factors that shape the disproportionately high mental health risks they face and to promote their right to quality mental health services. High rates of depression, anxiety, substance misuse, suicide, and post-traumatic stress disorder are commonly reported issues among Indigenous Peoples (Commission on Social Determinants of Health 2007; Chmielowska and Fuhr 2017). However, Indigenous leaders and researchers challenge the overuse of disorder- and deficit-focused biomedical approaches and narratives in relation to the mental health and psychosocial well-being needs among Indigenous Peoples (O'Keefe et al. 2022).

Given the historical, intergenerational, and ongoing social oppression (Rylko-Bauer and Farmer 2016) that has affected and continues to affect Indigenous Peoples, the overuse of biomedical diagnosis and treatment approaches among Indigenous populations runs the risk of pathologizing: (1) traumatic experience(s), (2) the person who had something happen to them that caused the traumatic experience(s), and (3) their mechanisms for coping with the traumatic experience(s) (WHO 2023b). This potential for pathologizing represents a complex situational risk of harm to Indigenous Peoples with mental health and psychosocial needs, which discrimination, bias, and stigma in accessing MHPSS services can exacerbate and complicate. Indigenous youth, in particular, may be deterred from seeking or receiving help with mental health and psychosocial well-being concerns due to fear of discrimination and distrust of authority with the systems that deliver services (Jongen et al. 2023).

Most Indigenous youth have states of well-being. However, research from Canada, Australia, New Zealand, and the United States (CANZUS)[1] suggests that Indigenous youth experience overall higher rates of mental health challenges than their non-Indigenous peers, although there is considerable variation within and between populations (Jongen et al. 2023). It has also been widely noted that disproportionately high rates of suicide affect youth populations in many Indigenous communities—the fourth leading cause of death among all 15- to 29-year-old people globally (Indigenous and non-Indigenous)—which is thought to be linked to the increasingly complex dynamics of discrimination amid changing social, cultural, economic, and environmental determinants (PAHO 2016; WHO 2021b). While these research endeavors focused on risks, Indigenous researchers and Indigenous youth are conducting new strengths-based research to advance an intersectionality of resilience framework that moves beyond risks to include overlapping individual, social, and structural resilience-promoting processes (Njeze et al. 2020).

[1] Referred to in the Indigenous health literature as the CANZUS states, they are states where Indigenous Peoples live among a predominantly English-speaking majority and culturally survive despite marginalization.

The Mental Health Continuum and First Nations' Mental Wellness Continuum Framework

The mental health continuum conceptualized mental health and psychosocial well-being along a continuum, from states of thriving, to surviving, to struggling, and to in-crisis conditions (Patel et al. 2018). This broad view of mental health and psychosocial well-being more accurately reflects the diversity of mental health and psychosocial needs among Indigenous Peoples than the biomedical model alone.

Figure 1: Mental Health Continuum of Care (University of Waterloo n.d.)

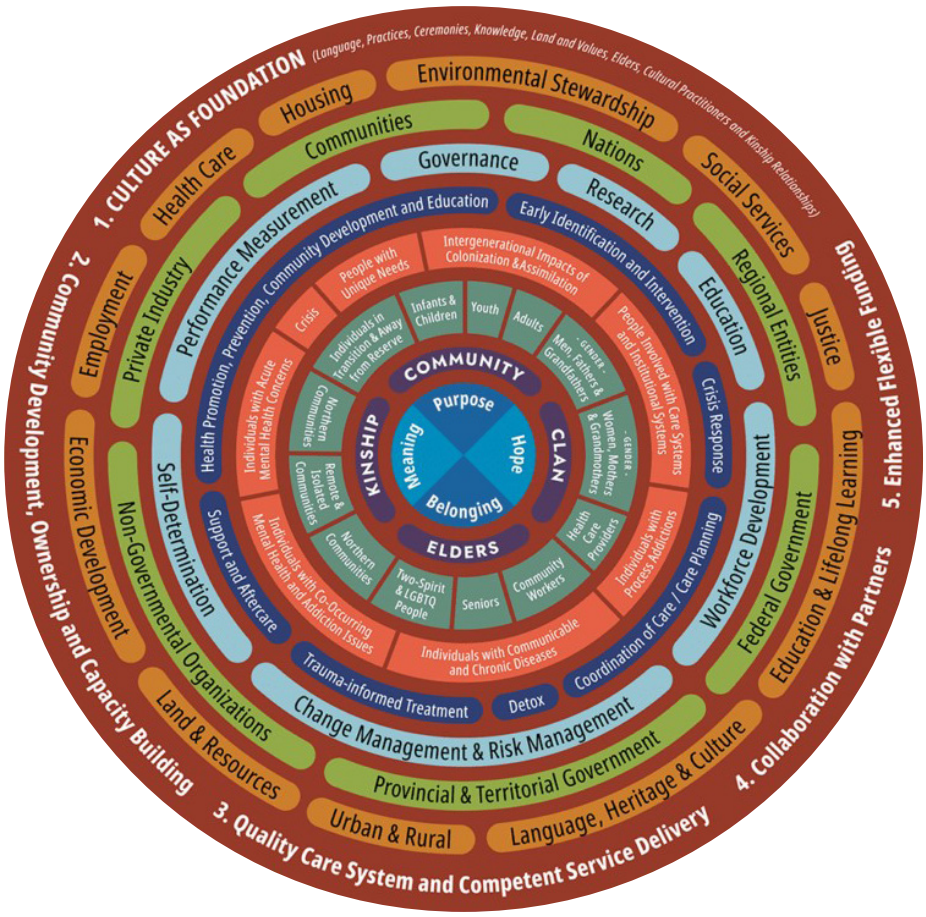
Source: Adapted from the University of Waterloo Thrive Toolkit

To meet the needs of Indigenous Peoples and Indigenous youth across the mental health continuum, MHPSS programming should include interventions across a continuum of care:

- Promotion interventions strengthen aspects of mental health and psychosocial well-being
- Prevention interventions reduce the likelihood of worsening mental health or distress, or progressively disabling conditions
- Care interventions treat moderate to severe mental health conditions and support recovery

The general mental health continuum/continuum of care model provided the basis for partnership among a network of First Nations' agencies, organizations, and communities; Indigenous mental health leaders; and Health Canada (the federal department responsible for helping the people of Canada maintain and improve their health) to engage together on the development of a coordinated, comprehensive mental wellness framework in response to ongoing mental health and substance misuse concerns among First Nations' communities. They jointly developed the First Nations Mental Wellness Continuum Framework (see Figure 2) that incorporates a vision of a continuum of mental wellness (orange ring), as well as guidance on how communities can achieve a comprehensive continuum of quality mental wellness programs and services to achieve that vision (dark blue ring). First Nations' health and wellness networks who led the process guided the framework to focus on the concept of mental wellness that respects, values, and uses First Nations' cultural knowledge, approaches, languages, and ways of knowing. In the context of First Nations communities, mental wellness is necessary for healthy individual, family, and community life and is supported by factors such as culture, language, Elders, families, and creation. Creation is a term that conveys an understanding of an Indigenous worldview that embraces land, animals, birds, physical elements, air, water, the universe, and all that it is as "relatives." While the framework is comprehensive, in MHPSS interventions, it is important to acknowledge the compounded effects of intergenerational trauma on Indigenous Peoples, stemming from displacement, seizure of ancestral lands, desecration of sacred grounds, forced migration, and systematic erasure of cultural practices related to traditional medicine and food practices. It is also important to note that much of the research, and the First Nations' Wellness framework, are based on Indigenous communities located in the United States, Canada, and New Zealand. As such, it is critical to recognize the uniqueness of each Indigenous community, and thus the need to engage, consult, and cocreate a framework that best suits each community's needs.

Figure 2. First Nations' Mental Wellness Continuum Framework



Legend (from centre to outer ring)

Four Directions (outcomes)—*Hope; Belonging; Meaning and Purpose.*

Community—*Kinship, Clan, Elders; and Community.*

Populations—*Infants and children; Youth; Adults; Gender—Men, Fathers and Grandfathers; Gender—Women, Mothers and Grandmothers; Health Care Providers; Community Workers; Seniors; Two-Spirit People and LGBTQ; Families and Communities; Remote and Isolated Communities; Northern Communities; and Individuals in Transition and Away from Reserve.*

Specific Population Needs—*Intergenerational Impacts of Colonization and Assimilation; People involved with Care Systems and Institutional Systems; Individuals with Process Addictions; Individuals with Communicable and Chronic Diseases; Individuals with Co-occurring Mental Health and Addiction Issues; Individuals with Acute Mental Health Concerns; Crisis; and People with Unique Needs.*

Continuum of Essential Services—*Health Promotion, Prevention, Community Development and Education, Early Identification and Intervention, Crisis Response, Coordination of Care and Care Planning, Detox, Trauma-informed Treatment, and Support and Aftercare.*

Supporting Elements—*Performance Measurement, Governance; Research; Education; Workforce Development; Change Management and Risk Management; and Self-determination.*

Partners in Implementation—*Non-governmental Organizations; Provincial and Territorial Government; Federal Government; Regional Entitites; Nations; Communities; and Private Industry.*

Indigenous Social Determinants of Health—*Environmental Stewardship; social Services; Justice; Education and Lifelon Learning; Language, Heritage and Culture; urban and Rural; Land and Resources; Economic Development; Employment; Health Care; and Housing.*

2-5. Key Themes for Mental Wellness—*Community Development; Ownership and Capacity Building; Quality Care System and Competent Service Delivery; Collaboration with Partners; and Enhanced Flexible Funding.*

1. Culture as Foundation—*Elders, Cultural Practitioners; Kinship Relationships; Language; Practices; Ceremonies; Knowledge; Land; and Values*

Structural and Historical Factors and Barriers to MHPSS Services

Table 1 presents structural and historical factors and barriers to MHPSS services through the lens of USAID's Six Domains of Inclusive Development.

Table 1: Inclusive development considerations for MHPSS with Indigenous Peoples

SIX DOMAINS OF INCLUSIVE DEVELOPMENT	STRUCTURAL AND HISTORICAL FACTORS	BARRIERS TO MHPSS SERVICES
LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES	▪ Colonization and the fundamental denial of human rights, freedoms, and identity, including denial of rights to land, and policies that forcibly separated children from families ▪ Forced displacement from ancestral lands[2] ▪ Using violence against Indigenous Peoples who resisted the injustices and the systems of colonization ▪ Colonial intrusions into traditional lifestyles, with associated rapid modernization, cultural disruption, and policies of cultural assimilation ▪ Persecution of community members who make use of Indigenous practices, including using Mother/ Native language ▪ Historical trauma[3] ▪ Indigenous girls with disabilities being taken from their families and placed into residential schools or foster families where they face high risk of abuse and neglect[4] ▪ Gaps in coordinated responses from the health sector as part of whole-of-community and whole-of-government solutions ▪ Lack of qualified mental health specialists, especially in rural areas ▪ Lack of Indigenous practitioners with advanced qualifications, knowledge, experience, and specializations in mental health ▪ Continued exposure to systemic discrimination and racism in health care settings	▪ Care/treatment services nonexistent in some places ▪ Funding and resource shortages and approaches to distributing funds ▪ Available services in local Indigenous communities limited in capacity to effect change ▪ Gaps in decentralization of services and related service delivery challenges ▪ Lack of prioritization of the needs, unique capabilities, and potential contributions to the development of their communities for Indigenous women and girls with disabilities ▪ Culturally inappropriate services ▪ Lack of access to traditional medicine[5] ▪ Service fragmentation and inadequate coordination between service sectors, and Indigenous and state-run governance entities ▪ Lack of service system infrastructure. ▪ Gaps in technology use, especially to facilitate the engagement of youth ▪ Relatively few evidence-based approaches to provision of culturally safe, effective, and early interventions

[2] MCI Consultation with members of the UN Global Indigenous Youth Caucus.
[3] Historical trauma refers to complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance.
[4] See Submission for the CEDAW Committee on the rights of indigenous women and girls.
[5] MCI Consultation with members of the UN Global Indigenous Youth Caucus

SIX DOMAINS OF INCLUSIVE DEVELOPMENT	STRUCTURAL AND HISTORICAL FACTORS	BARRIERS TO MHPSS SERVICES
CULTURAL NORMS AND BELIEFS	▪ Services without the engagement of Indigenous staff and organizations to guide programs and build trust with young people ▪ Limited MHPSS interventions that are adapted with Indigenous communities' ancestral stories, history and language ▪ Challenges for medical practitioners shifting to more collaborative care	▪ Self-reliance ▪ Informal supports used a first choice for help seeking rather than formal services ▪ Shame and fear
ROLES, RESPONSIBILITIES, AND TIME USE	▪ Lack of cultural humility among non-Indigenous mental health professionals and services (Lekas, Pahl, and Fuller Lewis 2020) ▪ Misunderstanding important community and cultural protocols and historical issues ▪ Lack of local leadership and community buy-in ▪ Long distances to reach services and associated travel costs	▪ Mistrust and gaps in knowledge-sharing between practitioners, consultants, and services ▪ Lack of engagement of youth, family, and teachers in the program ▪ Health professionals' perceptions that discrimination occurs ▪ Blurred professional and community boundaries for Indigenous workers ▪ Staffing shortages, high turnover, and long waitlists
PATTERNS OF POWER AND DECISION MAKING	▪ Distrust of mainstream systems and services ▪ Developing interventions that are not informed by local values and practices ▪ Lack of choice between Western and Indigenous methods of mental health treatment ▪ Limited opportunities to participate in and influence the design of MHPSS activities	▪ Overlooked considerations of language, diversity, and worldview. ▪ Limited cultural adaptation of digital MHPSS platforms ▪ Cultural misunderstandings and mistrust between Indigenous Peoples/communities and non-Indigenous services and practitioners
ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES	▪ Failure to incorporate strengths-based approaches ▪ Insufficient internet connection, limited access to communication technology in rural communities, and/or unfamiliarity with some forms of technology ▪ Technical difficulties, including poor audio and visual quality for video teleconferencing and difficulty establishing internet connection ▪ Limited resources, capacity, and knowledge among MHPSS staff on how to adapt services to meet Indigenous needs	▪ Informal supports used as first choice for seeking help, not formal services ▪ Gaps in outreach and information dissemination to families on available mental health services ▪ Gaps in skills to identify signs and symptoms of disabling distress and mental health conditions ▪ Long distances/geographic challenges to reach services and associated travel costs ▪ Fees for services

SIX DOMAINS OF INCLUSIVE DEVELOPMENT	STRUCTURAL AND HISTORICAL FACTORS	BARRIERS TO MHPSS SERVICES
PERSONAL SAFETY AND SECURITY	▪ Intergenerational, transgenerational, and multigenerational trauma from loss of belonging and loss of connection to land, kinship networks, power, autonomy, memory, traditions and community, and language ▪ Contemporary reminders of historical trauma, such as individually experienced discrimination and personal traumatic experiences in contemporary contexts, systems, and societal structures	▪ Stigma ▪ Confidentiality issues due to the small size of communities ▪ Exposure to microaggressions ▪ Lack of opportunity to participate in single-sex groups

Strategies for Engaging Indigenous Peoples in MHPSS Programming

The following strategies are organized along the socio-ecological model, starting with the individual, family, community, society, and then systems. More information on the socio-ecological model and how it relates to MHPSS can be found in Section 3 of the Youth MHPSS Toolkit, under USAID Positive Youth Development Framework, on page 9.

Individual Services

Make sure individuals have access to support for developing and maintaining improved MHPSS.

Indigenous Peoples tend to have a greater emphasis on communal well-being, which is reflected in the First Nations' Mental Wellness Continuum Framework (see Figure 2). The center of the framework reflects the elements of individual well-being as encompassing a sense of hope, belonging, meaning, and purpose. These are then supported by the next layer, which includes clan, community, kinship, and Elders. Standard Western mental health care services are recommended (e.g., social work, case management, clinical therapy, and therapy groups), but should be delivered alongside peer support and family- and community-based interventions.

Family-Based Services

Use family-based MHPSS strategies that include providing caregivers with opportunities to strengthen their caregiver–to–family member relationships and social connections.

As part of the development of health care and education systems and service delivery, Indigenous cultural models of intergenerational holistic health (that connect the health of youth with the health of the family and community) need to be expressed and advanced. Family and community empowerment should be supported for their participation in determining whether health care and other MHPSS services are culturally safe for youth by engaging communities in the monitoring and evaluation of the quality and effectiveness of the multisectoral, youth-focused MHPSS services.

Indigenous language learning should be promoted to facilitate connectedness to family, community, lands, and spirituality, as well as intergenerational connectedness, which promotes states of well-being, community healing, and wellness.

Kinship ties can be strengthened by implementing programs that engage youth, their caregiver(s), and other extended family members in intervention activities.

Family-based interventions, with youth and caregiver psychoeducation and self-care skill sessions, should be adapted to align with Indigenous cultural values and then implemented.

Community-Level Interventions

Raise awareness and support approaches for positive behavior change around mental health and psychosocial needs within health care, school, and community settings to address stigma and discrimination.

Create culturally adapted community gatekeeper training for suicide prevention (e.g., Applied Suicide Intervention Skills Training). Develop land-based resilience promotion programs. Support community-facilitated intergenerational learning initiatives that support listening skills, cultural expression, transmission of sacred knowledge, and cultural continuity (a key protective factor). Leverage culturally-grounded initiatives that facilitate Indigenous youth's immersion in cultural practices and traditions and/or to confront historical trauma (e.g., culture camps). Integrate sharing circles. Link Elders to the primary health care systems. Provide the Mental Health Gap Action Programme (mhGAP) training for Indigenous health care workers. Foster access to culturally adapted training in basic psychosocial skills for Indigenous community members. Develop intergenerational trauma training in non-Indigenous health care systems.

Develop programs that engage communities and schools in building safe, non-violent, inclusive, and effective learning environments that promote mental health and well-being.

Develop school-based, culturally adapted social-emotional learning programs and school-based, culturally sensitive suicide prevention programs. Advance Indigenous cultural models and practices in education systems. Create safe spaces for two-spirit youth. Use implementation measures to increase access to quality MHPSS services for Indigenous women and girls with disabilities, including by securing general accessibility (in its diverse dimensions), as well as access to alternate and accessible formats, sign language interpretation, plain language, support services, and assistive technology, as appropriate.

Society and Systems

Secure an effective policy, legislative, and financing environment that is inclusive of marginalized and underrepresented groups, available and accessible, and puts supportive mechanisms in place for quality MHPSS service delivery for all.

Leverage Indigenous communities' self-determination and self-governance to engage in suicide prevention leadership and policymaking. Indigenous leaders can pass resolutions to address youth suicide prevention and mental health, consult with Indigenous youth councils, and dedicate a multisectoral, interagency council to address youth suicide prevention and mental health. Develop collaborative hubs that facilitate the dissemination of culturally relevant MHPSS interventions by engaging and supporting Indigenous mental health leaders to drive policy decisions and strengthen Indigenous staff's capacity to lead culturally appropriate MHPSS programs. Foster access to culturally informed mental health and psychosocial well-being practices that are not integrated into health care systems and often have limited funding.

Table 2 presents 6 strategies and 24 activities for engaging Indigenous Peoples in MHPSS programming in alignment with the recommendations in the 2023 WHO landmark resolution on the health of Indigenous Peoples, which will be included in the Fourteenth WHO General Programme of Work. The strategies and activities draw from activities, interventions, and actions of the Inter-Agency Standing Committee's (IASC's) Guidelines for MHPSS in Emergency Settings[6] and IASC MHPSS Minimum Service Package (MSP), as well as the recommendations in the 2023 UNPFII Indigenous determinants of health report.

Table 2: Strategies for engaging Indigenous Peoples in MHPSS programming

STRATEGIES	INDICATIVE ACTIVITIES

1. Explore ways to integrate, as appropriate and safe, evidence-based traditional and complementary MHPSS services.	▪ Mainstream Indigenous youth's inclusion within MHPSS planning, such as programming and budgeting
	▪ Collaborate with Indigenous community leaders, where appropriate, on:
	  ▪ MHPSS integration across sectors and into wider systems
	  ▪ Decolonizing MHPSS capacity strengthening (e.g., use two-eyed seeing, the Indigenous knowledge gift of maintaining multiple perspectives)
	▪ Support Indigenous and non-Indigenous staff and volunteers to develop aptitude in cultural competence, cultural safety, and shared decision-making
	▪ Provide a series of sensitivity training for the Mission staff to undertake before engaging with the community

2. Adopt an inclusive, participatory approach. Account for Indigenous knowledge and practices.	▪ Support learning about local, Indigenous culture-informed MHPSS practices and healing systems ▪ Make sure Indigenous definitions of mental health and psychosocial well-being are expressed and determined ▪ Promote and facilitate coordination on MHPSS activities with Indigenous representatives, healers, scholars, and Elders and with youth ▪ Advocate for research on how Indigenous cultural practices and languages contribute to MHPSS prevention, promotion, and care
3. Encourage the recruitment and retention of Indigenous Peoples as MHPSS staff and volunteers.	▪ Acknowledge that Indigenous staff/volunteers are important for safe, effective Indigenous traditional and spiritual supports, including communal healing practices ▪ Design roles for linguistic and cultural mediators ▪ Use an intercultural approach to training and capacity strengthening ▪ Dedicate human resources to organize culturally relevant care for Indigenous staff and volunteers, including in the context of public health emergencies

[6] The 2007 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings are widely considered unifying standards for MHPSS across the humanitarian–development–peacebuilding nexus.

STRATEGIES	INDICATIVE ACTIVITIES
4. Contribute to MHPSS capacity strengthening with and for Indigenous Peoples.	▪ Support Indigenous Peoples' realization of their right to maintain, control, protect, and develop their cultural heritage, traditional knowledge, and traditional cultural expressions ▪ Support the empowerment of Indigenous communities to conduct MHPSS assessments, context analyses, mapping of MHPSS services and referral pathways, and monitoring and evaluation ▪ Develop MHPSS impact indicators that are relevant to the culture, language, and context and develop locally determined, appropriate tools to measure them ▪ Facilitate co-design processes for MHPSS cultural adaptation
5. Address the MHPSS needs of Indigenous Peoples.	▪ Use Indigenous concepts and approaches to collaborate with community members to address the MHPSS needs ▪ Strengthen access to MHPSS services with full consideration to Indigenous social, cultural, and geographic realities, including inter-/multi-generational trauma and complex mind–body–spirit challenges ▪ Mobilize and support communities to foster access to Indigenous cultural, healing, and spiritual supports to mental health and psychosocial well-being ▪ Provide culturally relevant and safe MHPSS interventions as part of youth's health, education, protection, and livelihoods programming ▪ Secure adequate cultural adaptation of MHPSS interventions, activities, and approaches ▪ Collaborate with Indigenous community members, as appropriate, to create opportunities for Elders and youth to meaningfully connect
6. Promote the dissemination of basic, accessible, MHPSS information.	▪ Disseminate key messages in local Indigenous languages to promote mental health and psychosocial well-being among Indigenous populations ▪ Make information available on the mental health rights of Indigenous Peoples is in accessible formats and in Indigenous languages

Illustrative Case Examples for MHPSS Programming with Indigenous Peoples

The published evidence about MHPSS service delivery for/with Indigenous youth is limited, with few evaluations of interventions or programs that show what works (Jongen et al. 2023). Two case studies are presented below to illustrate MHPSS programming that includes Indigenous youth, is responsive to the continuum of care, uses contextually and culturally relevant approaches, and attends to cultural competence and cultural safety. Inclusion of Indigenous youth can be prioritized in MHPSS programming. The case studies are *ACCESS Open Minds (ACCESS OM)* and the *Cultural, Social and Emotional Wellbeing Program*, both of which address MHPSS needs using Indigenous concepts and approaches to collaborate with community members.

ACCESS OM (Hutt-MacLeod et al. 2019)

ACCESS OM is a pan-Canadian project that worked to improve youth's mental health care in the First Nation community of Season, a rural Mi'kmaq community, by blending Indigenous and Western methodologies. The project transformed a preexisting "Fish Net Model" of a youth mental health center. The youth mental health center had built upon community-identified priorities and delivered an assortment of interventions by using multiple methods to cast a wide net across the community.

The profile of Indigenous youth who participated in ACCESS OM (Shah et al. 2023) included:

- Youth who accessed services in First Nations' sites ranged in age from 11 to 29 years
- More girls/women than boys/men accessed services and 17 percent identified as LBGTQI+
- It is likely that half experienced a moderate and one-fourth a severe mental health condition
- Fifty-one (51) percent of youth were either referred by family member or self-referred

Interventions included Standard Western mental health care services (e.g., social work, case management, psychology and clinical therapy services, therapy groups); peer support; programming activities for all-age youth, families, and community members; cultural support (e.g., connecting youth with Elder support, residential school survivor, and descendant services; providing youth and families with opportunities to engage in Mi'kmaq traditions and practices); and crisis services.

The ACCESS OM model aligns service delivery across five objectives: (1) early case identification, (2) rapid access to initial assessment, (3) availability of appropriate services, (4) engagement of youth and families, and (5) elimination of transitions in service based on age. The transformational process also aligned with data from a small participatory research study associated with the project, which suggested that a more multi-level resilience process engaging family and community would be culturally aligned with the community.

The intervention also needed to respect Mi'kmaq traditions, values, learning, language, and historical contexts and respond appropriately to the needs of the youth in the community, while integrating wellness-supporting elements of Western knowledge. The intervention adopted the **"Two-Eyed Seeing" approach** as a guiding principle. Mi'kmaq Elders Albert and Murdena Marshall created the approach with the idea that for the benefit of service, one eye can have the perspective of seeing the strengths of Indigenous ways of knowing and the other eye can see the strengths of Western ways of knowing, and both perspectives can be used.

Integrated Community Mental Wellness Model – ACCESSS OM is one of six teams that function together with the aim of providing a community-based, community-driven mental health and substance misuse services delivery model that serves the youngest to the oldest clients. **Early evaluation** findings suggested that youth were more likely to access services when stigma had been reduced, yet there was still hesitance to invite family members into their journey of care. Lastly, the services were modified during the COVID-19 public health emergency by shifting to phone and telehealth services for all except the crisis services.

The Cultural, Social and Emotional Wellbeing (CSEWB) Program (Darwin et al. 2023; The University of Western Australia n.d.)

CSEWB is a holistic framework of mental health and well-being and suicide prevention that incorporates Indigenous Australians' unique social and cultural aspects of self (in seven domains): connection to (1) country, (2) culture, (3) community, (4) family, (5) spirituality and ancestry, (6) body, and (7) mind. CSEWB recognizes that the individual and their sense of self are embedded inseparably in community and family, and that social, historical, and political determinants affect CSEWB.

The CSEWB program was developed to promote the cultural, social, and emotional well-being of Aboriginal people. It is open to Aboriginal people over the age of 18 years. It incorporates strategies of empowerment, healing, and leadership, building resilience and giving people strength. Non-Aboriginal people who are well-known in the community can also enter the program. Consultations were conducted with 11 Aboriginal communities across Australia that elicited a better understanding of the intergenerational trauma, effects of stolen generations, racism and discrimination, and other factors contributing to mental health conditions and distress in those Aboriginal communities.

The project activities involve exploring concepts of self, including a personal understanding of the impacts of colonization; being given a task to complete; and taking an active collaborative role in the design, development, and implementation of the program.

Evidence from evaluations – Data from five sites show improvements in:

- Confidence to seek employment and become employed
- Relationships with children, partners, and extended family and community, including the prevalence of family violence
- Knowledge about Aboriginal history
- Understanding of the impacts of intergenerational trauma and other determinants affecting their lives
- Ability to speak up and become empowered
- Development of strategies to cope with grief and loss around suicide, poverty, mental illness, and deaths affecting themselves, families, and communities

Learning – Select key insights from the program report, inclusive of findings from related programs, to inform policymaking include:

- Indigenous Australians, families and communities, determine whether care is culturally safe. Therefore, their experiences in the health system need to be understood to evaluate and monitor the quality and effectiveness of health care provided to them.
- Improvements in Indigenous Australians' mental health and well-being will be limited unless racism in the health system is identified and addressed.

Recommendations for program design and illustrative interventions for Indigenous Peoples MHPSS programming that is responsive to the needs and inequities Indigenous populations face should include (1) strengths-based mental health promotion approaches, (2) prevention approaches to improve the social determinants of mental health, and (3) care approaches to ameliorate distress and treat mental health conditions. Services should be delivered through community, multisectoral system (e.g., health, education, social welfare, labor, housing) and clinic entry points or platforms to meet a populations' mental health and psychosocial needs. Programming across the continuum of care, with attention to supporting the empowerment of Indigenous Peoples to improve social determinants of mental health, will contribute to increased access to safe, appropriate, culturally relevant MHPSS services among Indigenous Peoples (WHA 2021).

Design and implement programming using culturally and contextually responsive approaches in alignment with IASC MHPSS Core Principles (i.e., human rights and equity, participation, do no harm, building on available resources, integrated support systems and multi-layered supports) such as:

- Community-based psychosocial approach
- Intersectional approach, with particular attention to young Indigenous women, Indigenous youth with disabilities, and young Indigenous women with disabilities
- Indigenous conceptual approaches, including (Gone and Kirmayer 2020):
  - Culture as cure approach: Illumination of Indigenous cultural orientations, processes, and practices pathways to mental health and psychosocial well-being
  - Indigenous cultural identification approach: Focus on how identity and belonging affect resilience and mental health and psychosocial well-being
  - Cultural, ecological, and spiritual dimensions approach: Attention to cultural, ecological, and spiritual dimensions of mental health and psychosocial well-being, with simultaneous downplaying of individual dimensions
  - Traditional stories approach: Use of traditional stories interventions to support family and community systems, share cultural knowledge, and valorize and affirm cultural identity

Prioritize both cultural competence and cultural safety throughout all consultations, interventions, activities, approaches, and services:

- Cultural competence typically emphasizes practitioners' knowledge, skills, and attitudes.
- Cultural safety focuses on issues of power in the context of helping relationships as embedded within larger institutional structures.

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