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A collaboration to inform the development of an Indigenous wellbeing instrument

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Abstract

Indigenous constructs of wellbeing and wellness vary greatly from the construct of mental health in the Western paradigm of health. Yet Western instruments, validated within Western populations, are often used to assess the wellbeing or mental health of Indigenous peoples. This is to the detriment of the health of Indigenous peoples. To support the decolonisation of the psychology discipline and the psychometric validity of its measurements, it is necessary that Indigenous wellbeing measures are developed that are shaped around the worldviews, values, and aspirations of Indigenous peoples, rather than their Western counterparts. Specifically, Indigenous wellbeing measures must not only align to Indigenous cultural, social, economic, and environmental priorities, but the measurement design must also consider individual, family, tribal, and community needs. Data results should be openly accessed and utilised by Indigenous peoples to benefit the health of Indigenous peoples. Senior Indigenous researchers from Aotearoa (New Zealand), Australia, Canada, and the United States of America, present a collaborative approach to inform the development of a global measure of Indigenous wellbeing.

Keywords: Indigenous measurement, social and emotional wellbeing, Indigenous wellness, mental health, social equity, culture, language, traditional knowledge, tribal development

> "Our Indigenous Ways of Knowing tend to feature stories, oral transmission, and knowledge to action. Therefore, when we are envisioning Indigenous health and wellness measurement, there will need to be parallel Ways of Knowing. If, how, and when these different knowledge systems are combined is a non-trivial task; particularly if we are not [to] subordinate but

rather uplift and honour Indigenous Ways of Knowing." (King & King, 2018).

Introduction

The International Group on Indigenous Health Measurement (IGIHM) is a network of Indigenous and allied persons working in government statistical agencies, universities, as well as Indigenous communities and organisations in Canada, Aotearoa/New Zealand, Australia and the United States (US). IGIHM regular teleconferences provide a forum for knowledge exchange and mobilisation on improved methods and policy development which strengthen the collection, analysis, dissemination and use of health information for Indigenous populations. Much of IGIHM's focus has been morbidity and mortality, as is typical amongst epidemiologists and biostatisticians.

In 2013, at an in-person IGIHM meeting in Montréal (Canada), Professor Malcolm King, then the Scientific Director of the Canadian Institutes of Health Research's Institute of Aboriginal Peoples' Health (CIHR IAPH), championed the concept of Indigenous wellness and the need for its measurement. The result was a collaboration between IGIHM, CIHR IAPH and the First Nations Health Authority of British Columbia (Canada) to organise an Indigenous Wellness Day at the 2014 IGIHM meeting in Vancouver (Canada). The Indigenous Wellness Day was to be by and for Indigenous people, and therefore only Indigenous speakers – Elders, Knowledge Holders, community members and academics – were on the agenda. After this highly successful meeting, IGIHM created an Indigenous Wellness Working Group, with two elected co-chairs (Professor Teshia Solomon and Professor Malcolm King). The two co-chairs had limited time and IGIHM has no available resources for their Working Groups. Consequently, the Wellness agenda did not progress much.

At the 2017 IGIHM meeting in Atlanta (US), Professor Malcolm King and Dr Alexandra King established a panel dedicated to Indigenous Wellness. The speakers were Michelle Connolly (US), co-chair of IGIHM, Dr Kahu McClintock (Aotearoa/New Zealand) as well as on behalf of Professor Pat Dudgeon (Australia), Dr John Waldon (Aotearoa/New Zealand) and Professor Malcolm King (Canada), with Dr Alexandra King and Professor Malcolm King as co-chairs. Discussions were successful in progressing an Indigenous Wellbeing Framework.

Three subsequent face-to-face meetings were held, first in February 2018, hosted by Aotearoa (joined by Sir Professor Sir Mason Durie and others), then in November 2018 in Perth (associated with the Youth Suicide meeting) and Sydney (associated with HOSW). There have also been regular virtual meetings since Atlanta 2017, hosted by Aotearoa Dr Kahu McClintock supported by Michelle Connolly, Professor Pat Dudgeon, Professor Malcolm, and Dr Alexandra King to finalise discussions and this article.

The collaboration of these experienced Indigenous wellbeing researchers has given impetus to the development of the global Indigenous wellbeing framework, informed by Indigenous Ways of Knowing and Doing and findings from national health surveys.

This article avails what these Indigenous researchers have drawn from their experiences of Indigenous wellbeing specific to the Māori people of Aotearoa (New Zealand), the Aboriginal and Torres Strait Islander peoples of Australia, the First Nations, Inuit and Métis in Canada, and the American Indians, Alaskan Natives and Native Hawaiians in the US. Within these countries, there are diverse groups of Indigenous peoples, and our aim is to use language that reflects our respect towards the differences between these peoples while also exploring the values shared between Indigenous peoples across nations. The purpose of this article is to highlight Indigenous data gaps and provide a synthesised Indigenous lens that may inform the development of a global measure of Indigenous wellbeing.

Since colonisation, a widespread practice of the West has been to compare the health and wellbeing of Indigenous people with the health and wellbeing of their non-Indigenous counterparts. While such comparisons may be useful, their utility is limited, confined to the objective measurement of universal outcomes of health, such as disease prevalence, educational

attainment, housing, and employment (Cram, 2014). These outcomes of health are also influenced by historical, political, social, and cultural determinants of health, that are generally not considered in these comparisons. Comparisons with other Indigenous populations who share similar world views and values, similar colonial histories, and similar positions in society, are more likely to be helpful to Indigenous people (Durie, 2006:16).

Wholistic, subjective assessments of Indigenous peoples do not readily lend themselves to cross-population comparisons because they are largely linked to Indigenous-specific measurements and values. The purpose of the collaboration of Indigenous authors presented here is to bring together evidence of shared perspectives on wellbeing. This evidence towards a universal Indigenous wellbeing construct will guide future psychometric development of an Indigenous wellbeing instrument to address the Indigenous data gap. The development of such a common construct provides an opportunity to generate data by Indigenous people, for Indigenous people, that is important to Indigenous people and communities, and psychometrically valid. The access and utilisation of such data decolonises psychology to benefit of the health of Indigenous peoples and communities.

Colonisation

Discourses and measurements of mental health and wellbeing that have been developed by the West and validated using Western populations perpetuate the hegemony of Western psychology (Dudgeon et al., 2020; Dudgeon & Walker, 2015; Martin & Mirraboopa, 2003). Indigenous psychology provides an alternative discourse that challenges this hegemony and expresses of the right of Indigenous peoples to self-determination (United Nations General Assembly, 2007). Decolonising psychology requires the revitalisation of Indigenous knowledge systems and the use of these philosophies and constructs to generate theories of global discourse (American Psychological Association, 2011). Contemporary Indigenous mental health cannot be considered apart from the impact of colonisation.

The mental health status of Indigenous peoples throughout the globe cannot be considered apart from colonisation and its traumatic impacts. The first wave of colonisation was in all cases characterised by frontier violence and dispossession and was relatively recent for most colonised countries and their Indigenous peoples (Bain & Foster, 2003). The details of colonisation differ between Indigenous peoples, yet the impact on health and wellbeing has been universally and profoundly negative. Examples from each country are discussed below.

In Aotearoa, the devastation that followed from the colonial experiences of the 1800's resulted in disruption of the crucial bond between Māori and the natural environment, their land. This bond is elemental to Māori Indigeneity (Durie, 2005). Opportunities for cultural expression and cultural endorsement within society's institutions were also severely restricted, disrupting cultural identity.

Following the colonial invasion of Australia, the Aboriginal and Torres Strait Islander peoples were subject to legislation that controlled all aspects of their lives (Dudgeon et al, 2014). Against this background and until the early 1970s, the forcible removal of thousands of Indigenous children from their homes, to be assimilated, occurred (Human Rights and Equal Opportunity Commission, 1997). These policies effectively disrupted connection to kinship (family), community, culture, and Country (land). In the face of continued colonisation and oppressive government policies, cultural survival became paramount in Aboriginal and Torres Strait Islander communities (Lovett, 2014).

Colonisation was not a single incident in Canada, but rather was experienced differently over the course of several hundred years by the 634 diverse First Nation communities, the historic Métis settlements and predominantly Métis communities running from Ontario through the prairies and into British Columbia, and the Inuit communities in the north and east of this part of Turtle Island. Shifting power differentials built up over time as European numbers and influence increased, counter-mirrored by shocking numbers of Indigenous people dying as a result of disease, starvation, and other aspects of colonisation. Today, as a direct result of colonisation, with its explicit agenda of disconnection from land, loss of language and

culture, exacerbated by colonial-induced socioeconomic and other deprivation, the Indigenous peoples of Canada experience increased social and health inequalities (King et al., 2009; Truth and Reconciliation Commission of Canada, 2015). In 2016, close to 1,7 million people in Canada self-identified as Indigenous, representing 4.9% of the population.

Similarly, the Native Americans have endured hundreds of years of war, displacement, loss of land, and the total annihilation of some tribes. Prior to colonisation in the early 16th Century, an estimated four to twelve million American Indians lived in what is now the continental United States. By 1890, a low point of 237,000 remained. In 2010 there were 5.2 million, only 1.6% of the population (Connolly et al., 2019). Today there are 573 federally recognised Tribes, which have Tribal sovereignty - the legal standing of sovereign domestic dependent nations. However complex jurisdictional issues, including federal, state, local, and Tribal governments, affect almost every aspect of life on Indian land (Connolly et al., 2019).

In each country, colonisation brought widespread experiences dispossession, disempowerment, loss, and trauma that continue today. These political, social, and political determinants have an enduring impact on Indigenous health. Yet, in the face of considerable adversity, the resilience and strength of Indigenous peoples is evident through the protective role of Indigenous wellbeing.

Indigenous Wellbeing

In the West, physical health may be conceptualised as the absence of disease, and mental health, the absence of disorder. Across the world, non-Indigenous Western cultures tend to use common definitions and measurements of mental health which are invariably centred around the self, be it in a physical or mental sense. Indigenous understandings of wellbeing are far broader and more multifaceted and wholistic than the absence of disease and disorder or the pursuit of individual happiness or success. Indeed, imbalances within the dimensions of wellbeing may constitute illness.

In Aotearoa, the *Whare tapa whā* concept (Durie, 1985) is a widely accepted Māori model of health based on four elements of life: the physical, emotional, mental, and spiritual. Each of the components is viewed as interconnected and contributes to the holistic construction of Māori health. Weakness in one or more of the elements of life is viewed as bringing an imbalance. In addition to these elements of life, indicators of Māori wellbeing may be expressed as Māori participating fully:

- as *Māori.*
- in *te Ao Māori* (the Māori world, including language, culture, and customs); and
- in *te Ao whānui* (wider society, including family, tribe, and community). [1]

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023* (Commonwealth of Australia, 2017) states that health is also understood in Aboriginal and Torres Strait Islander cultures differently to non-Indigenous concepts of health. Physical and mental health are considered within a broader concept called Social and Emotional Wellbeing (SEWB). The SEWB Framework includes connections of the self to, and interconnections between, seven domains: physical health, mental/emotional health, kinship, community, culture, Country, and spirituality/ancestors (Gee et al., 2014).

While the SEWB concept varies between Aboriginal and Torres Strait Islander peoples, shared features remain:

- Holistic.
- Inseparable from cultural, social, historical, and political determinants that impact health and wellbeing.
- Connects the health of an individual to the health of their kin and community, and to the land and spiritual world; and
- Affirms a collective sense of wellbeing (Gee, et al., 2014).

In Canada, Inuit, Métis, and First Nations are highly diverse, both within and across groups. Their knowledge systems come from Mother

[1] https://www.tpk.govt.nz/en/whakamahia/whanau-ora/about-whanau-ora.

Earth, informed by the distinct waters, lands and natural world in which each nation or group finds itself. This, in turn, informs understandings of wellness specific to each. Underpinning many, if not most, are wholistic appreciations that life, with physical, emotional, mental, and spiritual aspects intricately woven and interacting together, support what is viewed a strong and healthy person (King, et al, 2009; Wilson, 2003). Balance extends beyond the individual realm such that good healing and wellness are relational – we live in harmony with each other, with our community and nation, as well as with the temporal and spirit worlds (King et al, 2009; Wilson, 2003).

There are similarities between American Indians and Alaska Natives and Indigenous peoples in Canada. In fact, there are border Tribes, where Tribal lands are in both the United States and Canada. Practices of wellness and traditional healing vary within many Indigenous communities, but there are some basic shared themes:

- Indigenous health and wellness focus on the community and a collective sense of wellbeing.
- Indigenous health and wellness are wholistic. Wellness is physical and mental, and also cultural and spiritual; and,
- Lands and place play a prominent role and hence contribute to wellness (Connolly, 2017).

Across these varied philosophies there are several parallel Ways of Knowing regarding Indigenous wellness. The proposed global dimensions of Indigenous wellness are discussed below.

Indigenous Global Dimensions of Wellbeing

Four overarching Indigenous Global Dimensions of Wellbeing are proposed from the Indigenous literature sources of this article. These are Physical, Kinship, Cultural, and Spiritual. Within each of these overarching dimensions of wellbeing, specific dimensions exist. An overarching dimension represents the broad metaphysical construct that is being described and the specific dimensions represent more measurable categories of ideas and behaviours that indicate connection to the overarching construct. Additionally, each of the dimensions is interconnected and interrelated. Whether these dimensions are inseparable or distinct may be explored in the future construction and validation of a global Indigenous wellbeing measure. A measure of wellbeing that includes these dimensions is appropriate for Indigenous peoples in Aotearoa, Australia, Canada, and USA.

Global Developments on Indigenous Wellbeing

The distinction between Western conceptualisations of mental health and Indigenous conceptualisations of wellbeing, found in Indigenous Ways of Knowing and described in the Indigenous psychology literature, have been further supported by national surveys of wellbeing. Close collaboration with Indigenous peoples, to ensure that Indigenous values, health concepts, and priorities are reflected in the dimensions of Indigenous wellbeing, are presented here. This approach requires that measures be drawn that are based on Indigenous notions of wellbeing and health. It must also develop priorities for data creation, interpretation, and reporting (King et al, 2009).

In 2013, Statistics New Zealand carried out *Te Kupenga*, the first National Survey of Māori Wellbeing, a report to undertake a detail of self-assessed, *whānau*[2]. *Te Kupenga* was developed to reflect an Indigenous world view in its development as well as its content and took lead from the development and application of the *Whare Tapa Whā* model (Durie, 1985). Māori stakeholders were integrally involved in developing the survey which content recognises practices and wellbeing outcomes that are specific to Māori culture.

[2] http://archive.stats.govt.nz/browse_for_stats/people_and_communities/maori/TeKupenga_HOTP13.aspx

Table 1Indigenous Global Dimensions of Wellbeing

Overarching dimension - **Specific**	**Individual** - **Physical** - **Mental** - **Emotional**	**Collective** - **Family** - **Kinship/Tribal** - **Community**	**Cultural** - **Language** - **Cultural Knowledge** - **Cultural Practice**	**Spiritual** - **Spirituality** - **Ancestors** - **Land**
	The overarching dimension of individual wellbeing includes specific variations of the individual wellbeing construct including Physical, Mental, and Emotional dimensions. The individual wellbeing dimension includes aspects of wellbeing that are embedded in intra-personal, bodily, or individual experiences and typically recognised under Western ideas of health and mental health (Anderson, 1999). Protective factors include human rights, access to services, access to traditional healing and medicines, and Indigenous therapies that address grief and trauma. Risk factors include physical and psychological genocide, racism and discrimination, burden of chronic disease, lack of culturally safe and accessible health and mental health services.	The overarching collective dimension includes specific Family, Kinship/Tribal, and Community dimensions. In an Indigenous context, identity is, to a large extent, a collective experience (Durie et al., 2009). Protective factors include reconciliation, systems change, safe and stable housing, income, family therapies. Risk factors include social genocide, social exclusion and economic disadvantage, family violence, children in out-of-home care.	The overarching culture dimension includes specific Language, Cultural Knowledge, and Cultural Practice dimensions. Cultural beliefs and values have an important connection to health and healing (Wilson, 2003). Protective factors include self-determination, cultural revitalisation, cultural security, appropriate models of care. Risk factors include cultural genocide, cultural clash, and tokenism.	The overarching spiritual dimension includes specific Spirituality, Ancestors, and Land dimensions. Land is central to wellbeing, shapes the lives of Indigenous peoples and communities, and connects them with spirituality (Wilson, 2003). Protective factors include epistemic pluralism, land rights, treaty, healing Risk factors include spiritual genocide, dispossession of land, impact of mission life, existential despair
Aotearoa	Within *Te Ao Māori* there is a general acceptance that physical health can have a positive influence on mental and emotional wellbeing and vice-versa. It is inconsistent with Maori values to isolate mental wellbeing from physical wellbeing. Kingi & Durie (1999) believed it was unhelpful to offer psychological therapies/treatments without taking into account physical health (Kingi & Durie, 1999).	In Aotearoa, post colonisation, for some *whānau* (family) groups, bloodlines, genealogy is not the only understanding of belonging but is also understood in the context of a *kaupapa'* (agenda) of a shared passion with immediate and extended group. A unifying vision, passion, values, and beliefs is still fundamental to this grouping (Lawson-Te Aho, 2010). While different perceptions of what constitutes *whānau* (family) exist the *whānau* it is	The education system sought to prohibit and exclude the use of *te reo Māori* (language) which resulted in internalised racism for students of Māori descent (Pihama et al, 2017). The inferiority of things Māori was reinforced in the assimilative education system and the intergenerational transference was evident. Language is crucial to Indigenous identity, health, and relations (Makokis, 2007). Through Māori affirmative action in 1987, the	Mead (2003) advocated *wairua* (spirituality) was a means of controlling in a social and cultural context based on respect and valued beliefs. This was viewed as a responsibility of safeguarding that *ngā mea wairua* (things pertaining to the spirit world) sustained carefully progressed as a vital part of *te ao Māori* (Māori world). The Māori beliefs of *mana* (power and authority), *ihi* (an energy force within), *wehi* (the expression of the force), *mauri*

Overarching dimension - Specific	Individual - Physical - Mental - Emotional	Collective - Family - Kinship/Tribal - Community	Cultural - Language - Cultural Knowledge - Cultural Practice	Spiritual - Spirituality - Ancestors - Land
	Paenga (2008) and reported that the traditional philosophies and practices incorporated in *kapa haka* (Māori performing arts) could contribute towards Māori wellbeing and identity. Paenga (2008) and further espoused Kapa haka as a distinctive Māori practice an essential connection for Māori to be able to continue traditional techniques and philosophies into what are physical demonstrations of *hauora* (health).	without doubt still remains the basic l construct within Māori society (Irwin et al., 2011). Wellbeing may also be expressed as participating fully in *te Ao whānui.*	Māori Language Act granted official status to *te reo Māori* in New Zealand. In 1989 the Education Amendment Act acknowledged *kura kaupapa* (schools instructed in the Māori language) and *whare wānanga* (Māori tertiary institutions) (Ministry of Culture and Heritage, 2016).	(the essence of life), *tapu* (respectful discipline), *noa* (familiar and without barriers) are related to the understanding of *wairua* (Chaplow et al., 1993; McClintock et al., 2018).
Canada	In Canada given the diversity of geography, topography, and ecology across what has become known as Canada, there are a multitude of community- and nation-specific understandings of wellness. The medicine wheel, embraced by many, describes the four aspects of life as: the physical, emotional, mental, and spiritual.	To the Indigenous people of Canada, connections to family and others, are among the many essential components of wellness. All these connections form processes of Indigenous healing that differ from non-Indigenous processes. Healing often involves consultation and public processes that can include offerings and gatherings as well as shared preparing and undertaking. It is a collective process. In addition, more than the affected person and the healer can be engaged in these processes of healing (Powers, 1982).	Throughout the colonised world, Indigenous languages continue to be lost, and with them, an essential part of Indigenous identity. Therefore, language revitalisation is a health promotion strategy. Kirmayer & Valaskakis (2009) state that high levels of health and wellness coincide with continuing to transmit cultural knowledge, language, and traditions to the next generation.	King & King (2018) maintain we are strongly interconnected with territory. In the cycle of life, our DNA becomes part of our territory, nourishing future generations of the many life forms with whom we co-inhabit. Our spirituality is diverse, including ancestral Ways of Knowing and Doing, as well as those from Christian denominations and other belief systems. King & King (2018) maintain that Indigenous people have a stewardship responsibility for the lands, waters, and natural environment, as well as four-legged, winged, and finned relatives. These should not be perceived as resources, but rather indicators of the overall wellness of a region. If we, collectively and including the ecology, cannot support the creatures that once roamed our territories, say eagle or buffalo, there is un-wellness in our world which will ultimately affect our own wellness.

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Australia	Connection to body, mind and emotions are considered inseparable domains of Indigenous wellbeing (Gee et al., 2014). A positive sense of wellbeing in oneself is requisite to positive connections with others and a sense of connectedness with the other domains.	Family, kinship, and community connections are central to the life and wellbeing of Indigenous people in Australia (Gee et al., 2014; Salmon et al 2019). Aboriginal and Torres Strait Islander people's kinship connections extend beyond the western understandings of bloodlines (NSW Department of Health, 2010). Family and community life rely on reciprocal care arrangements within kinship (Adams et al., 2014). Within these kinship arrangements, individuals have a place and space, which contributes to the health and wellbeing of the individual and the collective whole community (NSW Department of Health, 2010).	Aboriginal and Torres Strait Islander people's cultural identity is nurtured through connections with kinship, community, spirituality, and Country (Dudgeon, et al, 2014; Gee, et al. 2014). The essence of cultural survival and human rights is the ability to be self-determined and to live a cultural life. Human rights, in its most simple form, is about making decisions and choices that enable individuals and communities to live a life that reflects and honours culture, including access to country, access to education that supports cultural life, and the resources to pass on language (Behrendt & Vivian, 2010). Indigenous language promotes a sense of belonging and increases positive feeling and pride in oneself and one's group.	Connection to spirituality and Country is essential to the maintenance and development of Aboriginal culture, it is a core domain of wellbeing (Gee et al., 2014). Grieves (2008) describes spirituality in the context of the interconnectedness between people and their environments. A disruption or dysfunction of the spirit may cause illnesses and disability (Maher, 1999). For instance, traditional healers, of the Anangu people in Central Australia, believe the *kurunpa* is the spirit living inside people, giving life to the body and to the country (Poroch et al., 2012). In this example, the spiritual connection to country reflects the broader understanding that spirituality is central to the health and wellbeing of individuals and their spiritual connections, including family, kin, and community. "Connection to Country involves a person's spirit, which comes from Country, becoming the central identity of that person and, as they grow, the protector and guardian of his or her Country. When a person passes, the spirit returns to its Dreaming place to become a child spirit again, awaiting another spiritual rebirth, thus connecting Country with people, their Dreaming place, language, kinship systems, and law and culture" (Salmon et al. 2019: 5)

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USA	Health and wellness are both physical and mental, as well as being inextricably linked to the other dimensions.	Kinship is also a value at the heart of Native American ways of being and seeing because all of life, was understood as being relational. This was the harmonious balancing, that was viewed as necessary in the physical dimension, amongst tribes and individually, as well as socially with the combinations of body, mind, and spirit. The American Indians traditionally believed in the principle of the circle a balance and that there is a natural and human order that continues (Sachs, 2011).	In the USA, the 573 federally recognised Tribal communities are diverse and typically have different languages and cultures. Although many Indigenous languages have been lost, some languages do remain. Only 73% of American Indians/Alaska Natives spoke only English at home in 2010 compared to the entire population (Connolly et al., 2019). An analysis of the languages spoken most often at home (after English and Spanish) were Indigenous in seven of the fifty States. (Buckingham, 2018)	In 2016, the Sioux tribe of Standing Rock North Dakota claimed international and national presence on their ancestral lands and their waters, in a bid to save not only the physical but the spiritual importance of their existence (Connelly et al. 2019). The risk of sacred waters being contaminated, and their ancestral burial sites being consumed left no doubt in the minds of the Sioux tribe that the construction of an oil pipeline would contribute further towards a spiritual and physical disruption to their lives. However, the pipeline went ahead for economic gain against the wishes of the original landowners and the many other Indigenous people from around the globe who with their views and their presence supported them[3].

[33] https://americanindian.si.edu/nk360/plains-treaties/dapl

The survey provided statistics on four key areas of Māori cultural well-being including: *Whanaungatanga* (relationships), *Tikanga* (Māori customs and practices), *Te Reo Māori* (the Māori language), and *Wairuatanga* (spirituality)[4]. While there has been criticism of the survey construct pertaining to *Te Kupenga's* validity and reliability it remains a basis for future exploration (Kukutai, et al., 2017) of Wellbeing principles and processes grounded in a Māori world view.

Proceeding the work of Te Kupenga was the influential model of Māori health Te Whare Tapa Whā (Durie, 1985), developed from Rapuora – the first survey of Māori women's wellbeing (Murchie,1984). It also laid the foundation for the Hua Oranga a Māori Health Outcome Measure, available to health services in Aotearoa. The construct of Hua Oranga has four components (Durie, 1994; Kingi & Durie, 1999): *Whānau* (family unit), *hinengaro* (mental – thoughts and behaviour), *tinana* (physical –movement and activity), and *wairua* (spirituality – connection with higher energies) The four dimensions were also to be used in relation to the unique perspective of three key stakeholders, *tangata whaiora* (consumers), treating clinicians, and *whānau* (family).

A validation process was undertaken in 2010 (McClintock et al., 2011). The option that was strongly favoured as the definitive Hua Oranga measurement was accepted for two reasons, one because of its psychometric properties, greater inter-rater reliability, and its better utility as reflected in the qualitative feedback. Participants of the validation process agreed all who with tangata whaiora should be encouraged to utilise the Hua Oranga (McClintock et al., 2011). However, the most important condition was education in the Hua Oranga and understanding in the application of the Whare tapa whā (McClintock et al., 2011).

Appropriate cultural service provision as well as relevant assessment processes with *tangata whaiora* and *whānau* needs to involve utilisation of the Hua Oranga. This process can monitor mental health outcomes for Māori in the diverse environments in which they present (McClintock et al., 2011). It is expected treatment and care is more aligned what tangata whaiora (consumers) and their whānau want. For clinicians, the new approach would lead to better health outcomes for the people they serve (McClintock et al., 2011).

The Household, Income and Labour Dynamics in Australia (HILDA) Survey[5] is a household-based panel study that surveys the same people over time to provide longitudinal data on the lives of Australians. Started in 2001, the HILDA Survey provides policymakers with insights about Australian households, enabling them to make informed policy decisions across a range of areas, including health. Based on analyses of the eighth wave (2008) of the HILDA Survey, 53% of Indigenous respondents (versus 61% of non-Indigenous respondents) reported that they had 'been a happy person' all or most of the time in the previous 4 weeks and 51% of Indigenous respondents (versus 37%) reported that they had 'felt so down in the dumps' nothing could cheer them up at least some of the time over the same period. Both differences were statistically significant. Therefore, the HILDA Survey data provided evidence that mental health was found to be lower for Indigenous Australians than non-Indigenous Australians.

In contrast, however, evidence from the same survey presents a different picture for life satisfaction, which may be more indicative of Indigenous wellbeing. Around one-third of both Indigenous and non-Indigenous respondents (34% and 32%, respectively) reported levels of life satisfaction lower than 8 out of a 10-point Likert-scale. However, a significantly higher proportion of Indigenous (41%) than non-Indigenous respondents (32%) reported a value of 9 or 10. An interpretation may therefore be that Indigenous Australians reported lower levels of mental health yet are more likely than non-Indigenous Australians to say that they are satisfied with their life, reflecting higher levels of wellbeing.

Results from the Australian Bureau of Statistics Australian Aboriginal and Torres Strait Islander

[4] http://archive.stats.govt.nz/browse_for_stats/people_and_communities/maori/te-kupenga.aspx

[5] https://melbourneinstitute.unimelb.edu.au/hilda

Health Survey 2012-2013[6] found that 30% of Indigenous respondents reported high/very high psychological distress in the previous four weeks, a rate 2.7 times higher than non-Indigenous respondents.

These National surveys have been criticised for the small Indigenous samples used to generate these statistics, and more importantly, the data collection topic priorities that fail to understand Indigenous people through anything but a lens of disparity, deprivation, disadvantage, dysfunction, and difference (Walter, 2016). The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing,* first endorsed for 2004-2009 and then again for 2017-2023, must guide future National investigations of the health and wellbeing of Australia's Indigenous peoples. To this end, Mayi Kuwaya[7] is a major new Aboriginal-led longitudinal study of culture, health and wellbeing, the data is yet to be released.

In Canada, the First Nations Regional Health Survey is an example of a successful grass-roots initiative, led by Indigenous peoples for Indigenous peoples. The first round began in 1997. The second iteration was published in 2007 and the phase three was published in 2018[8]. The latter was the most successful round, with 24,000 surveys completed in 250 communities. It is recognized that FNHRS only applies to First Nations living "on-reserve".

Using a cultural framework four key areas were surveyed: Action, Reason, Relationships and Vision. Relationships was further composed of Personal Wellness, Community Wellness, Language and Culture, and Residential Schools. The results indicated (p.36 and p.133).

- More than one third of adults (36.6%) reported that cultural or traditional activities contribute to their overall health.
- Nearly three-quarters of First Nations adults (71.0%) agreed or strongly agreed that traditional spirituality is important to them.
- The majority of First Nations adults reported either a very strong (33.1%) or somewhat strong (47.5%) sense of belonging to their community.
- The majority of First Nations adults (87.9%) reported having some knowledge of a First Nations language. Of those who had knowledge of a First Nations language, nearly one-third (30.1%) could speak it fluently.
- First Nations adults reported feeling in balance physically (68.9%), emotionally (68.1%), mentally (69.8%) and spiritually (68.1%) most or all of the time.
- The lifetime prevalence of suicide ideation and attempts among First Nations adults was 16.1% and 11.2% respectively. Suicide ideation significantly decreased in the RHS Phase 3 compared with 22.0% reported in the RHS Phase 2 and 30.9% in the RHS Phase 1.

The United States has a general approach for the health of the country, largely managed by the Centre for Disease Control and Prevention[9]. These efforts include:

1. National health Indicators and objectives, updated annually;
2. Community health assessments for States, Tribes and Territories; and,
3. Community Health Improvement Plan, which reflect more of a long-term approach.

The basic measures included have largely been developed by and for the entire country, so Indigenous communities have needed to think about conducting their own, modify and or add culturally relevant measures if their interests are to be included. Data for specific Tribes (communities) tend to be limited a resource issue, invisibility also due to small sample sizes and lack of legislative commitment to acknowledge Native

[6] https://www.abs.gov.au/ausstats/abs@.nsf/0/9F3C9BDE98B3C5F1CA257C2F00145721?opendocument

[7] https://mkstudy.com.au/

[8] https://fnigc.ca/sites/default/files/docs/fnigc_rhs_phase_3_volume_two_en_final_screen.pdf

[9] https://en.wikipedia.org/wiki/Centers_for_Disease_Control_and_Prevention#Datasets_and_survey_systems

Americans. There is much work to be done (Connolly et al., 2019).

Protocols for Utility of an Indigenous Wellbeing Instrument

The measurement of Indigenous wellbeing requires an approach that reflects a holistic Indigenous worldview. Such a worldview must include individual wellbeing (including physical, mental, and emotional dimensions), relationships between people (including family, kinship or tribal, and community dimensions), culture (including language, cultural knowledge, and cultural practice dimensions), and spirit (including spirit and land dimensions). Quantifying and monitoring this development may be grounded in:

- an adaption of current measures like *Te Kupenga* and *Hua Oranga*;
- the nine principles in the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing;*
- the development of the *First Nations Regional Health Survey,* and
- the inclusion of all peoples or explicit statements noting absences. For example, the National Health and Examination Survey (NHANES) excludes Alaska and Hawaii and Reservations, resulting in the absence of American Indians and Alaskan Natives (AIAN) estimates from this major nutritional survey.

The development and validation of an *Indigenous Wellbeing Instrument* is beyond the scope of this article. Yet future developments must be informed by the details throughout this article, drawn from a combination of thought and led from Indigenous experiences within Aotearoa, Australia, Canada, and the USA. A robust literature review and factor analysis process is needed to determine the structure and measurement invariance across samples, validation and reliability processes conducted in Wellbeing services will be needed, and appropriate application, service provision, assessment and treatment processes will need to be guided by principles of data sovereignty to support self-determination and governance.

Data sovereignty remains a key issue and inherent right for all Indigenous peoples. Indigenous peoples have been subject to centuries of research that has ultimately had little value or benefit, indeed is often detrimental to self-determination and empowerment (Walter, 2016). Kukutai et al. (2019 p. 3) believes Indigenous Data Sovereignty is an important lever for Indigenous peoples to assert collective rights and interests in data, and to share in the benefits and value that can be generated from it. An Aboriginal-led initiative, Maiam nayri Wingara[10], defines Indigenous Data as any knowledge or information, in any medium, which is about or may affect Indigenous peoples or communities. The right of Indigenous people to have ownership over their data is called Indigenous Data Sovereignty. Ownership entails access, application, reuse, management, creation, collection, analysis, interpretation, and dissemination Indigenous Data. Governance is the right of Indigenous peoples to autonomously make decisions about Indigenous data, to ensure that data on or about Indigenous peoples reflects the priorities, values, cultures, worldviews and diversity of Indigenous peoples, communities, and nations. The development and application of an Indigenous measurement must take lead from these values and beliefs.

Conclusion

The current paper provides a framework to guide the development of an Indigenous wellbeing instrument. Although Indigenous peoples across and within nations are characterised by significant diversity, we have presented evidence that Indigenous peoples are impacted by histories of colonisation and continued political and social determinants that distinguish the Indigenous and non-Indigenous construct of health. Yet, importantly, cultural determinants also have a strong protective role on the wellbeing of Indigenous peoples and demonstrate the differing paradigms of Indigenous balance and

[10] https://www.maiamnayriwingara.org/

Western disease and disorder. Although the expressions and practices may vary, four shared higher-order dimensions and 12 lower-order dimensions are presented here. The development of the Indigenous lens in each nation is presented, and the importance of data sovereignty and governance is discussed.

The Indigenous data gap must be closed. The development of a global Indigenous lens enables Indigenous peoples to advocate an alternative paradigm to Western conceptualisations of health. The development of this literature provides a voice for Indigenous values and a culturally safe evidence base, to the benefit of Indigenous peoples and to uplift and honour Indigenous Ways of Knowing.

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