Indigenous Fall Prevention Symposium

Report to the Public Health Agency of Canada
Prepared by Dr. Vicky Scott
August 24, 2018

Inuit Elder Emma Reelis

We will honour our elders
Till the dawn meets the dusk
They entrusted a legacy
From the oceans to the dusts.
(From a poem by Zelda Ouakawoot)
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Executive Summary

Falls and related injuries are a major health issue for Indigenous older adults. However, little is known about the scope of the problem and little is being done by way of prevention. Indications are that the rate of fall-related injuries among Indigenous older adults is much higher than among non-Indigenous older adults. To address this problem, the Indigenous Fall Prevention Symposium (IFPS) was held on June 11, 2018 in St. John’s Newfoundland in conjunction with the 4th Canadian Fall Prevention conference. The event was sponsored by the Public Health Agency of Canada and organized by fall prevention researcher, Dr. Vicky Scott, in partnership with researchers from Memorial University and an Advisory Committee comprised of those who work with Indigenous older adults, an Indigenous elder at risk for falling, policy makers who work on older adult and/or Indigenous health, and leaders in fall and injury prevention research.

The IFPS was attended in person by 44 participants and another 28 participants registered to attend via webinar, with some representing groups of online participants. All provinces, and most territories in Canada were represented. Other countries represented in person and via webinar included Australia, New Zealand, China and the United States. The purpose of the Indigenous Fall Prevention Symposium (IFPS) was to better understand the experience of falls and resulting injuries in Indigenous communities with a view to promoting preventive efforts. Information was gathered from a number of sources leading up to the IFPS and at the event to guide future steps. The primary source being the findings from the working groups at the symposium, and from a pre-event Needs Assessment Survey, Advisory Committee feedback, pre-event interviews with elders and family members, the symposium presentations, participant interactions and the symposium evaluation results. Themes arising from these sources were synthesized into the following key recommendations for action:

1. Develop fall and injury prevention programs that reflect the needs, traditions and culture of Indigenous older adults.
2. Reduce inequities in Indigenous communities that limit the ability to prevent falls and related injuries among older adults.
4. Educate health and social service providers on fall and injury prevention, and on issues of cultural safety for older Indigenous adults.
5. Promote research on fall and injury prevention for Indigenous older adults.

Next steps include disseminating this report to the symposium participants with the video of the event and the four presentations given on existing Indigenous fall prevention projects. The majority of participants shared their contact information with the intent of creating an Indigenous Fall Prevention Network to begin addressing action items coming out of the symposium.
Acknowledgements

Thank you to the members of the IFPS Advisory Committee for their excellent ideas, assistance and support in planning this Symposium. Particular thanks to Drs. Jeannette Bryne and Carolyn Sturge Sparks from Memorial University for their leadership in arranging the venue, transportation, volunteers and technical support. Thanks also to Newfoundland and Labrador Injury Prevention Coalition for their sponsorship of the refreshments.

Thank you to Inuit Elder Emma Reelis from the St. John’s Native Friendship Society for providing the opening and closing prayers and to Elders, family members and care providers from remote communities who provided background information and helpful ideas for topics for discussion, particularly Elder Elizabeth Penashue from Kanekuanikat, near Churchill Falls, her daughter Ms. Kanani Davis, and Elder Shirley Goudie from Postville, Labrador. Finally, thank you to the Public Health Agency of Canada for sponsoring this event.

Photographs were provided by Rich Blenkinsopp, Marketing & Communications, Memorial University of Newfoundland.

Carolyn Sturge Sparks, Joanne Bowater, Natasha Kuran, Elder Emma Reelis, Jeannette Bryne, Vicky Scott and Ashely Kwon (from left to right).

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Background

We know that among the general population of older adults aged 65 years and older, one third typically fall at least once each year and one-third of these falls result in injury that limits normal activity. Falls are the leading cause of injury-related hospitalization and death among individuals aged 65 years and older and 95% of hip fractures are due to a fall. Even without an injury, a fall can lead to negative mental and physical outcomes, such as fear of falling, loss of autonomy, greater isolation, confusion, immobilization and depression.

Less is known about the state of falls and related injuries among Indigenous older adults, but indications are that fall-related injury rates are considerably higher among this population compared to non-Indigenous older adults. One Canadian study showed fall injury rates almost twice those of non-Indigenous older adults, including for hip fractures due to a fall. An American study showed that the fall-related death rate among Native Americans aged 50 years and older was twice that of non-Native American seniors.

There are a number of reasons why indigenous older adults are at greater risk for falls and related injuries. Indigenous peoples generally receive poorer quality of health care and tend to live shorter lives compared to non-Indigenous people, with the difference ranging from 2.4 to 20 years. Geriatric conditions such as dementia, cardiovascular disease and late-onset diabetes manifest earlier for those of Indigenous ancestry and more elderly Indigenous people report multiple co-morbidities. In addition, many health issues among Indigenous people are deeply influenced by the early historical events of colonialism, residential schools and policies that disadvantage Indigenous people. Health outcomes are further impacted by issues such as racism, poverty and lack of access to health services. Unsafe housing, hazardous pedestrian walkways and lack of safe transportation in many Indigenous communities also pose fall and injury risks. As depicted in Figure 1, these determinants are key to understanding higher rates of chronic health problems, including higher rates of fall-related injuries among older people of Indigenous ancestry.

Figure 1
Indigenous Determinants of Health

Purpose

The purpose of the Indigenous Fall Prevention Symposium (IFPS) was to better understand the experience of falls and resulting injuries in Indigenous communities with a view to promoting preventive efforts. To accomplish this the IFPS brought together those with experience of working with Indigenous older adults and those with knowledge of what prevents falls and related injuries, with the goal of sharing ideas and creating a national and international network of those with an interest in fall prevention in Indigenous communities.

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5 Adapted from: PHSA Indigenous Cultural Competency Training: C. Redding, Provincial Health Services Authority in BC, 2010
Planning Phase

1. Needs Assessment Survey

The first step in planning for the IFPS was to conduct a needs assessment survey of health and social services providers in Indigenous communities, policy makers and fall prevention programmers and researchers. The survey (See Needs Assessment Survey: Appendix 1) was sent using a ‘snow-ball’ method, with known contacts asked to forward to those in their networks with an interest in Indigenous fall prevention. Forty-one responses were received with all stating that they would be interested in attending the IFPS but for some, the cost of travel would be prohibitive. Twenty-seven of the 41 respondents indicated that they have prior experience working in fall prevention among Indigenous older adults. The following quotes represent the extent of this involvement:

- “I have extensive injury prevention experience at the Aboriginal community level and nationally. I just completed a report on special needs in an indigenous context that included indigenous elders, and which also included falls prevention.”
- “8 years working in indigenous communities across Canada from a home care lens (training health care aides). In addition, chronic disease prevention work with a focus on physical activity and wellness incorporating indigenous world views.”
- “I manage health and wellness programs at the St. John’s Native Friendship Centre. Many Aboriginal older adults who attend programs are living on their own, so we talk about ways to make the home environment safer to prevent falls. Our programs are very focused on health and healing to keep older adults healthier, longer.”
- “We have trained over 200 community leaders in our training program which has included both our Diabetes Intervention Program as well as our Fall Prevention Exercises.”
- “LTC Home and Community Care Nurse for Serpent River First Nation. Work collaborative with OT and PT with clients at risk for falls.”
- “I am from Six Nations of the Grand River. We have a population of over 26,000. There is a high incidence of elders and falls. We currently; have a Falls Prevention program and are Accredited by Canadian Standards. We receive a small amount of funding from the LHIN to conduct a Falls Prevention program. The falls prevention program includes the Physiotherapist; Physiotherapist Assistants and is held in the Adult Day Center.”
- “Our region serves two reserves and urban dwelling (ok maybe off-reserve is a better term for our rural region) older adults. We have an Indigenous Fall Prevention group who meet bi-monthly. We are about to provide home support exercise programming and comprehensive fall assessments on our two reserves. We support a pole walking group (bought the poles, trained the leader).”

Of the 41 survey respondents, 26 said that they did, or might, have funding to cover travel to the IFPS and 14 stated that they did not have any access to such funding. Fourteen of the 41 stated that they would be able to attend via webinar rather than in person. The following
represent some of the responses to the survey question asking for suggestions or comments about what to include in the IFPS:

- “I think this symposium is a great idea and I would find the information very valuable as I live in a province with a high population of Aboriginals and I run a community fall prevention program for one of our provincial health regions.

- “Indigenous populations have been identified not only by our regional Stay on Your Feet committee but also as a target population for our health unit in our strategic plan. We have had many discussions on how to target and best serve this population! This would be a great need for us and would surely benefit the clients we are trying to reach. Look forward to hearing more!”

- “Currently our health region is part of the blurring the lines program. We can now provide rehab services onto reserves however have not received any additional funding for this. We are a rurally based rehab program in Manitoba and resources have always been significantly less than in urban Winnipeg. I think this is a great idea to be able to improve the health and safety of elders. It would be great to be able to offer these programs to all Manitobans as in our region we have limited formal fall prevention for anyone. We do access the falls prevention network for literature and handouts, however often these clients need specific training or exercise programs in fall prevention. Best wishes in this program development.”

- “We would suggest that you have healthcare professionals there offering a training/certification program so that participants are leaving with more than just information in their tool-kit but practical exercises and training that they can take back to support their communities to implement. We have numerous therapists and doctors who have helped us design our programs including Mandy Shintani, Vancouver based Occupational Therapist, who has a Masters in Gerontology and founded Urban Poling Inc nearly 12 years ago.”

- “Saugeen First Nation Home and Community Care program is dedicated to Elders Safety and Injury Prevention and would love to learn more about what you may have to offer.”

- “I would like to have more information on the topic of Aboriginal elders who have falls and falls prevention (specifically in the home environment).”

- To be able to participate in a session with other First Nation individuals who are frontline workers and/or home care providers/family members would be beneficial.”

- “Just so you know, based on my experience, if there are webinars (live or recordings) available at no cost, it is likely that many First Nations Community staff in Ontario would be interested in viewing them or in participating. In Ontario, professionals from Provincial Services who provide primary care in First Nations Communities would also likely benefit from this event. I know most communities have limited funding for their programs and any dollars invested in travel and training cannot be spent on direct client care. This is a limiting factor in community’s capacity to send staff to this kind of training, but I estimate that 3 to 5 communities in Ontario may consider this venue. If additional funding becomes available to cover for travel and registration costs, quite a few more communities will consider attending.”

The above findings were useful in the planning phase and helped inform the topics and format to be used for the IFPS.
2. Advisory Committee

Recruitment for Advisory Committee members was conducted between October and December 2017, with recommendations from partners at Memorial University Aboriginal Health and sponsors at the Public Health Agency of Canada. Advisory members were recruited for their ability to inform the content and format of the IFPS, ability to assist in notifying potential participants and those with the potential to influence change based on the IFPS outcomes. Every effort was made to include national organizations that represent Indigenous people including:

- The Assembly of First Nations
- Indigenous and Northern Affairs Canada
- First Nations and Inuit Health
- Inuit Tapiriit Kanatami
- The Métis Nation
- Nunatsiavut Department of Health & Social Development
- First Nations Health Authority of British Columbia
- Institute of Indigenous Peoples’ Health, Canadian Institutes of Health Research
- The Arctic Institute of Community-Based Research
- Newfoundland Aboriginal Women’s Network
- St. John’s Native Friendship Centre

Interest in the topic of fall prevention was expressed by all those contacted, however, not all were able to send representatives to join the Advisory Committee due to other commitments. Members joining the Advisory Committee represented those who work with Indigenous older adults, an Indigenous elder at risk for falling, policy makers who work on older adult and/or Indigenous health, leaders in fall and injury prevention research, faculty from Memorial University with the ability to organize logistics for the symposium and academics with an interest in Indigenous fall prevention research. Meetings were held on January 9th, March 20th and May 31st, 2018.

Through Advisory members contacts, an interview with an Indigenous older adult and a family member of an older adult were arranged to assist in gathering information that would help set the program for the IFPS and better understand the lived experience of older adults at risk for falls in remote Indigenous communities.

Dr. Scott interviewed Elder Shirley Goudie, the Town Manager in Postville, Nunatsiavut, and arranged for her to participate in an Advisory Committee meeting to tell her story about fall risk for older adults in her community. Ms. Goudie described her community as former Hudson’s Bay trading post on the Labrador coast 182 km north of Happy Valley Goose Bay. Postville is a community of 190 people, of which 32 are aged 65 years or older. Ms. Goudie spoke about how active the older adults are in her community, despite the challenges of living and working on the land. In particular, she spoke about an older man in her community aged 88 years who lives by himself, with some home care, and uses a walker. He had a fall the previous year and broke his hip. He had a stroke a few years earlier and has other health
problems, but despite all this he is still active and uses his skidoo in the winter to continue hunting and trapping. At the meeting, and on a telephone conversation with Dr. Scott, Ms. Goudie talked about her own experience of being at risk for falling. She talked about her daily concern about slipping on ice in the winter or tripping over door sills and on steps – particularly those without handrails. She had a hip replacement 18 years ago when she was 49 years old and thinks that she will soon need to have the other hip done.

Ms. Goudie described the challenges of getting medical care in her community. For any surgery, serious injury or health problem it is necessary to fly to St. John’s NL via Happy Valley Goose Bay. She described how difficult this can be as flights do not operate every day and are often delayed due to weather – sometimes for many days. When the aircraft is needed for emergencies passengers are left to wait until the aircraft returns. She also talked about how difficult the older people find being away from home and in the strange surroundings of big cities and hospitals.

Another interview was conducted March 7th, 2018 with Kanani Penashue-Davis, the daughter of Elder Elizabeth Penashue from Sheshatshiu, Nunatsiavut (42 km north of Happy Valley Goose Bay). I was unable to speak directly with Ms. Penashue as she is most comfortable speaking in her local Innu language. Ms. Davis, an Innu Educator from St. John’s who joined the IFPS Advisory Committee to represent her mother had hoped to bring her mother to St. John’s to speak at the IFPS. Unfortunately, this did not happen due to changes in Ms. Penashue-Davis’ schedule shortly before the symposium. During the interview and in a subsequent internet search, I was able to learn a little about this remarkable woman and about her experience of being at risk for falling.

Ms. Penashue lives in a community of approximately 1,285 on the Labrador coast, where 96% if the residents are Innu. She has nine children, 33 grandchildren and five great-grandchildren. Ms. Penashue was born into a hunting and trapping family who lived at Kanekuanikat, between Esker and Churchill Falls, Labrador. Her family moved to Sheshatshiu in the 1960s, when the government encouraged the community to relocate with the plan of integrating them into Canadian society “through education and a more settled lifestyle.” Ms. Penashue and her husband “attempted to go back to the old way of life, to return to the land”. However, low-level military flying exercises out of Goose Bay over the Innu hunting made this impossible.

Ms. Penashue became a leader in the opposition to low-level flying and continues to promote the traditional lifestyle and Innu relationship with the land, including organizing walks from

Goose Bay to Minei Nipi Lake and canoe voyages along the Churchill to focus attention on the problems that would arise from the damming of the Lower Churchill.

Ms. Penashue was unable to undertake the walk this year because she fell and injured her knee.

Information was also obtained during Advisory meetings from members who lived and worked in remote Indigenous communities. One member spoke about the challenges of accessing information and being part of meetings such as the IFPS. She is a nurse who works with Indigenous older adults and knows about the risks and consequences of falls and related injuries, yet she was unable to attend the IFPS in person due to lack of funds and also unable to participate via the webinar option due to low band-width in her community in Northern Nunavut.

Table 1
IFPS Advisory Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Organization</th>
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<tbody>
<tr>
<td>Vicky Scott</td>
<td>Clinical Professor, School of Population and Public Health, Faculty of Medicine, University of British Columbia</td>
</tr>
<tr>
<td>Jeannette Byrne</td>
<td>Associate Professor, School of Human Kinetics and Recreation, Memorial University, St. John’s, NL</td>
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<tr>
<td>Carolyn Sturge Sparks</td>
<td>Coordinator, Aboriginal Health Initiative, Faculty of Medicine, Memorial, NL</td>
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<tr>
<td>Joanne Bowater</td>
<td>Policy Analyst, Aging and Seniors Unit, Division of Aging, Seniors and Dementia, Public Health Agency of Canada</td>
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<td>Natasha Kuran</td>
<td>Division of Aging, Seniors and Dementia, Public Health Agency of Canada</td>
</tr>
<tr>
<td>Janice White</td>
<td>Health Promotion Coordinator, Co-Chair Labrador Regional Wellness Committee</td>
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<tr>
<td>Carrie Robinson</td>
<td>Senior Policy Analyst – Health, Assembly of First Nations</td>
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<tr>
<td>Melita Paul</td>
<td>NunatuKavut, Community Projects Coordinator</td>
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<td>Bev Forsey</td>
<td>Physiotherapist at Injury Prevention Consulting, Labrador-Grenfell Health</td>
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<tr>
<td>Fabio Feldman</td>
<td>Manager, Seniors Fall and Injury Prevention, Older Adult Program, Fraser Health Authority</td>
</tr>
<tr>
<td>Jennifer Shea</td>
<td>Community Health and Humanities</td>
</tr>
<tr>
<td>Elizabeth Pearce</td>
<td>Home &amp; Community Care Manager, First Nations Health Authority, B.C.</td>
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<tr>
<td>Barbra Narsaiy</td>
<td>Home and Community Care Clinical Practice Consultant, First Nations Health Authority, B.C.</td>
</tr>
<tr>
<td>Heather Bursey</td>
<td>Home Support Program Coordinator, Nunatsiavut Department of Health &amp; Social Development</td>
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</tbody>
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Kanani Penashue-Davis
Innu Education Director, Mamu Tshishkutamashutau Innu Education

Breannah Tulk
St. John’s native Friendship Centre

Shirley Goudie
Elder and Town Manager, Postville, Nunatsiavut, NL

Linda Wells
Executive Director, Newfoundland Aboriginal Women's Network (NAWN)

3. Logistics

The logistics of the IFPS were greatly enhanced by the efforts of two Advisory members (Drs. Jeannette Byrne and Carolyn Sturge Sparks) from Memorial University (MUN). This included providing a venue at MUN in a theatre style room with capacity of up to 100 and audio-visual opportunities that included filming of the event. In addition, Dr. Sturge Sparks in her capacity as Coordinator, Aboriginal Health Initiative at MUN, was able to arrange an Elder from the St. John’s Friendship Society, Ms. Emma Reelis, to provide opening and closing prayers for the IFPS and for Ms. Catharyn Anderson, Memorial University’s Special Advisor to the President on Aboriginal Affairs to provide opening remarks and the official land acknowledgement for the event.

Dr. Byrne, in her capacity as co-lead on the Canadian Fall Prevention Conference, and Dr. Scott as a member of the Conference Planning Committee, were able to have the IFPS as an event within the conference and to organize transportation for participants from the conference venue to attend the IFPS at MUN. They were also able to have the IFPS registration posted on the conference website.

Ms. Catharyn Anderson, Special Advisor to the President on Aboriginal Affairs, MUN.
Symposium Event and Outcomes

1. Program

The program for the IFPS was planned and organized over three Advisory Committee teleconferences between January and May 2018 and at the Canadian Fall Prevention Conference planning committee meetings. It was decided by the conference committee that a half-day symposium could be allotted to the event within the conference schedule. The starting time of 1 pm was decided to allow conference participants to have lunch and take the transportation provided to MUN for the symposium.

The order and events on the program were structured to have an opening prayer by an Indigenous Elder and an acknowledgement of the Indigenous peoples of Newfoundland on whose traditional lands the event was being held by Memorial University’s Special Advisor to the President on Aboriginal Affairs. This was followed by an overview of the scope and nature of the problem of falls for Indigenous older adults and presentations by speakers who conducted research and/or program delivery on Indigenous fall prevention. The remainder of the afternoon was devoted to group work, reporting to the larger group, open discussion and questions. The event concluded with summary comments and a closing prayer.

2. Participants

Recruitment of participants for the IFPS occurred through a number of methods, including posting an invitation notice (Appendix 2) on the Canadian Fall Prevention Conference website, and forwarding the notice through members of the Advisory Committee and to all those who responded to the Needs Assessment Survey.
A total of 44 people registered to attend in person and another 28 registered to attend via webinar. For those who attended via webinar, some mentioned that there were multiple people in the room, so the actual number is not known. Countries represented in person and via webinar included Australia, New Zealand, China and the United States (including those representing the Indian Health Services and the Alaska Native health services). All provinces, and most territories in Canada were represented. Over one-third of the participants stated that they represented those who work directly with Indigenous older adults and a third to a half stated that they worked, or conducted research, in the field of older adults fall prevention.

3. Presentations

Four invited presentations were given at the IFPS. Two represented programs in British Columbia and one from Ontario. The final presentation was of a fall prevention program and study in Australia. The presenters for this program travelled from Australia to participate in the IFPS and to present at the Canadian Fall Prevention Conference.

All programs presented had in common the approach of working in partnership, or under the leadership, of local Indigenous leaders and health care providers. Other common aspects included the challenges of reaching out to remote and isolated Indigenous communities as well as issues of language across Indigenous groups within countries and challenges of translating materials into messages that make sense to Indigenous older adults. Another
common issue raised by all is the importance of cultural safety, whereby services are provided in a way that reflect respect for Indigenous cultures and an openness to learning the cultural traditions and ways of being of Indigenous peoples.

Presentations are available on the MUN website along with the video of the entire IFPS. The four presentations and presenters are as follows:

- *Strategies and Actions for Independent Living (SAIL) for First Nations Program* - Ms. Elizabeth Pearce, First Nations Health Authority and Dr. Vicky Scott, SAIL-FN Project Lead, B.C.
- *Safe for Elders, Safe for All* – Ms. Ashley Kwon, presenting on behalf of a consortium of Nlaka’pamux communities within the Fraser Canyon, B.C.
- *Grey Bruce Indigenous Fall Prevention Strategy* - Ms. Emily Powell, Indigenous Fall Prevention Strategy, Grey Bruce Health Unit, Ontario; Cynthia Porter, Norma Tobey and Angie Webber, with the Chippewas of Nawash Home and Community Care Program

The following are some of the highlights from each presentation.

1. *Strategies and Actions for Independent Living (SAIL) for First Nations*

The *SAIL-FN* project was developed in partnership with the First Nations Health Authority (FNHA) of British Columbia. Fall prevention is viewed as part of the BC First Nations Perspective on Health and Wellness as shown in Figure 2 below. This model has the person at the center surrounded by the supports and services to promote the person’s best possible state of wellness. These services include home support services where fall prevention has been integrated for older adults with a focus on enhancing mobility and preventing fall-related injuries.
SAIL-FN is a fall training program that also includes fire prevention, as many of the same risk factors apply to both. SAIL-FN consists of a set of resources for home support workers, nurses and others who provide in-home care to frail older adults in First Nations communities. Resources were developed over a three-year project in partnership with First Nations communities, and direct input from staff, elders and family members. The final materials are owned by the First Nations Health Authority and all BC First Nations Communities. SAIL-FN materials consists of fall risk assessment tools, a fall and injury tracking system, fall and fire prevention awareness resources, two exercise programs and implementation guidelines. One of the key resources is the Fall and Fire Prevention Checklist (shown below), an interactive tool for elders and their care providers to identify and reduce fall and fire risk in the home.
2. *Safe for Elders, Safe for All*

The *Safe for Elders, Safe for All* program, also from British Columbia, used a participatory research method that relied on the First Nations bands involved in the project to identify their needs with regard to fall prevention and to work toward solutions. Solutions were developed over many years with consultation and pilot testing of strategies to find those most culturally appropriate and acceptable to the First Nations elders, families and local support staff. The project team found that fall prevention strategies designed for large urban settings did not work in remote First Nations communities. Emphasis was put on creating resources that would reflect the local culture, traditions and ways of life. Images for the resources were carefully chosen to depict local elders and local activities as shown in the images on the *Safe for Elders* calendar below. The project is ongoing and continues to evolve and spread.
Safe for Elders Calendar Cover

Safe for Elders Calendar Inside
3. Grey Bruce Indigenous Fall Prevention Strategy

The Grey Bruce Indigenous Fall Prevention Strategy represents what can be done in a remote community with limited resources for fall prevention. The program is delivered by local home care staff in the Chippewas of Nawash community in southern Ontario.

Strategies include a home exercise program with assessments using the Timed-up-and-Go, Sit-to-Stand and a Functional Fitness Confidence Scale used to determine fall risk. This is combined with cognitive and sensory assessments, nutrition screening, medication reviews, home assessments and referrals. Ongoing evaluation of the program is leading to a continuous improvement cycle.

4. Ironbark Program

The Ironbark Program in New South Wales, Australia is a fall prevention and exercise program for older Aboriginal people. The program was developed in collaboration and partnership with older Aboriginal people and their communities. The program is ongoing with an education program based on 'yarning circles'. The program reflects important issues that need to be considered when working with Aboriginal people, including understanding diversity, building trust, showing respect and being inclusive. Diversity among Aboriginal communities is reflected in their belief systems, culture, spirituality and in how they live their lives. Aboriginal communities differ with regard to local issues and needs and this impacts how fall prevention will be received. In developing the Ironbark Program, it became clear that successful programs require taking time to listen carefully and to engage in open and honest discussion about the needs of those impacted by the issue. A challenge to the spread of the program is the fact that Australian Aboriginals have over 300 languages with over 600 dialects.

4. Synthesis of the presentations

The following key themes arose across the four presentations:

a) Fall risk assessment:
   Fall risk assessment was a key aspect of all four Indigenous fall prevention programs that were presented. These assessments included questionnaires to assess overall fall risk,

8“In the Yarning circle process all participants are provided with an opportunity to have their say in a safe space without judgment. Each participant speaks, one at a time, is heard and not interrupted. This is a process that involves and develops deep listening, sharing of knowledge and development of higher order thinking skills and establishing rules of respect.”

mobility and strengths test, cognitive and sensory testing, home safety and assessments of the fear of falling.

- Fear of falling is being assessed in some Indigenous fall prevention programs where older adults are asked how fearful they are about having a fall. Only those who have fallen express this fear. It was suggested that Indigenous older adults are more familiar with being on the ground and may even see the earth as protective or sacred and do not have the same fear of being on the ground that non-Indigenous older adults may have.

b) Lack of training by care providers to ensure the cultural safety of Indigenous older adults.

c) Participation by Indigenous people in all aspects of fall prevention program development, delivery and dissemination, including:

- Gaining the trust of older Aboriginal people is paramount to effective communication but not an easy thing to do. The negative influences of colonialism and past atrocities have left many wary and closed to change driven by outsiders.
- Ability to establish trust can be enhanced by having Indigenous people directing, guiding and delivering all aspects of the program.
- Communication can be enhanced by having communities that are using a fall prevention program to share their experience with new communities.
- Having fall prevention activities take place where elders gather.
- Giving ownership of the program to the local community.
- For researchers in Aboriginal communities, it is important that they take the time to show respect for the culture and traditions and not assume that their agenda and timelines will be those that meet the community’s needs.
- It is important to be flexible and adjust the program, when needed, to suit individual needs and capacities.
- Researchers and program leaders from outside of the community need to be aware of local cultural practices that may pose barriers to program operations. This includes special ceremonies, time for grieving the loss of community members and the need for elders to attend to unexpected family and community issues.

d) Obtaining funding to support Indigenous fall prevention research and programs.

5. Group Work

The in-person participants were divided into six small groups, each with a group facilitator and recorder. One group was linked to the webinar participants through a video link and email so that they could respond to questions and provide comments. Each group was asked to address the following questions and report back to the larger group:
• What is being done now in Indigenous communities to reduce the risk of falls and related injuries for older adults?
• What are the gaps in knowledge that need to be addressed to move fall and fall-related injury prevention forward in Indigenous communities?
• What actions do you recommend to address these gaps?


The group work findings are organized under the three questions that were posed to participants – see Appendix 3 for the group work findings. The following reflects the key themes of the group work based on flip charts generated by the groups and from the recordings of the group presentations.

Question 1: What is being done now in Indigenous communities to reduce the risk of falls and related injuries for older adults?

Theme 1: Existing programs
A few programs exist but they operate in isolation, i.e., not shared across or within countries. Those that exist tend to reflect a collaborative and holistic model with Indigenous elders and local community services providers working in partnership with health care providers and fall prevention experts. The focus has been “Indigenous led and driven” projects. Components of existing programs include fall risk assessments and interventions such as exercise, vision screening and home modifications. Strategies for delivering interventions include elder advisory circles, games, intergenerational knowledge transfer of traditional hunting and gathering practices, provision of safety equipment and mobile fall prevention clinics.

Theme 2: Existing research
A few programs have been developed and studied for their suitability for use in Indigenous communities, but more research is needed to determine effectiveness in reducing falls and related injuries over time.

Question 2: What are the gaps in knowledge that need to be addressed to move fall and fall-related injury prevention forward in Indigenous communities?

Theme 1: Lack of local and traditional knowledge
Initiatives for health promotion in Indigenous communities often fail to reflect local and traditional knowledge. In particularly the traditional knowledge and wisdom of older Indigenous adults. Older Indigenous adults are the best source of knowledge about their own needs and what will work in their communities. They know the traditional practices of living off the land that bring them physical, spiritual and mental well-being. Designated Elders in Indigenous communities are well positioned to introduce and lead new initiatives they believe in.
In addition, the acceptance and viability of new initiatives depends on having the local knowledge of services providers. This knowledge needs to be reflected in the design, testing, implementation and evaluation of all new programs. It has been observed that there is a “lack of buy-in when outsiders (non-Indigenous) deliver messages as opposed to local knowledge holders”. Accessing the local and traditional knowledge requires good communication and trust. This takes time, understanding local customs and ways of communicating (such as talking circles, use of talking sticks, etc.), translation for those who do not speak English and clarification of understanding for terms and concepts that have different meanings for different cultures.

**Theme 2: Lack of relevance to local needs**
The theme of lack of relevance primarily deals with lack of attention to the social determinants of health in Indigenous communities. This includes a lack of recognition of the historic events of colonization that have led to loss of land, isolation, poverty, family and cultural alienation, restrictions to local hunting and food gathering practices, lack of access to health services and poor housing. The impact of these conditions magnifies fall risk for older Indigenous adults in numerous ways including lack of funds for safety equipment and home repairs, access to health services, risk for depression and addictions, and lack of funds, or access to, common items such as medications, eye glasses, good footwear and nutritious food. As one of the symposium work groups reported:

“Be aware of social determinants of health – not a cookie-cutter approach among Indigenous communities – they all differ. Issues for some communities may include cost of shoes, food insecurity.”

Lack of attention to social determinants also impacts Indigenous older adults in urban centers where those living in poverty often have mental health and addiction issues that are poorly addressed by local health services that do not tackle the root causes. Fall prevention efforts will have little influence if these more pressing issues are not addressed.

**Theme 3: Lack of education:**
Lack of education at all levels was a major theme. As one group reported, this includes service providers and policy makers:

“Service providers and policy makers to have more knowledge about what is important for fall prevention and that education should be focused on those who are making the decisions that affect the programs and policies that could be important for fall prevention.”

An example is the lack of education about non-insured health benefits.

**Theme 4: Lack of funding**
There is not only a lack of funding but also a gap in the knowledge about funding sources and how to apply for funding. Many of those who make decisions about funding for Indigenous communities do not understand the impact and cost (human and financial) of falls to individuals and the health care system. Inequalities exist in isolated communities to physical and financial access to services and safety equipment.
Question 3: What actions do you recommend to address these gaps?

Theme 1: Culturally relevant FP programs
Cultural relevance for FP programming in Indigenous communities was a major theme. A number of actions were recommended to address culture relevance including:

- having FP programs that can be adapted to fit with local needs and resources
- adapting FP programs and education to be flexible to local ways of communicating, the need for ceremony and recognition of events (such as a death in the community) that will take precedence over attending a FP event
- building community capacity across all generations to lead and support FP activities and encouraging leadership from local “knowledge holders” on traditional practices and “ways of knowing”
- enhancing communication by embracing local communication practices, having more interpreters, providing better internet and telephone services to remote communities, and enhancing “health literacy” across all ages
- providing courses on culture safety to non-Indigenous health care providers and administrators
- collaborating with local Indigenous organizations (such as Tribal Councils) on optimal ways of integrating FP into community services
- ensuring the FP interventions are linked to systems for referrals for medical and social services
- providing support to local health care providers to advance their education and fall prevention training, such as funding to take online FP courses
- creating a national/international online network for sharing Indigenous fall prevention strategies for cultural relevance

Theme 2: Education

9 The Patient Protection and Affordable Care Act of 2010, Title V, defines health literacy as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions (Retrieved August 9, 2018 from https://www.cdc.gov/healthliteracy/learn/index.html).

10 “...an approach to healthcare that recognizes the contemporary conditions of Aboriginal people which result from their post-contact history.” Where “the power to define the quality of healthcare to Aboriginal patients according to their ethnic, cultural and individual norms.” (Brascoupe & Waters. Cultural Safety: Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness. Journal de la santé autochtone, November, 2009).
Recommended actions to address the current gaps in fall prevention education include providing evidenced-based education in colleges and universities for health care providers such as nurses, physicians, occupational and physical therapists, home care workers and others who provide direct care to Indigenous older adults.

A number of groups also recommended community education opportunities for elders and all generations to better understand why older adults fall in their communities. This should include more opportunities for Indigenous older adults to share their knowledge with younger generations on how to practice traditional ways of living off the land to promote better health through physical activity and eating local foods. “Knowledge holders” have much to offer younger generations about the local culture that will build capacity for the mental, spiritual and physical well-being of all community members.

**Theme 3: Social Determinants**

Social determinants were identified as an important consideration for developing and implementing FP programs in Indigenous communities. In particular, attending to housing needs, lack of transportation, poverty, lack of employment and education opportunities, and lack of local health services were mentioned. For FP, action needed with regard to housing focused on safe access, hygiene and safety. Actions to address some of the health service issues focused on having more physicians, physical and occupational therapists and pharmacists. Telehealth was also mentioned, the required action being the need for better internet services in order to access telehealth and other online medical information. For all issues related to social determinants it was stressed that the resources (human, financial, print, etc.) all reflect locally identified needs and the cultural safety of those in need.

**Theme 4: Equity**

The theme of equity covers issues that directly or indirectly affect fall risk, including equal (to non-Indigenous communities) and fair access to funding, human resources, education, transportation, communications, health care services and housing. Two groups cited the Jordan Principle as an approach for address these issues. The Jordan Principle is a child-first principle intended to resolve jurisdictional disputes within, and between, provincial/territorial and federal governments concerning payment for services to First Nations children when the service is available to all other children (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3448536/). The principle proposes that there is a legal obligation by governments to provide programs and services on-reserve that are reasonably comparable to those available off-reserve.

**Theme 5: Research**

The theme of research covers a range of issues including filling knowledge gaps on the risks and prevention of falls and related injuries, who to involve in the research and how to obtain research funding. Recommendations were made for cost effectiveness studies and qualitative studies on the acceptance and relevance of FP interventions.
Enhancing participation in research by Indigenous health care providers, older adults and family members was recommended. This includes partnering with existing Indigenous groups, organizations and decision makers, such as Band Councils. There was also an emphasis on the need for more academic positions for Indigenous people and to “train more Indigenous researchers. CIHR likes to see Indigenous research partners but there are few available with the necessary training.”

Symposium participants flagged a need for:

“System navigators to work and advocate for FP, such as grant applications, i.e., find the experts who can ‘walk in both worlds’.”

Action is also required to access or generate more data to better understand the state of the problem of falls and related injuries in Indigenous communities and an analysis of common themes and how to address them in ways that are culturally acceptable and cost effective. In addition, studies are needed on how to integrate FP with current programs and services that are successfully operating in local communities.

**Symposium Evaluation Findings**

The evaluation of the IFPS completed by participants contained four questions and a request for other comments. The evaluation form was completed by 12 of 44 participants. The following is a summary of the evaluation findings.

1. **What did you find most helpful today?**
   **Summary:** Most people mentioned that they found the Group Work portion of the symposium most helpful. Participants enjoyed learning from each other and the speakers, particularly learning about current programs and research.

2. **What could be improved?**
   **Summary:** The strongest theme under recommended improvements to the symposium was to involve more Indigenous people, such as having a panel of Elders. The need for more funding for fall prevention programming and changes needed to building codes were also mentioned.

3. **What action will you take to improve fall prevention for older adults in Indigenous communities following this symposium?**
   **Summary:** Key themes on actions to be taken include learning how to navigate the system; embracing cultural safety and humility; educating health care providers and community members; learning how to adapt programs for local delivery; matching programs to local needs and wants; improving communication with attention to language barriers; collaborating with initiatives with similar goals; and funding.
4. Other comments: The main theme was appreciation for the organization of the symposium.

Conclusions

A great deal has been learned through the planning and holding of the IFPS. This includes learning of the strong interest in this issue across many sectors. We also learned that this interest extends across a number of countries, many of which have similar challenges and an interest in providing similar solutions. We learned of a gap in research on this issue but found that there are a number of promising initiatives that are worthy of future effectiveness studies. Across all the sources of information gathered in the planning and implementation of the symposium key themes arose to guide future actions. These include the need to improve communication on the issue of fall and injury prevention and to listen to, and work with, Indigenous older adults, their families and care providers to understand their needs and draw on their knowledge and experience of how to move forward. We also learned the importance of developing programs that are culturally relevant and integrated into existing services and governance structures. We learned of inequities in health care services, education, housing, transportation, communication systems and funding opportunities in Indigenous communities. We learned of the importance for a holistic approach to fall and injury prevention that reflects the broader health determinants and recognizes the impact of the historical injustices of colonialism. Finally, we learned of many creative ideas and a strong determination and enthusiasm to find solutions to address this important issue.

Recommendations

Based on the findings from all sources (needs assessment survey, interviews with elders, open discussions at the symposium, presentations, group work and evaluation findings) the following are recommendations for promising approaches and paths of interest to improve efforts in fall prevention for older adults in Indigenous communities:

1. Develop fall and injury prevention programs that reflect the needs, traditions and culture of Indigenous older adults.
   For example:
   a. Researchers and program developers to work with local older adults (elder community leaders and knowledge holders) and service providers to learn about local ways of communicating (with translators where needed), local cultural and traditional practices, to ensure that fall and injury prevention initiatives fit with local needs, practices and customs – always taking time to ensure mutual understanding.
b. Researchers and program developers to collaborate with local governance structures (e.g., Band Councils) and leaders of existing services to integrate fall and injury prevention strategies with local protocols and successful practices
c. Involve younger generations in prevention initiatives to carry on the knowledge of the elders and traditional practices that promote spiritual and physical health

2. Reduce inequities in Indigenous communities that limit the ability to prevent falls and related injuries among older adults.
   For example:
   a. Health services: provide equal and fair access to health services as provided in non-Indigenous communities
   b. Housing: all new construction in Indigenous communities to reflect universal design standards\(^1\) for safety and accessibility and funding for existing structures to meet universal design standards
   c. Transportation: increase transportation options and promote safe access for older adults using boats, planes and other modes of transportation when seeking medical services
   d. Communications: increase internet and telephone services to remote communities to promote education and networking for collaboration fall and injury prevention
   e. Food security: promote access to traditional food sources to promote healthy diets and instill traditional hunting and gathering practices in younger generations
   f. Safety equipment funding: ensure that funds are available to supply fall prevention equipment that is identified in research to prevent falls and injuries, such as grab bars, walking aids, hip protectors and ice grippers

   For example:
   a. Create an online network of those interested in Indigenous fall and injury prevention research and programming, e.g., though the Ontario, Fall Prevention Community of Practice LOOP (https://www.fallsloop.com), where there are private network options.
   b. Hold more meetings, symposia and conference with a focus on fall and injury prevention for Indigenous older adults where funds are made available for meaningful participation by Indigenous older adults and their care providers

4. Educate health and social service providers on fall and injury prevention, and on issues of cultural safety for older Indigenous adults.
   For example:
   a. Colleges and universities to incorporate training on fall and injury prevention for older adults into their curricula

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b. Provide access to health and social service providers in Indigenous communities to online, or on-site, courses in fall and injury prevention for older adults

c. Medical and social service organizations (hospitals, clinics, welfare agencies, etc.) to offer courses in cultural sensitivity and cultural safety for Indigenous clients

5. Promote research on fall and injury prevention for Indigenous older adults.
   For example:
   a. Academic institutions to promote opportunities for Indigenous researchers
   b. Make hospital data available on fall-related injuries among older Indigenous adults in order to better understand the scope and nature of the problem
   c. Research funding agencies to build capacity for Indigenous fall and injury prevention research
   d. Research funding agencies to offer dedicated grant opportunities for fall and injury prevention research for Indigenous older adults
   e. Funding agencies to assist communities in navigating the grant application process and completing the required forms
   f. Post information on current and future funding opportunities related to Indigenous fall and injury prevention, such as from the following:

   **Canada**
   - Canadian Institutes of Health Research
     - http://www.cihr-irsc.gc.ca/e/49857.html
   - Institute of Indigenous Peoples Health
     - The Institute of Indigenous Peoples' Health (IIPH) fosters the advancement of a national health research agenda to improve and promote the health of First Nations, Inuit and Métis peoples in Canada, through research, knowledge translation and capacity building. The Institute’s pursuit of research excellence is enhanced by respect for community research priorities and Indigenous knowledge, values and cultures.
       - http://www.cihr-irsc.gc.ca/e/46895.html
   - Canadian Mortgage and Housing – National Housing Strategy
     - http://www.cmhc-nhs.ca/
     - Questions: mailto:Innovation-Research@cmhc-schl.gc.ca
   - Canadian Nurses Foundation
     - http://cnf-fiic.ca/what-we-do/research/research-grants/
     - Every year the Canadian Nurses Foundation provides seed funding to support pilot studies and research projects on nursing care issues that builds research capacity and improves patient or client outcomes.
   - New Horizons for Seniors Program: Community-based Projects
United States
• Indian Health Service
  • Tribal Injury Prevention Cooperative Agreement Program (TIPCAP):
    The Indian Health Service provides funding for tribes to develop their infrastructure in injury prevention to address the disparity in the unintentional injury problem.
  • https://www.ihs.gov/InjuryPrevention/tipcap/

Next Steps

Next steps are to share this report with the participants of the IFPS and encourage the sharing of this report with others interested in promoting fall prevention programming and research for Indigenous older adults. In addition, participants will be sent a link to the Memorial University website to access the video of the IFPS and copies of the presentations. All participants, their colleagues and community members, are encouraged to use the participant list, with contact information, to work together for future action and advocacy for this important issue.

Links to additional resources to help with next steps include:

• Report, video and presentations of the Indigenous Fall Prevention Symposium
  www.canadianfallprevention.ca

• Media coverage of the Indigenous Fall Prevention Symposium
  Andrea Kelly, June 29, 2018. Memorial University Gazette,
  https://gazette.mun.ca/public-engagement/sharing-experience/
Appendices

Appendix 1
Needs Assessment Survey

Subject: Please respond re: Expression of Interest in Elders Safety and Fall Prevention Symposium

Dear Colleague in Elders Safety and Injury Prevention:

Falls and resulting injuries are serious health problem for older adults in Aboriginal communities. It is known that in some Canadian provinces the rate of fall-related injuries resulting in hospital admissions is twice as high for Aboriginal older adults compared to non-Aboriginal older adults (Jin, 2015). Please find attached two background papers on this topic.

The purpose of this email is to determine if there is interest in participating in a symposium on Fall Prevention for Aboriginal Elders. The intent of the symposium would be to better understand the experience of falls and resulting injuries in Aboriginal communities with a view to promoting preventive efforts. If sufficient interest exists, this event will be held in conjunction with the National Falls Prevention Conference to be held in St. Johns Newfoundland, June 10\textsuperscript{th}-13\textsuperscript{th}, 2018.

Please forward this email to any others that you know who may be interested. All replies to be send to Dr. Vicky Scott at vicky.scott@hiphealth.ca before April 30, 2017.

Please underline or bold your responses to the following questions:

1. Do you have any experience working in fall prevention among older adults in Aboriginal communities?
   - Yes
   - No
   - If yes, briefly describe:

2. Would you be interested in attending a symposium on fall prevention for Aboriginal elders?
   - Yes
   - No
   - If yes:
     - Would you have a source of funding to cover your expenses to attend?
       - Yes
       - No
     - Or, would you rather attend via a webinar link.
• Yes
• No

3. Please provide any suggestions or comments with regard to the planning of the *Fall Prevention for Aboriginal Elders Symposium*:

Thank you,

Vicky Scott, RN, PhD
Clinical Professor
School of Population and Public Health, Faculty of Medicine
University of British Columbia
Canada
E: Vicky.scott@hiphealth.ca
Url: www.canadianfallprevention.ca

Appendix 2

Invitation to the Indigenous Fall Prevention Symposium

Dear Colleagues in Indigenous Fall and Injury Prevention:

You are invited to participate in the Indigenous Fall Prevention Symposium (IFPS) on June 11, 2018 in St. John’s Newfoundland. Please share this invitation with those in your network with an interest in this topic.

This event is sponsored by the Public Health Agency of Canada and held in partnership with Memorial University. The purpose of this event is to bring together those with an interest in the issue to discuss what is known, where gaps in knowledge exist and what can be done to improve fall prevention among Indigenous older adults in Canada.

The Symposium will be held in conjunction with the 2018 Canadian Fall Prevention Conference held in St. John’s NL June 11-12 (www.fallsprevention2018.ca). There is no charge to attend the IFPS and conference registration is not mandatory for participation. The IFPS will be held from 1:00 to 4:30 pm at Memorial University, St. John’s Newfoundland. There is also a webinar option for those unable to attend in person.

To register by June 4th, please reply to the project lead, Dr. Vicky Scott at vjbs@shaw.ca with your name, affiliation, email and telephone number AND your response to one of the following options:

1. I will attend the IFPS in person AND will be attending the Canadian Fall Prevention Conference
2. I will attend the IFPS in person AND will NOT be attending the Canadian Fall Prevention Conference
3. I will attend via webinar
4. I am interested but unable to commit at this time
5. I am unable to attend

Names and affiliations will be shared in print at the symposium to facilitate introductions. However, as this symposium is a unique opportunity for networking on this important topic, please indicate if you are willing to also share your email with other participants. Yes/No

The agenda, room number, background reading and webinar details will be sent to registered participants in early June. Unfortunately, there is no funding available to support travel to this event. Apologies for any duplicate emails.

Thank you,
Dr. Vicky Scott, IFPS Chair
Drs. Jeannette Byrne and Carolyn Sturge Sparks, IFPS Co-leads
Appendix 3: Group Work Findings

I. **QUESTION 1: WHAT IS BEING DONE NOW IN INDIGENOUS COMMUNITIES TO REDUCE THE RISK OF FALLS AND RELATED INJURIES FOR OLDER ADULTS?**

   i. Fall Prevention (FP) programs – community lead and managed.
   ii. Addressing social determinants of health. Not just “illness” or “injury”.
   iii. N. Labrador project “Going Off and Going Strong” – intergenerational experience to transfer knowledge on hunting and gathering and sharing harvest with the community. Elders feel valued and are being active, i.e., preventing falls through being physically and emotionally healthy.
   iv. Not much other than a few isolated programs.
   v. Australian survey found that almost nothing is being done.
   vi. Acceptance of data: anecdotal and qualitative.
   vii. Indigenous lead and driven research.
   viii. In NL/Labrador, some transportation is being provided for various activities (FP and other). Some facilities for health care available that is closer to home community, e.g., dialysis).
   ix. In Ontario, has some programs but they tend to come and go.
   x. Community engagement and needs assessments.
   xi. House modifications
   xii. Provision of safety equipment, such as home safety kits
   xiii. Vision screening
   xiv. Elders advisory circles
   xv. Many small projects exist on FP especially where elders already meet and gather, e.g., funding for ice grippers
   xvi. Use of games to engage elders on FP topic
   xvii. Good to start small and grow over time
   xviii. Partnerships with Public Health exist
   xix. Clinics, such as mobile clinics in B.C. and elsewhere
II. **QUESTION 2: WHAT ARE THE GAPS IN KNOWLEDGE THAT NEED TO BE ADDRESSED TO MOVE FALL AND FALL-RELATED INJURY PREVENTION FORWARD IN INDIGENOUS COMMUNITIES?**

i. Let the elders lead – with support where needed.

ii. Need comprehensive measures in terms of programs and services. For example, a nutrition program in a remote community can be cost prohibitive, e.g., where the cost for a bag of milk can be as high as $12. Need to promote local foods but this can be impacted by things such as a ban on use of caribou meat or use of sled dogs.

iii. Services providers and policy makers to have more knowledge about what is important for fall prevention and that education should be focused on those who are making the decisions that affect the programs and policies that could be important fall prevention.

iv. Need to figure out how FP fits within the context of other issues and how FP “rates” in terms of other priorities (social and economic), particularly how Indigenous people see the importance of FP in comparison to other issues.

v. How to make the case to decision makers (communities, service providers, gatekeepers) to show the importance of FP within the larger context of competing demand for funding.

vi. Elders and their knowledge is new gone. Disconnected.

vii. Loss of traditional knowledge as the elders pass on. The traditional practices of hunting, fishing and gathering are important to good health and fall prevention but need to pass this on to younger generations. Need to create the link to fall prevention of these activities.

viii. Gaps in language use. Not using language people are using in their communities.

ix. Asking “What do you want?” This is not being done.

x. Gaps in knowledge about housing issues and proper building.

xi. Not building homes right from the start that are suitable for elders or others with disabilities.

xii. Lack of funding and knowledge about funding sources

xiii. Lack of health knowledge by individuals and policy makers.
xiv. Lack of communication between community and health services.

xv. Loss of traditional knowledge.

xvi. Outreach in urban centers for mental wellness, addictions and polypharmacy

xvii. Need more efficient health care referrals

xviii. Lack of funding and lack of knowledge of available funding

xix. Jurisdictional barriers that prevent access to care

xx. Lack of by-in when outsiders (non-Indigenous) delivering message as opposed to local knowledge holders

xxi. Language issues, such as need for interpreters for elders who do not speak English

xxii. Need better education and communication about non-insured health benefits

xxiii. Delays in treatment and services

xxiv. Staff turnover

xxv. Be aware of social determinants of health – not a cookie-cutter approach among Indigenous communities – they all differ. Issues for some communities may include cost of shoes, food insecurity

xxvi. Gap in physical and financially accessible services

xxvii. Relevant and safe resources – more mobile clinics

xxviii. Need financially accessible assessments and interventions

xxix. Priorities may differ and not ready to hear a message on FP

III. QUESTION 3: WHAT ACTIONS DO YOU RECOMMEND TO ADDRESS THESE GAPS?

i. Need to teach FP to nursing and OT/PT students

ii. Jordan’s principle\(^{12}\) – get on with action and worry about the funding later

iii. System navigators to work and advocate for FP, such as grant applications, i.e., find the expert who can “walk in both worlds”

\(^{12}\) Jordan’s Principle is a child-first principle intended to resolve jurisdictional disputes within, and between, provincial/territorial and federal governments concerning payment for services to First Nations children when the service is available to all other children.
iv. Promote accessibility, sustainability and education.

v. Materials and resources need to be adaptable for difference communities

vi. Need resources in terms of funding, people and knowledge.

vii. Doing cost effectiveness studies to demonstrate savings to governments and agencies for prevention efforts.

viii. Big issue is to address the social determinants of health (housing, access to food, transportation, cultural safety) because if we can improve these determinants we can help reduce falls. Need holistic care models.

ix. Need FP programs that are culturally relevant, and context relevant, that address diversity, need for ceremony and are person-centered.

tax. Culturally informed and trauma informed care.

xi. Let elders lead and provide support for them to pass on knowledge.

xii. “Going off Going Strong” Program (generational programs)

xiii. To address the barrier of competing needs, to incorporate FP within other programs to combine resources. Need to get more information and Indigenous input on how to make this work. Need to know where the resources are.

xiv. Need to train more Indigenous researchers. CIHR likes to see Indigenous research partners but there are few available with the necessary training.

xv. Need to integrate FP within current services and practices. Identify common links between interventions. Hold discussions with stakeholders/users to gain FULL understanding.

xvi. Need more data (using informed consent and through establishing relationships) to inform good practice, find out what is needed and wanted, understand common and difference themes, and how to share resources.

xvii. Need patience along with time, funding and structure changes.

xviii. Building community capacity such as engaging youth, local culture and knowledge holders

xix. Streamlining referral process

xx. Elders participation in research and program development

xxi. Cultural safety training

xxii. More comprehensive vision for injury prevention, including mental, emotional and spiritual
Identify social determinants of health

More interpreters

More avenues for collaboration and sharing

Coordinated, integrated efforts – avoid duplication

Need coordinated approach – look for existing Indigenous groups (e.g., tribal councils to work with)

Target messaging to specific groups at early stages

Need flexible program that can be tailored to First Nation communities

Include younger age groups in prevention strategies

Health literacy is a barrier – need to make sure the elders understand

Poverty dictates priorities – must be addressed, with consideration for issues of depression, self-worth etc.

Housing issues – safety, access, hygiene

Education for all age groups with open communication

Telecommunications for isolated communities

Strength and balance activities along with environment and community assessments for hazards, e.g., uneven sidewalks and walkways

Isolated communities need to address transportation issues and lack of services (no PT, OT, pharmacy or physicians) – some don’t have computers or good internet access

Need a national site for Indigenous fall prevention, similar to www.stopfalls.ca

FP Assessment needs to have the right resources (financial and human) to deliver, diagnose etc. to find and intervene in the root cause of the fall. Must be relevant for the community and fit the understanding of the individual elders and their community.

Plan-Do-Study-Act approach – need to see the whole picture and not get stuck in one stage

Need ongoing research