Johnston Research Principles for Literature Review

RESPECT

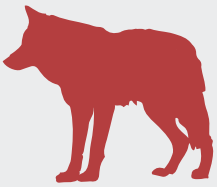
Honouring Indigenous communities priorities and needs

WISDOM

Understanding of spiritual teachings

COURAGE

Willingness to venture beyond one's comfort zone



HUMILITY

Listening to Elders to lead the research

TRUTH

Not afraid to expose deeply-rooted issues

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Johnston Research

JRI Literiture Review Guidelines

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1 Introduction

Overall Approach

The Johnston Research principles for literature review are meant to serve as an overall guiding focus for the work you undertake. The issue and literature review questions you formulate need to reflect the essence of these principles.

RESPECT – Honouring Indigenous community's priorities and needs
WISDOM – Understanding of spiritual teachings
COURAGE – Willingness to venture beyond one's comfort zone
HUMILITY – Listening to Elders to lead the research
TRUTH – Not afraid to expose deeply-rooted issues

Guiding Principles for Conduct

Literature reviews must reflect:

1. Action oriented research focus and questions – concisely define the research objective / purpose
2. Research questions must be linked to the topic at hand's known objectives, for example,
    a. What are the exemplary mandates or objectives of the work of traditional healing practitioners?
    b. What are the known principals and guiding approaches of traditional healing land-based programs?
    c. What are the current best-known objectives of Native child welfare agencies, such as those listed under their profession, or on leading agency websites.
3. Once the objectives are known, determine the basis of the approach in the specific discipline, area of focus, you are studying, and extract themes / principles, etc..
4. From these themes prepare your research questions.
5. Research questions must be focused on the actions and not the historical issues / challenges of the research topic. You can bring in current political agendas, as a basis for guiding the research. The profession of the topic can provide guiding rationale for the study. Community identified needs and priorities can also be that rationale, without digging up the past, ensure your approach is strengths-based.
6. Ensure you are prepared and able, or supported, in taking-on a complex approach to understanding the research, involve thought leaders, understand spiritual teachings, and don't be afraid to expose deeply-rooted issues.

2 Defining Literature Review, In General

Definition

A literature review is an objective, critical summary of published research literature relevant to a topic under consideration for research. However, due to a shortage of published literature on Indigenous health and wellness this literature will find strengths in grey-literature as well as spoken-word. The literature review is meant to create familiarity with current thinking and research on a particular topic, and may justify future research into a previously overlooked or understudied area. The written literature review consists of the following four (4) components:

1. Introduction

A concise definition of a topic under consideration (in our case these will be our hypotheses), and a description of the knowledge gathered (its source, and its relationship to the larger body of knowledge on the topic).

The introduction should also note intentional exclusions, in addition to assumptions recognized and how these were addressed in the work completed (this is about decolonizing ourselves and our work).

Another purpose of the introduction is to state the general findings of the review (what do most of the sources conclude), and comment on the availability of sources in the subject area.

2 Main Body

There are many ways to organize the evaluation of the sources. Chronological and thematic approaches are each useful example.

Each work should be critically summarized and evaluated for its premise, methodology, and conclusion. It is as important to address inconsistencies, omissions, and errors, as it is to identify accuracy, depth, and relevance.

Use logical connections and transitions to connect sources.

We will utilize the Ways Tried and True rubric to organize our findings.

3 Conclusion

The conclusion summarizes the key findings of the review in general terms. Notable commonalities between works, whether favourable or not, may be included here.

This section is the reviewer's opportunity to justify a research proposal (this is a critical step that should be kept in mind throughout this research, given it will be necessary to justify the need for future funding). Therefore, the idea should be clearly re-stated and supported according to the findings of the review.

4 References

As well as accurate in-text citations, a literature review must contain complete and correct citations for every source.

We will use APA style (I can share an APA guide on request).

3 Literature Review Topics

Question/problem:	What are our hypotheses?
Significance:	Why will a given topic be important for the goals of the XX project and for XX Community members / citizens?
Primary resources:	The main data sources will be…
Secondary sources:	Where can you find secondary sources (grey literature and spoken word)
Methods:	The research will be conducted as follows...
Justification:	The method is most appropriate because...
Limitations:	What are the foreseeable limitations [what are the shortcomings of the methodology in explaining some aspects of the topic]

4 General Inspirations and Advice for Literature Reviews

After reading your literature review, it should be clear to the reader that you have up to-date awareness of the relevant work of others, and that the research question you are asking is relevant. However, don't promise too much!

When readers come to your paper, they will not just assume that your research or analysis is a good idea; they will want to be persuaded that it is relevant and that it was worth doing.

They will ask questions such as:

- What research question(s) are you asking?
- Why are you asking it/them?
- Has anyone else done anything similar?
- Is your research relevant to practice/theory in your field?
- What is already known or understood about this topic?
- How might your research add to this understanding, or challenge existing theories and beliefs?

Critical Thinking

It is important that your literature review is more than just a list of references with a brief description of each one. Merriam (1988:6) describes the literature review as:

> *'an interpretation and synthesis of published work'.*

This very short statement contains some key concepts, which are examined in the table below.

Concept	Explanation	Associated critique
Published work	Merriam's statement was made in 1988, since which time there has been further extension of the concept of being '**published**' within the academic context. The term now encompasses a wide range of web-based sources, in addition to the more traditional books and print journals.	Increased ease of access to a wider range of published material has also increased the need for careful and clear critique of sources. Just because something is 'published' does not mean its quality is assured. You need to demonstrate to your reader that you are examining your sources with a critical approach, and not just believing them automatically.
Interpretation	You need to be actively involved in **interpreting** the literature that you are reviewing, and in explaining that interpretation to the reader, rather than just listing what others have written.	Your interpretation of each piece of evidence is just that: an **interpretation**. Your interpretation may be self- evident to you, but it may not be to everyone else. You need to critique your own interpretation of material, and to present your rationale, so that your reader can follow your thinking.
Synthesis	The term '**synthesis**' refers to the bringing together of material from different sources, and the creation of an integrated whole. In this case the 'whole' will be your structured review of relevant work, and your coherent argument for the study that you are doing.	Creating a **synthesis** is, in effect, like building interpretation upon interpretation. It is essential to check that you have constructed your synthesis well, and with sufficient supporting evidence.

References

If you can find a few really useful sources, it can be a good idea to check through their reference lists to see the range of sources that they referred to. This can be particularly useful if you find a review article that evaluates other literature in the field.

Hand searching of journals

No electronic literature search can be 100% comprehensive.

Often hand searching of journals will reveal ideas about focus, research questions, methods, techniques, or interpretations that had not occurred to you. Sometimes even a key idea can be discovered in this way.

Blaxter et al. (2001:103) recommend this method, in addition to other more systematic methods, saying:

> *'Take some time to browse – serendipity is a wonderful thing.'*

Keeping a record of your search strategy is useful, to prevent you duplicating effort by doing the same search twice, or missing out a significant and relevant sector of literature because you think you have already done that search. Increasingly, examiners at post-graduate level are looking for the detail of how you chose which evidence you decided to refer to. They will want to know how you went about looking for relevant material, and your process of selection and omission.

Plagiarism is regarded as a serious offence by all Universities, and you need to make sure that you do not, even accidentally, commit plagiarism.

It is important to keep control of the reading process, and to keep your research focus in mind. Rudestam and Newton (1992:49) remind us that the aim is to 'Build an argument, not a library'.

References

1. Blaxter L., Hughes C. & Tight M. (2001) How to research. Buckingham: Open University.
2. Merriam S. (1988) Case study research in education: a qualitative approach. San Francisco, CA:Jossey-Bass.
3. Rudestam K. & Newton R. (1992) Surviving your dissertation. London:Sage.

5 Sample Methods Write-Up

5.1 Research Team Process

The literature review team is composed of four Haudenosaunee student researchers, a research consultant and the XX project manager. We first met on May 8th, 2017 at XX Building to become acquainted, hear an overview of the project to date, discuss our role in the project and decide on a course of action going forward. Each team member was responsible for a different research topic but we worked through a collaborative process – by sharing knowledge, strengths, resources and contacts, to aid each other in the four different areas of the literature review and through collective decision-making. We met regularly throughout the process, approximately once a week, to check-in with each other regarding our progress and to discuss any concerns or issues.

5.2 Meeting with Project Collaborators

Another key aspect of this process was meeting with the project manager and the organisations and funders involved in the mental health services integration project. The research team met with and presented at the collaborators group meeting on June 23rd, 2017 at XX Building and with the funding government representatives on June 29th, 2017 at the Local Health Integration Network (LHIN) in Grimsby, ON. These were opportunities for the researchers to share our progress to date and get feedback from all the key stakeholders.

This was also helpful to get a better understanding of the project and all the people involved after coming into the project as an outsider. These meetings helped solidify what exactly was expected from us (the research team) so that we could deliver meaningful and useful information to the group.

5.3 Literature Review Process

There were five main steps of the literature review process:

Step 1: Make Contacts with Expert Collaborators to Identify and Access Key Documents and Resources

The initial step was to contact those in the mental health sector to direct us to relevant literature on each topic. For this topic, we searched the websites of other Haudenosaunee communities to ascertain whether or not they had developed a policy framework for mental health services. We contacted the health directors at some of the communities, such as Oneida on the Thames and Ahkwesáhsne to find out if they had any policy frameworks for their own communities – which they did not. However, we were directed to the Thunderbird Partnership Foundation who published the *First Nations Mental Wellness Continuum Framework*, which was a key document in this review. The *First Nations Mental Wellness Continuum Framework* was used as a starting point to establish fidelity elements.

Step 2: Locate Policy Documents that Mandate Service Provision

The second step of this process was to identify policy documents that mandate mental health service provision for Indigenous peoples in Canada. I identified several sources which demonstrated the policy context for Indigenous mental health care. This included such documents as the Mental Health Strategy for Canada, Ontario Aboriginal Health Policy, the Truth and Reconciliation recommendations, and the United Nations Declaration on the Rights of Indigenous Peoples.

Step 3: Locate Key Guiding Documents to Identify Elements for the Fidelity Index

The First Nations Mental Wellness Continuum Framework (FNMWC) (Assembly of First Nations & Health Canada, 2015) was identified as a comprehensive framework within which key elements for developing a policy framework had already been researched thoroughly. This meant that it was a key document to help guide the inclusion and review of other policy frameworks.

After briefly reviewing the FNMWC for key elements, I searched Google for "Aboriginal or Indigenous mental health strategy or policy framework". I downloaded policy frameworks at the regional, provincial, national and international level that focused on mental health or addictions strategies for Indigenous populations. I did not include documents that did not focus on either mental health or addictions and were not directed towards Indigenous populations.

After locating several documents, I met with the project manager to confirm what elements the collaborating organisations would be interested in having more information about. This meeting helped clarify that I was on the right path in terms of the review of the policy frameworks and I was able to proceed.

Step 4: Use "Ways Tried and True" to Identify Documents for Inclusion in Fidelity Index

All the researchers used the Aboriginal Ways *Tried and True Assessment Rubric* (See Section 7) to assess the quality of a document before including it in the fidelity index. Each policy framework was scored from 1-4 based on the degree to which it met the following criteria: community-based; building on community strengths and needs; wholistic; integration of Indigenous cultural knowledge; partnership and collaboration; sustainable approach; and evaluation and effectiveness.

For this particular topic, the category "evaluation and effectiveness" was not assessed because it asks the degree to which an intervention had the desired outcome. In this case, there was no realistic method to assess whether a policy framework had achieved the desired outcomes because this would require an in-depth analysis of the health status in each country or region that was included in the literature review.

Policy frameworks that scored 60% or higher on the *Aboriginal Ways Tried and True Assessment Rubric* were included in the fidelity index. In total, 8 policy frameworks were reviewed and included in the fidelity index for this topic (see Section 6).

Step 5: Read Mindfully the Included Documents and Organize Elements into the Fidelity Index

The final step of the literature review process was to review each of the policy frameworks that had passed the *Aboriginal Ways Tried and True* criteria for inclusion and identify fidelity elements for the index (see Section 6). As the FNMWC had already identified several key elements these were used in the fidelity index as a starting point. The following policy frameworks that were reviewed were included under these themes, and new ones were added as necessary.

From the eight policy frameworks that were reviewed, nine key elements were identified:

1. Culture as foundation
2. Community development, ownership and capacity building
3. Quality care system, competent service delivery and skilled workforce
4. Elements of a comprehensive continuum of care
5. Supporting groups with complex or specific needs
6. Collaboration and communication with partners
7. Enhanced flexible funding
8. Increasing the evidence base
9. Implementation of policy and governance structure

The elements that were identified are not in order of importance or relevance. Each of these elements will be explored in greater detail in the next section.

6 Using a Fidelity Index to Organize Research Themes

6.1 Developing a fidelity Index

A fidelity index is an alternative approach that enables the identification of key activities, processes or approaches to program or policy initiatives.

The assumption is that once the key elements of programs or policies are documented, that there is confidence that a specific set of processes will result in x, y, z outcomes. The fidelity index prioritizes key elements which contribute to program or policy success.

Each index should have about 10 – 12 elements, however there may be fewer. These elements should be defined using literature. Literature should be sought which demonstrates the impacts of the elements. For example, the element is demonstrated in the literature to impact youth resilience and physical and mental health.

A fidelity index is developed by identifying three major items and is developed using three columns for ease of access.

1. The first column identifies the elements themselves. This is a statement of the element.
2. The second column provides brief points on the aspects of each of the elements, such as the specific detail which support the element. For example, the element reaches the fullest potential impact when a community worker is regularly supported by a case manager and the community worker receives supportive training.
3. The third column lists the literary references that support links to impacts / outcomes and provides fuller detail about the qualities which support the elements in the program or policy design.

6.2 Sample Fidelity Index Write-up

This section will include a review of each of the nine fidelity elements in greater detail, and discuss their relevance and importance and highlight anything noteworthy from the fidelity index.

Culture as Foundation

The importance of culture in guiding all aspects of the health system was stressed heavily. For example, culture should guide program development, delivery, implementation and evaluation so that the care that is being received is culturally relevant and appropriate. Reporting and evaluation of activities should be developed and designed to measure success as it is defined by a Haudenosaunee perspective.

There also needs to be an understanding among service providers and funders of what Haudenosaunee culture is, so that services are accurately reflecting the needs of the Six Nations community. This can be achieved through cultural competency and safety training and embedding it into healthcare practices.

Another key point that was discussed frequently was considering the role of language in the healthcare system. The community should have the option to receive healthcare in their language of choice. This means that service providers should be able to deliver services in a Haudenosaunee language.

Community Development, Ownership and Capacity Building

Ensuring the community has meaningful control at all service levels including design, delivery, implementation, and evaluation was a key theme. This means that there should be greater flexibility at the community level to make changes based on their needs and priorities. This would include flexibility to adjust and adapt programs, and ability to modify funding arrangements, such as implementing block funding models. Greater community control and ownership over the health system will ensure that the needs of the community are being met.

Increased access to training and skills development opportunities for service providers, especially Six Nations service providers, is essential to building capacity within the community. More Six Nations service providers who are well trained and educated and working in the healthcare system will help ensure that community priorities are being reflected in service provision.

Establishing **Partnership Agreements** is demonstrated in the NSW Aboriginal Health Partnership Agreement 2015 – 2025[1] with with the community can increase self-determination as the community is able to determine what is relevant to them and to participate in determining how services will be provided. For example, the New South Wales Aboriginal Health Partnership Agreement 2015-2025 is a signed agreement between the NSW Department of Health (in Australia) and the governing body for Aboriginal health, which establishes clear collaborative service delivery processes. Developing partnership agreements would be an effective way to deliver services that reflect community priorities.

1. http://www.health.nsw.gov.au/aboriginal/Documents/Aboriginal-Health-Partnership-Agreement.pdf

Quality Care System, Competent Service Delivery and Skilled Workforce

There was great emphasis on developing a solid continuum of care and skilled workforce to provide the best possible care to the community. The first element of a quality care system is that it prioritises and is responsive to community needs. Secondly, it must be culturally "competent". It is up to the community to define what "competence" means in the context of healthcare. However, a culturally competent care system would offer trauma-informed care that recognises the impact of colonization on the community.

A quality care system can be developed by **defining program and service delivery standards** and establishing a set of **clear roles and responsibilities** of service providers, funders, managers, etc. This point was stressed in several of the policy frameworks. This will ensure that clients know what to expect when accessing services and the organization has clear **obligations and responsibilities** to fulfill. It would also be useful to develop performance measurement tools to assess the organisation or programs effectiveness.

Developing a quality care system also involves investing in the workforce by increasing formal and informal professional development opportunities and training, creating safe work environments and fostering worker wellness.

The National Native Addictions Partnership Foundation (NNAPF, n.d.) has developed a guide called *Worker Wellness Guidebook: Employee and Employer Roles and Responsibilities*[2] which outlines the importance of self-care and provides strategies for creating a safe working environment. It also describes employee and employer responsibilities for supporting worker wellness. It also includes such things as an example of an Employee Performance Appraisal Form which could be used in an organisation to track employee performance.

There were several good examples from Australia on how to develop the Indigenous mental health workforce. This included the *NSW Aboriginal Mental Health Workforce Program*[3] which includes strategies for worker recruitment, training, supervision, mentoring and support and promoting mental health worker qualifications and competencies. There are also two examples of an Indigenous workforce strategic policy framework *Good Health - Great Jobs: Aboriginal Workforce Strategic Framework 2016 – 2020* (NSW Department of Health, 2016) and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework* (Aboriginal and Torres Strait Islander Health Workforce Working Group, 2016).

2. http://thunderbirdpf.org/nnapf-document-library/

3. http://www.health.nsw.gov.au/mentalhealth/workforcedev/Pages/aborig-mh-wrkforce-prog.aspx

Elements of a Comprehensive Continuum of Care

A mental healthcare system will be effective if it provides a strong continuum of care. A strong continuum of care will provide services such as health promotion strategies, prevention, interventions, detox, treatment and aftercare. A first step in strengthening the continuum of care is to identify and address service gaps. This can be achieved through extensive collaboration and communication with relevant partners. Another tool to assess the strength of the continuum of care would be to develop indicators of community wellness and strategize how to improve health status in the community. The First Nations Mental Wellness Continuum Framework has outlined a comprehensive continuum of care which could be used as a model (Assembly of First Nations & Health Canada, 2015).

Supporting Groups with Complex or Specific Needs

A strong continuum of care will recognise and provide adequate services for groups who have complex cases or needs that require specialized attention. This means that mental health care should not use a "one size fits all" approach, and should be adaptable or directed towards the special needs of clients. This could include specific consideration for programming and services for those with co-morbid addictions or physical health issues, in the justice system, youth and children, etc. This will require collaboration between health and social service providers, and training opportunities for the workforce to develop skills needed to treat and interact with clients with complex cases.

Collaboration and Communication with Partners

Extensive collaboration and communication was stressed in all the policy frameworks. This includes ongoing collaboration between all relevant organisations, levels of government, community members and funders and even extending the network beyond. Effective collaboration requires establishing strong leadership amongst the involved parties who are able to model the types of relationships that are necessary.

A tool for clearly articulating roles and responsibilities is to develop a **Memoranda of Understanding** or **Relationship Agreement**, which can help increase understanding and accountability for all parties involved. An example would be the Relation Agreement established by First Nations groups in British Columbia which outlines the roles, responsibilities and accountabilities of each partner (First Nations Health Council, First Nations Health Authority, & First Nations Health Directors Association, 2012). An example here in Ontario is the Aboriginal Healing and Wellness Strategy.

In addition, in Six Nations, O Gwadeni:deo has developed a model collaboration agreement that they use for outlining relationships and responsibilities with other organizations.

Enhanced Flexible Funding

A huge barrier to making progress in improving mental health is not only the underfunded areas along the service continuum, but the lack of flexible funding arrangements to address community needs and priorities. Going forward, it would be beneficial to eliminate barriers such as project-based, time-limited and siloed funding models. This flexibility would allow communities to carry over or redirect funding into other areas as needed.

Increasing the Evidence Base

In order to identify whether or not interventions and programs are having a positive impact it is necessary to **monitor health status** changes over time. Therefore, it is necessary to create **coordinated research activities** as well as **performance measurement tools** to build a stronger evidence base and understand what works and why. It is also necessary to identify *Haudenosaunee-specific health status indicators* that can be measured and monitored on a regular basis.

Implementation of Policy and Governance Structure

Proper implementation of policy requires a governance structure that can support the process. This could be in the form of a **Mental Health Authority**, who's responsibility it would be to develop an implementation and evaluation strategy for mental healthy policy, establish key performance indicators, and oversee research.

The FNHA was established through the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* and can therefore act as a model for a successful governance structure. The FNHA has a simplified version of the governance structure, as well as an outline of roles and responsibilities for partners.

The World Health Organization has developed series of 13 modules called the *Mental Health Policy and Service Guidance Package*[4] to help establish a mental health governance structure for policy development and service planning[5]. The WHO suggests starting with the *Mental Health Policy, Plans and Programmes* module because it is a detailed guide for developing and implementing policy and using the other modules in conjunction as needed[6].

This resource would be best used as a starting point for developing mental health policy in Six Nations because the purpose of the package is to assist policy-makers and service planners in addressing mental health. These modules are accessible, and easy to follow and understand and provide clear, direct steps for implementing the WHO's recommendations.

4. http://www.who.int/mental_health/policy/essentialpackage1/en/

5. See WHO Checklist for Evaluating a Mental Health Plan http://www.who.int/mental_health/policy/WHOPlanChecklist_forwebsite.pdf and WHO Checklist for Evaluating a Mental Health Policy to help draft a mental health policy and plan and to evaluate their adequacy http://www.who.int/mental_health/policy/WHOPlanChecklist_forwebsite.pdf?ua=1

6. See WHO Mental Health Policy and Service Guidance Package for a brief description of each of the 13 modules in the package (scroll down a bit on the web page to find the 13 modules: http://www.who.int/mental_health/policy/essentialpackage1/en/

7 Using Ways Tried and True to Rate Interventions

Ways Tried and True was developed for the Aboriginal Methodological Framework for the Canadian Best Practices Initiative.

The purpose of the Ways Tried and True Framework is to provide a step-by-step guide to support the:

- Identification of Aboriginal public health interventions, and
- Application of the Ways Tried and True (WTT) assessment process to identify interventions to be included on the portal.

The interventions selected using the Ways Tried and True Framework assessment process, are intended to inspire and support public health practitioners, program developers, evaluators and others by sharing information on programs and processes that have been proven as moving Aboriginal peoples into a cyclical motion encompassing positive transformation. Given the great diversity of Aboriginal communities, peoples and cultures, it is not expected that any one intervention will work for all possible applications. However, it is hoped that in sharing examples from specific contexts, the insights and lessons learned will benefit others, to launch new services, adjust programming, or provide insights into new policy.

The assessment process consists of two tools: a screening checklist and a rubric. The process was shaped by: 1) input from the expert working group; 2) Aboriginal community-based health practitioners and researchers (totaling 82 professionals); and 3) a review of the literature. See appendix A for the list of Ways Tried and True Working Group members.

For details on the rationale and theoretical foundation of the assessment tools and processes please see the Ways Tried and True: Aboriginal Methodological Framework (WTT Framework).

http://publications.gc.ca/collections/collection_2015/aspc-phac/HP35-59-2015-eng.pdf

7.1 Intervention Assessment: Approach And Methodology

The section below outlines the criteria and steps that are used to assess and select interventions for the WTT section of the Best Practices Portal (BPP), including the tools that reviewers will use to evaluate interventions. Assessment involves four steps:

1. Identify interventions
2. Apply screening criteria to interventions
3. Score interventions according to the rubric
4. Create an annotation file for interventions scoring at least 16 of 24 possible points.

Step 1: Identifying Interventions

The following provides some guidelines for identifying Aboriginal interventions as these interventions may not be well-represented in commonly used sources such as academic journals.

1. Targeted review of literature and resources

There are a number of organizations that have collected information on best practices, promising practices and/or Aboriginal research and evaluation studies. A listing of sites and reports are identified in the table below. Over time new sources will emerge and as such this list should be seen as a starting point and should not preclude investigation of other compilations of public health interventions in Aboriginal contexts.

Table 1. Sites for Targeted Literature Reviews

Name Of Organization	Web Link	Findings/Observations
Health Council of Canada's Innovative Practice Portal[7]	http://innovation.healthcouncilcanada.ca/sites/default/files/Page%20PDFs/IP_Framework_Eng_final.pdf	• Includes 118 Aboriginal-specific practices. • Differentiates between emerging, promising and leading practice. • Specific focus on maternal child health initiatives.
McMaster Health Evidence	www.healthevidence.org	• Summaries of predominately academic review papers. • Includes 37 Aboriginal-specific /Aboriginal-inclusive reviews. • Rating scale differentiates between strong, moderate and weak evidence.
ASTIS (Arctic Science and Technology Information System) Database	http://www.aina.ucalgary.ca/scripts/minisa.dll?HOME	• Inuit specific research and publications.
Aboriginal Health Research Directory	http://ahrnets.ca/database/	• A database of Aboriginal health research.
Métis Health Research Database	http://www.metiscentreresearch.ca/find_articles	• A database of Métis specific research.

6. The Health Council of Canada is no longer operating; however Carleton University library is maintaining the site.

2. Systematic review of the literature

Aboriginal interventions are likely to be multi-disciplinary, as such while the standard medical search engines may prove useful; other inter-disciplinary search engines should also be consulted. Further, the gray literature will be an important source of Aboriginal interventions and general Google searches will also prove useful.

- Google
- Google Scholar
- PubMed
- Scopus
- Cochrane Library
- ERIC
- Sociological Abstracts
- Social Services Abstracts

For further details on searching for reviews of public health interventions, see: www.vichealth.vic.gov.au/cochrane.

3. Soliciting volunteer submissions

Given what we know about the state of evaluation in Aboriginal contexts, we anticipate that submissions from volunteers will be an important source for identifying interventions. Invitations to submit interventions should be signed and distributed by the Agency. Interventions may be solicited through a number of communication channels including:

- Working Group members, consultants and staff distribute an invitation to their contacts.
- Disseminated through NationTalk[8], the Ontario Public Health Bulletin (OPHB), the bimonthly e-bulletin of the University of Victoria Centre for Aboriginal Health Research (CAHR), and/or in the National Collaborating Centre for Aboriginal Health's quarterly e-newsletter.

Depending on the topic, it may prove worthwhile to conduct key stakeholder interviews to find out about innovative and successful programming.

Step 2: Apply Screening Criteria to Interventions

The following criteria will be applied to all retrieved interventions. An intervention not meeting all of the criteria will not be considered for further analysis. These criteria are based on the Agency's current *Promising Practices* exclusion criteria with some adaptations to be consistent with Aboriginal approaches.

8. NationTalk press release advertisements or announcements start at $172.00 Cdn.

Table 2. Screening Checklist for Ways Tried and True
The following checklist will be applied to all interventions. Interventions that do not meet **all** of these criteria will be excluded from further review.

Basic Screening Checklist	
Impact: Positive results are reported.	• Yes • No (Exclude)
Community Involvement: Must demonstrate at least minimal involvement from the community in planning, developing, implementing and/or evaluating the intervention. If the intervention is introduced to the community from outside (i.e., government, NGO, researcher), it must be clear that the community has had at least some input into adapting and/or implementing the intervention.	• Yes • No (Exclude)
Quality of Evidence: Sufficient information is available to evaluate the effectiveness of the intervention. Accepted quality of evidence includes: peer reviewed reports/journal articles, gray literature reports, internal reports, reports emphasizing lived experiences and using Aboriginal specific data collection methodologies including story-telling, talking circles, and testimonials. Digital stories in the form of videos, blogs and other formats will also be accepted as evidence.	• Yes • No (Exclude)
Focus: Addresses a chronic disease or health promotion topic using a community-based or population health approach. (**Excluding clinical interventions**)	• Yes • No (Exclude)
Source: Authoritative/credible source of the intervention with contact information readily available. Credible sources include: community-based developers, academic partners, evaluators, researchers, peer reviewers etc.. Interventions must have been developed free of commercial interests that may compromise integrity.	• Yes • No (Exclude)

Step 3: A Rubric for Identifying Aboriginal Practices

The rubric on the following page was constructed based on the literature (described in the WTT Framework) and the operational definitions provided in Appendix A. This rubric will be used by reviewers to assess Aboriginal-specific interventions that have passed the screening checklist criteria.

A rating scale of one to four is provided for each of the six criteria. Four is considered a high score and one is a low score. Reviewers provide a rating between one and four for each criterion based on the source documents provided. In some cases it may be necessary to consult with those implementing the initiative to obtain additional information. Reviewers should assign the point value that most closely aligns with the reported evidence. Each intervention will receive a rating for each criterion as well as a total score out of 24. Only those rated at 16 points or higher will be annotated. An assessment matrix like the one in Appendix B should be developed to support the assessment process.

The following is a step-by-step process for applying the rubric.

1. All interventions are screened in or out on the basis of the screening tool (in most cases this can be done by reviewing an abstract and/or project summary).
2. Each screened-in intervention is given a score (1-4) on each *Ways Tried and True* criteria as well as an overall score (out of 24).
3. A brief rationale and examples are prepared for each rating assigned.
4. Interventions that score 16 or higher will be included on the *Ways Tried and True* section of the Portal
5. Quality Control: Interventions are assessed by two reviewers. If discrepancies arise, the reviewers need to reach a consensus on the final rating, together.

Table 3. Ways Tried and True: Aboriginal Assessment Rubric within Public Health Interventions

Criteria	Criteria #1: Community-based	Rationale/ Examples
Definition	The degree to which First Nations, Inuit, Métis stakeholders (community members, service providers, community leaders, Elders) are involved in the planning, design, delivery, adaptation and evaluation of an intervention.	
1	The idea for the intervention comes from outside of the community[9] and is implemented with limited community involvement (involves the community without formal structures such as a project committee).	
2	Adaptation of a mainstream approach to an Aboriginal context, with structures (committees, preplanned community engagement meetings) involving the community in the adaptation.	
3	The intervention is based on a need identified by the community and is led by community members, but rooting of the intervention within the systems of the community has not yet taken hold.	
4	The intervention is based on a need identified by the community and a strong community process is established. For example, action taken from within the community to address the need and ownership of the intervention (e.g., design through to evaluation) is deeply-rooted within the systems of the community.	
More Information Required		

9. Community refers broadly to a grouping of people and may include a First Nations reserve, an urban community, or a Métis or Inuit settlement

Criteria	Criteria #2: Wholistic	Rationale/ Examples
Definition	The degree to which an intervention addresses multiple issues from a wholistic approach on each of the following (4) dimensions: (1) Wellness: mind (knowledge development, awareness, skills), body (physical activity, nutrition), emotion (relationships, healing), spirit (mental wellness, confidence, self-esteem, coping) [e.g., medicine wheel model may be used] (2) Implementation environments (e.g., school, community, home, workplace, businesses) (3) Nature of target group (e.g., children, youth, Elders, families, community members or leaders, organizations) (4) Involvement of cross sector departments (e.g., education, health, governance, justice, social services)	
1	The intervention is one dimensional (one target group, one activity, one partner) and has not engaged a wholistic perspective.	
2	The intervention addresses a few dimensions but remains limited in terms of targeted implementation environment, view of wellness, involvement of community partners and participants.	
3	The intervention is multi-dimensional has targeted multiple implementation environments, participant groups, departments in the community and is based on a wholistic view of health.	
4	The intervention is wholistic, targeting numerous environments (school, home, work), and/or participant groups (children, Elders, families, community leaders), community departments and implements a wholistic view of health.	
More Information Required		

Criteria	Criteria #3: Integration of Indigenous Cultural Knowledge	Rationale/ Examples
Definition	The degree to which the intervention formally addresses and incorporates the values, culture, shared experiences and principles of the community or group in which it operates.	
1	Values, knowledge, culture and community perspectives play an informal role in the intervention (e.g., an articulated theory, process or structure has not been identified).	
2	Indigenous knowledge has been used to adapt a mainstream approach using an articulated theory, process and/or structure; however not within a community participatory process.	
3	Articulated structures (committees, focus groups, processes) are in place to ensure that Indigenous knowledge is applied to the intervention within a participatory process.	
4	The values, culture, and perspectives of the community are integrated into and continue to inform all aspects of the intervention, from planning through to implementation.	
More Information Required		

Criteria	Criteria #4: Building on Community Strengths and Needs	Rationale/ Examples
Definition	The degree to which an intervention recognizes community capacity or readiness (identifying strengths and weaknesses within the implementation environment) at the outset, and builds-in mechanisms to leverage strengths and fill gaps through the implementation process.	
1	Intervention shows informal acknowledgement of community strengths and needs (gaps). Capacity may be being built, but not among First Nations, Inuit or Métis peoples within the community.	
2	Intervention design formally acknowledges and builds on strengths of First Nations, Inuit or Métis peoples. Members of these groups within the community are building limited skills and/or resources as a result of the intervention.	
3	Intervention design acknowledges and builds on strengths of the community and attempts to fill gaps in community expertise, resources, services (e.g., the community staff, members are building extensive skills, resources as a result of the intervention).	
4	The intervention contributes to a growing and evolving community and is an example and inspiration for others (e.g., intervention team has expanded program based on initial success; other First Nations, Inuit or Métis peoples are using the intervention as a model).	
More Information Required		

Criteria	Criteria #5: Partnership and Collaboration	Rationale/ Examples
Definition	The degree to which the intervention is supported by other organizations or institutions within and/or external to community (federal, provincial, municipal government, NGOs, institutions). The emphasis is on collaborative approaches to addressing needs/issues. **Funders are only counted as partners if they provide more than funding to the relationship.	
1	There are no collaborative relationships or partnerships associated with the intervention.	
2	The intervention utilizes a collaborative approach which defines a strategy for involving partners or collaborators; however, there have been substantial challenges in implementing the plans or involving partners.	
3	The intervention involves active partners and/or collaborators who are guided by a collaborative strategy; however, there is room for improvement in deepening the partnerships/ collaborative relationships (e.g., a few challenges have been identified with partnerships).	
4	The intervention involves active partners and/or collaborators who are guided by a collaborative strategy, and these partnerships and/ or collaborations are recognized (i.e., by the community) for their contribution to addressing needs/issues (e.g., the identification of project champions may be an indication of the quality of relationships).	
More Information Required		

Criteria	Criteria #6: Effectiveness	Rationale/ Examples *Include examples of all outcome types*
Definition	The degree to which an intervention has achieved significant (substantive[10] or statistical) positive intended and/or unintended outcomes among target groups (e.g., program participants, communities, organizations, and/or partners).	
1	Emerging data suggests positive outcomes among target groups, but reporting is preliminary or limited (i.e., the evidence is based on early stages of implementation and/or evidence is limited or difficult to verify)	
2	Significant achievement (substantive[11] and/or statistical) of knowledge and /or awareness change among the target group(s). Limited partnership, networking and/or development of organizational capacity among the target group(s).	
3	Significant achievement (substantive[12] and/or statistical) of positive outcomes (e.g., attitudes, intentions or values, building partnerships, networks, and developing organizational capacity) among the target group(s). Achievement of some positive behavior change outcomes however, changes may not yet be statistically or substantively significant among the target group(s).	
4	Significant achievement (substantive[13] and/or statistical) of positive behavior change outcomes (e.g., personal or professional practice change, organizational/ systems, and/or policy change) among target group(s).	
More Information Required		

10. The term substantive significance is applied broadly to mean more than the quantitative effect size but inclusive of qualitative or practical considerations such as cultural, political, or economic significance. Stated another way the substantive significance refers to the degree to which the findings are significant within the community and context in which they are observed.

11. Ibid 2

12. Ibid 2

13. Ibid 2

Step 4: Annotation File

Once it is determined that an intervention is screened-in and scores 16 or more on the Rubric, an annotation file is prepared for each intervention. The *Ways Tried and True* will use the same annotation file that is used for *Best Practices* and *Promising Practices*. The annotation file is critical as it gathers important information about the context in which the intervention was carried out and is the information that will be shared with end users. The areas covered by the annotation file include: citation information and links, general description of the intervention, context of the intervention, implementation of the intervention, evaluation design of the intervention, intervention outcomes, adaptations, limitations, successes and key words.

A concise informative abstract of the initiative is formulated for each intervention utilizing the annotation file, denoting impetuous for start-up, wholistic features, Indigenous cultural knowledge priorities, and ways of in which community strengths were harnessed.

7.2 Operational Definition of Terms

While there is general agreement on the importance of these six basic concepts, less information is available on the operational definition of these terms. We have therefore developed operational definitions based on the literature and our experiences working in the field. These categories are not mutually exclusive; intervention elements are interconnected, consistent with the Aboriginal view of health and wellness, as described in section 3.1 below.

Community Based

In the context of the WTT Framework, the concept of community-based intervention is defined by the degree to which Aboriginal stakeholders (community members, service providers, community leaders, Elders) are involved in the identification of the need, planning, design, delivery, adaptation and evaluation of an intervention. A gold standard scenario is one in which an intervention is developed by the community (likely in partnership with others) based on an identified need or health priority.

The literature strongly supports locally driven interventions rooted in the context of community (Reading et al., 2007; AHF, 2006; Marriot & Mabel, 2001). Interventions that are strongly based in the community and have a high level of buy-in are more likely to demonstrate success or to be adapted to ensure they work, because of a vested interest by the community (Barron, 2003).

To say that a program or intervention is community-based may mean different things to different people, and gradations exist in the level of involvement an Aboriginal community or other stakeholders may exhibit in bringing an intervention to life.

To be considered for *Ways Tried and True*, interventions must demonstrate involvement from community.

Wholistic Approach

The National Aboriginal Health Organization (NAHO) defined wholistic health care as "an integrative approach – that seeks to balance the mind, body, and spirit with community and environment" (NAHO, 2011). The idea of wholism is strongly related to the SDOH, and more generally to a population health approach, in that wholism naturally recognizes the multitude of factors (socio-economic status, education, family dynamics, and health of a community) at play in reaching a state of wellness or well-being.

While wholistic approaches are favored in both a cultural and academic sense, a common challenge experienced by communities and organizations in developing interventions that are wholistic is the division among funding streams, which can preclude broad level approaches to health and wellness (PHAC, 2013).

In the context of the WTT Framework, the concept of wholism is divided into four key dimensions and is organized after the WTT Wholistic Model of Aboriginal Health (see the WTT Framework):

- Dimension 1: Wellness: mind (knowledge development, awareness, skills), body (physical activity, nutrition), emotion (relationships, healing), spirit (mental wellness, confidence, self-esteem, coping)
- Dimension 2: Implementation environments (e.g., school, community, home, workplace, businesses)
- Dimension 3: Nature of target groups participants (e.g., children, youth, Elders, families, community members or leaders)
- Dimension 4: Involvement of cross-sector department (e.g., education, health, governance, justice social services)

Wholism is assessed by the degree to which the intervention addresses each of these dimensions in a comprehensive way. The rationale for this approach is that interventions that are inclusive of these dimensions are more likely to be successful. Specifically, wholism should be demonstrated through process aspects that address multiple vantage points, including where the initiative takes place (is it a school-based intervention? if so, does it have a component for parents/families?) as well as the number/nature of stakeholders who are involved.

Integration of Indigenous Cultural Knowledge

The concept of integrating Indigenous cultural knowledge is similar to basis in the community but is more specific. Integration of Indigenous cultural knowledge is defined by the degree to which the intervention addresses and incorporates the values, culture, shared experiences and principles of the community or group in which it operates.

Indigenous cultural knowledge tells us about the values, culture, shared experiences and principles of a community (Alderete, 1996). Kirmayer, Brass, and Valaskakis (2009) (referring to Aboriginal traditions) posit that while rooted in the past, culture is not static, but changes and grows to respond to new ideas and new challenges.

Building on Community Strengths and Needs

Community development is the degree to which an intervention recognizes community capacity or readiness, identifies strengths and weaknesses within the implementation environment at the outset, and includes mechanisms to leverage strengths and fill gaps through the implementation process. Interventions that build on strengths and endeavor to address weaknesses are thought to be more effective (Barron, 2003). A WTT scenario is one in which a community-based program evolves, becoming an example for others as demonstrated through replication of the initiative in other Aboriginal communities.

Partnership and Collaboration

Partnership and collaboration is defined by the degree to which the intervention is supported within a community or organization (other departments or institutions) as well as by those external to the community (federal, provincial, municipal government, NGOs, institutions). Often times the development of the partnerships and collaboration is related to the presence of a project champion and the ability of those leading the project to develop strong relationships. The emphasis, in this case, is on meaningful collaboration between partners aside from existing funding relationships. A WTT scenario is where multiple departments are working together and in collaboration with government/NGOs or other partners to deliver an intervention and a project champion(s) has been identified.

Numerous researchers and experts in the field of Aboriginal health discuss the importance of recognizing, valuing, and integrating "multiple ways of knowing" (Brant-Castellano, 2001; Dion-Stout and Kipling, 2001; Anderson, 2003; Smylie et al., 2004). Indigenous knowledge is an important component as are other types of knowledge. Arguably, these ways of knowing become integrated through a process of partnership and collaboration.

> *Collaboration describes the longer-term and more deliberate efforts of organizations and groups to undertake new, joint activities. Collaboration, or partnership development (the two terms mean the same), is labour intensive* (Labonte 2003, p. 24).

While important in all contexts, partnership and collaboration bears particular significance in many Aboriginal settings as a result of jurisdictional and other historical barriers. The formation of a tripartite health plan between BC First Nations and the provincial and federal governments is lauded as a promising approach to bridging historical jurisdictional gaps as a mechanism to improving health and well-being (PHAC, 2013).

Effectiveness

For reasons discussed in depth in section 3.1, interventions that are successful in First Nations contexts might not always be evaluated, or may use alternative methods for evaluation. In the context of the WTT Framework, interventions must have reported positive outcomes (intended or unintended); however, the outcomes need not be demonstrated through a formal or standard evaluation.

Sufficient information must be available to establish the effectiveness of the intervention. Accepted quality of evidence includes: peer reviewed reports/ journal articles, gray literature reports, internal reports, reports emphasizing lived experiences and using Aboriginal specific data collection methodologies including storytelling, talking circles, and testimonials. Digital stories in the form of videos, blogs and other formats will also be accepted as evidence.

In the context of the WTT Framework, effectiveness refers to the degree to which an intervention has achieved substantive or statistical significant positive intended and/or unintended outcomes among target groups. Targeted groups may be specific cohorts or population subsets (e.g., Elders, youth, teachers, etc.), whole communities, organizations, and or partners. No distinction is made between intended outcomes (outcomes that were anticipated at the outset of an intervention) and unintended outcomes; with the focus instead on positive effects.

Within the definition, both statistical and substantive significance receive equal treatment based on the premise that the methods favoured in Aboriginal contexts may not always be ones that produce statistical data and even when they do, statistical significance may not translate to practical significance. Substantive significance is both a: 1. qualitative (e.g., meaningful or important in advancing social justice and reaching an equitable society), and 2. quantitative interpretation of results (e.g., a mathematical calculation designed to enhance statistical tests of significance). Donald Campbell (1963) defined substantive significance as describing results which are meaningful or important in advancing social justice such as policy changes towards a utopian society. Weiss (2000: 300) provides an example of such a situation. Evaluation results, found to be statistically significant, could "… show little effect-or seriously unpleasant side-effects." In terms of the WTT Framework, the term substantive significance is applied broadly to mean more than the quantitative effect-size but to also include qualitative or practical considerations such as cultural, political, or economic significance. Stated another way the substantive significance refers to the degree to which the findings bear relevance within the community and context in which they are observed. The determination of substantive significance is inherently more subjective but is something that should be able to be judged with some accuracy by those experienced in Aboriginal health.

The nature of the outcomes also bears importance within the definition for effectiveness, with demonstration of outputs being the lowest level demonstration of effect, followed by demonstrated increases in knowledge or awareness, and culminating in behavior change (including personal or practice, organizational/systems and or policy).

A WTT standard would be a scenario in which an intervention has demonstrated significant (substantive or statistical) achievement of positive behavior change outcomes (e.g., changes in: personal or professional practice, organizational/systems, and/or policy) for the target group(s).

7.3 Rubic Assessment Matrix

Intervention Name	Intervention 1	Rationale	Intervention 2	Rationale
Total Score				
Reviewer	1. Vv 2. bb		1. Vv 2. bb	
Citation				
Description				
Community Based				
Wholistic				
Integration of Indigenous Cultural Knowledge				
Building on Community Strengths and Needs				
Partnership and Collaboration				
Effectiveness				
Is the Intervention Adapted From Another Source?				
Other Comments				

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