Ethical Programming: Towards a Community-centred Approach to Mental Health and Addiction Programming in Aboriginal Communities

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Abstract

Individuals who are mentally ill, distressed, or struggling with addiction are among the most vulnerable in any Aboriginal community. However, in addressing their needs, Western medical models of diagnosis and treatment marginalize the historical and social context of their suffering, the social inequities that exacerbate their distress, and the inner strengths and resilience of Aboriginal peoples and their cultures to survive despite ongoing adversity. This paper is grounded in research that has documented the lived experiences of Aboriginal peoples. Learning from this experience, I argue for the

creation and application of an ethical framework in mental health and addictions programming that is led by Aboriginal health care leaders and based upon a blending of Aboriginal and Western understandings of moral governance. With the systematic application of ethical guidelines, success rates for prevention, promotion, and treatment programming will increase because of the added commitment to Aboriginal patients, clients, communities, and organizations; potential harm to vulnerable populations will decrease; and higher levels of trust between government health ministries and different levels of primary health care in Aboriginal communities, specifically community front-line health organizations and workers, will be achieved.

Introduction

The ultimate test of the validity of knowledge is whether it enhances the
capacity of people to live well.
Marlene Brant-Castellano (2000)

Individuals who are mentally ill, distressed, or struggling with addiction are among the most vulnerable in any Aboriginal community. However, in addressing their needs, Western medical models of diagnosis and treatment marginalize the historical and social context of their suffering, the social inequities that exacerbate their distress, and the inner strengths and resilience of Aboriginal peoples and their cultures to survive despite ongoing adversity. This paper focuses on a particular area of contemporary Canadian health care, mental health and addiction front-line prevention and treatment programming, that targets Aboriginal populations. I specifically argue for the creation of an ethical framework based upon a synthesis of Aboriginal and Western standards of moral responsibility to vulnerable populations to be built into the design, delivery, and evaluation of this form of programming.

My argument emerges from research that has documented and analyzed the experiences of impoverished First Nations and Métis women struggling with substance abuse and other mental health problems, including the challenges faced by front-line service providers as they attempt to address and improve both the recovery experiences and the broader health and social determinants that affect the lives of these women (Tait, 2000; 2003; 2006). The research suggests that the primary role played by ethical guidelines in protecting vulnerable populations against experiencing undue harm, such as those found in university-based research or in professional codes of ethics, does not exist simultaneously in the administration and application of front-line men-

tal health and addiction programming for the same populations. However, while this may be the case, I am in no way suggesting that front-line workers, or the disciplines in which they are trained (e.g., social work, addictions), lack moral grounding. Rather, I am concerned about where moral responsibility to clients, front-line workers, and communities lies within the larger bureaucratic structures in which programming is designed and delivered.

The application of research knowledge (i.e., research findings into policy and program delivery) currently receives significant resources and attention from national research and policy bodies. However, successful knowledge transfer in the form of government policies derived from evidence-based research or "best practices" in areas of mental health and addiction programming is hindered by the absence of ethical standards such as those attached to research and clinical or treatment care. As illustrated by the case study presented in this paper, the absence of a primary moral focus potentially makes vulnerable not only the individuals targeted by "best practice" programming, but also the front-line workers and communities responsible for delivering services. Equally important, Aboriginal self-determination as exemplified in health research under the principles of OCAP — Aboriginal ownership, control, access, and possession of research processes and products — generally remains underdeveloped in public health prevention, programming, and evaluation practices despite the significant role that public health programming plays within health care delivery in urban, rural, reserve, and remote Aboriginal communities. While self-government in the form of transfer of service delivery is occurring for some Aboriginal groups, notably Inuit and on-reserve First Nations, the large majority of public health funding for research, policy, and program development is invested in Western methods and models of prevention and treatment. National, regional, and local Aboriginal controlled public health strategies and initiatives derived from Aboriginal knowledge systems receive limited attention and are greatly underfunded, thereby leaving First Nations, Inuit, and Métis peoples to accept or modify underfunded Western models of service delivery to address their public health care needs.[2]

My inquiry is conceived within a critical applied Aboriginal health research (CAAHR) framework that draws upon indigenous scholarship (Ermine

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2.   FNIHB has, in recent years, funded the Assembly of First Nations to develop a public health framework. The report, which became available in 2006, "First Nations Public Health: A framework for improving the health of our peoples and our communities," became the framework upon which 3 pilot projects for a First Nations-generated approach to public health is being implemented. So while movement is slow in coming, recent initiatives such as this are beginning to address the imbalance.

et al., 2004; Ermine et al., 2005; Ermine and Hampton, 2007; Smith, 2005) and studies (Stern and Stevenson, 2006) medical anthropology (Adelson, 2000; Culhane, 1987; Farmer, 2005; Klienman, 1995; Klienman, 2006; Lock and Scheper-Hughes, 1990), feminist scholarship (Swift, 1995; Ginsburg and Rapp, 1995) and liberation theology (Farmer, 2005). A CAAHR framework seeks to challenge normative authority (e.g., government authority, privileging of intellect located within university environments) and to place Aboriginal peoples (individual and collective knowledge, experiences, and historical relations with one another and Euro-Canadians) at its centre. Furthermore, a CAAHR framework examines the ways in which the perceived "neutral" language of Western medicine, science, and government health care policy construct understandings of risk, uncertainty, and danger, and in doing so form the basis upon which a normative deficit-based approach to Aboriginal peoples' health is constructed. Finally, a CAAHR framework does not set aside the pain, suffering, and intergenerational realities and experiences of Aboriginal peoples resulting from colonial assaults, nor does it ignore the resilience and resistance of Aboriginal peoples to historical and contemporary adversity. Rather, a CAAHR framework questions how inequities, perpetuated by bureaucratic structures of government, permit the experiences of First Nations, Métis, and Inuit peoples to be reconstructed in ways that reinforce rather than challenge the ongoing marginalization and oppression of Aboriginal peoples, while simultaneously situating government bodies, including the institutions of Western medicine and science, as centres of authority.

Motivation for writing this paper stems from my interaction over the past decade with a range of stakeholders in Aboriginal health (band chiefs, health directors, nurses, front-line workers, and consumers) who have collectively expressed frustration and mistrust when describing their relationships with federal and provincial governments. While stakeholders in Aboriginal health have for several decades drawn upon Aboriginal cultural knowledge to advocate for the replacement of fragmented bureaucratic models of disease and illness with integrated culturally grounded approaches to health and healing, most feel that their calls have been silenced by more powerful political agendas and government bureaucracies that prohibit meaningful change in this direction.

In this paper I purposely invoke a moralizing strategy in my attempt to argue for distinctive changes to the ways that public health policies and practices are applied in mental health and addiction services targeting Aboriginal populations. More specifically, I seek to replace the primary focus from which

mental distress and addictions are considered, away from one of political and economic based decision-making (e.g., twenty-eight-day treatment programs) to one in which moral governance primarily informs policies and practice. In doing so, I claim solidarity with other stakeholders, offering what I see as pragmatic steps toward addressing the issue of structural violence within our health care system.[3] This answers, to some degree, the question about the role that an academic community-based researcher can play in the struggle for social justice in health care delivery to Aboriginal peoples. Drawing from anthropologist and physician Paul Farmer (2005), I understand that my solidarity with Aboriginal stakeholders and communities must be accompanied by practical arguments and actions that can be used to mobilize changes that diminish unjust hardship and suffering by those most in need. In this context, I equally embrace the role of advocate and academic, and claim health and health care to be a human right and that the actions of our health care system must ensure the safety of those most susceptible to harm. As a researcher, bearing witness to human suffering and despair is not enough, nor is it enough to speak on behalf of or with those who are vulnerable (Farmer, 2005). Instead, pragmatic solidarity pushes the researcher, the university, and government decision-makers towards action that contributes to potential solutions and hope based upon solidarity with the broader Aboriginal leadership and community.

Ethical Space and Cultural Safety

In this paper, I seek to operationalize the concept of "ethical space," which describes a space of possibility that emerges when two groups with distinct worldviews engage with one another in mutual collaboration and respect, creating new channels for dialogue between the groups (Ermine et al., 2004, p. 43). Led by Willie Ermine, the concept of ethical space has been developed by Canadian Aboriginal researchers (Ermine, 1995; Ermine et al., 2004; Ermine et al., 2005; Ermine and Hampton, 2007) to describe the unique requirements of conducting health research that upholds the core value of respectful collaboration between Aboriginal understandings of health and Western scientific knowledge. As a theoretical landscape, the ethical space facilitates de-

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3.   It is important to note that included in this group of stakeholders are government bureaucrats such as regional directors who commonly find themselves caught between their primary concern of supporting Aboriginal individuals, families, and communities in need with that of budget and political constraints that they work under. Commonly the structures under which they work tie their hands in ways that prevent them from creating the necessary conditions for successful implementation of best practice initiatives in Aboriginal communities.

velopment of cross-cultural linkages that are ethically sustainable and strive for equality of thought amongst diverse human communities. However, particularly difficult terrain for this new form of dialogue includes how to reconcile disparate contexts in which the respective knowledge systems are embedded. This means working to reconcile the scientifically based knowledge that defines much of the Western world with the worldview based on participatory consciousness and personal experiences with human, natural, and supernatural relationships found in Aboriginal learning traditions (Ermine et al., 2004). The new enterprise of the ethical space therefore requires cooperation between Aboriginal peoples and Western institutions. The work of this partnership embodies the potential to create new currents of knowledge that flow in several directions and overrun entrenched ways of thinking towards more inclusive, valid, and useful understandings (Ermine, 1995; Ermine et al., 2004; Ermine et al., 2005). In their discussion of health in Cree communities, Ermine and Hampton (2007, p. 345) illustrate this point:

> The process of achieving healthiness is to be found in the tradition of the people. To understand and achieve Cree/Indigenous health requires Cree ethos, to know the contours of Cree culture and traditions and its philosophical contributions to human wellbeing, and to follow these precepts. Unfolding this kind of health knowledge and knowing its determinants can be enhanced through the self-determination of the people that hold that spark of insight.

Further to understanding the application of ethical space to Aboriginal mental health care delivery is the concept of cultural safety. This approach was developed in Aotearao/New Zealand by Ramsden (1993, in Smye and Browne, 2002), a Maori nurse leader, in response to colonizing processes in her country. As an interpretive lens, cultural safety

> prompts us to ask a series of questions to unmask the ways in which current mental health policies, research, and practices may be perpetuating neocolonial approaches to healthcare for Aboriginal peoples. It becomes a vehicle for translating post-colonial concerns into praxis, pushing beyond culturalist approaches to policy. (Smye and Browne, 2002, p. 47)

Smye and Browne (2002, p. 49) argue that in the present context of mental health reform, the concept of cultural safety can be used to inform a series of moral questions about the "rightness" of policy decisions and actions initiated within the dominant health sector, such as,

> Do current mental health services fit well with aboriginal understandings of health, illness and healing, or are they at odds with them given the current so-

ciopolitical environment? How are the myriad social issues such as poverty and homelessness, that serve to curtail the life opportunities of many aboriginal people, and, as such, their health, being addressed by reform? Do the policies being examined and 'reformed' put aboriginal people's health at risk?

Ethical standards informed by the concept of cultural safety and developed and sanctioned by Aboriginal peoples within the ethical space have the potential to reconstitute how provincial, territorial, and federal health ministries and policymakers design, fund, and support front-line mental health and addictions prevention, promotion, and treatment services to Aboriginal populations. Their systematic application would provide a moral framework where medical professional standards[4] (e.g., those held by professional bodies such as Colleges of Physicians and Surgeons or Nurses' Associations) do not play an organizing role for practice. Such a framework would also provide for front-line workers, communities, and organizations a formalized moral framework to invoke when they believe that the quality of service that they are mandated to provide is violating certain ethical principles of health care delivery and respect for human dignity.

My argument also follows closely that of the Aboriginal Healing Foundation (AHF) and their development of ethical guidelines for Aboriginal communities doing healing work (2000). Grounded within Aboriginal values of individual and collective moral responsibility, the Code of Ethics guides Aboriginal communities in the performance of professional responsibilities and expresses the basic tenets of legal, ethical, and professional conduct (2000, p. 1). In this way the AHF provides to communities a formalized framework for maintaining moral accountability to the clients and groups that the programming serves.

In this paper, I argue that the systematic development and application of ethical guidelines will result in the success rates for prevention, promotion, and treatment programming increasing because of the added commitment to Aboriginal patients, clients, communities, and organizations; potential harm to vulnerable populations will decrease; and higher levels of trust between government health ministries and different levels of primary health care in Aboriginal communities, most specifically community front-line health organizations and workers, will be achieved. In the following pages, I specifically focus on the current relationship between government

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4.   As a result of legislation in each province or territory, institutions such as the College of Physicians and Surgeons protect the interest of the public with respect to licensing, medical practice standard setting, and discipline.

funding agencies and Aboriginal communities, rather than programming accountability covered by the AHF guidelines. I do so because I believe this is the starting point from which an ethical framework for mental health and addiction programming can emerge.

Western Ethics

The term "ethic" or "ethical code" refers to a system of principles that govern the morality and acceptable conduct of an individual or group. These principles define what is viewed as right and wrong, and in doing so guide the behaviour of individuals and groups. A contemporary example of ethical guidelines in research is the *Tri-Council Policy Statement (TCPS): Ethical Conduct for Research Involving Humans*, which has been adopted by the three major Canadian research agencies that fund research — Canadian Institutes for Health Research (CIHR), Social Science and Humanities Research Council (SSHRC), and the Natural Sciences and Engineering Research Council (NSERC) (CIHR, 2005). The guidelines are used by university research ethics boards (REBs) to determine whether the methods employed within a given research project pose any threat to the target study population. The guidelines state:

> An ethic of research involving human subjects should include two essential components: (1) the selection and achievement of morally acceptable ends and (2) the morally acceptable means to those end. The first component is directed at defining acceptable ends in terms of the benefits of research for subjects, for associated groups, and for the advancement of knowledge. The second component is directed at ethically appropriate means of conducting research. For example, even in the most promising of research initiatives, the Agencies object to a person being tricked into participating through a promise of false benefit. Part of the moral objection would concern the use of another human solely as a means toward even legitimate ends.

> The objection provides moral insight that proves pertinent to human research in several ways: First, it translates into the familiar moral imperative of respect for human dignity. It is unacceptable to treat persons solely as means (mere objects or things), because doing so fails to respect their intrinsic human dignity and thus impoverishes all of humanity. Second, it translates into the requirement that the welfare and integrity of the individual remain paramount in human research. Thus, the moral imperative of respect for human dignity translates into a number of important correlative ethical principles in research ethics. (CIHR, 2005, pp. 12–13)

Potential harms and benefits in research refer to the negative physical, psychological, social, economic, or legal impacts of research on a subject and/

or on society. Harms and benefits, which may at times be difficult to predict, vary according to the research discipline and the methodology used. Individuals or groups considered to be "vulnerable" from a REB standpoint are those individuals with diminished competence and/or decision-making capacity (Government of Canada, 2004a). The guidelines seek to provide special protection against abuse, exploitation, and discrimination. The Tri-Council guidelines state:

> [G]ood ethical reasoning requires thought, insight and sensitivity to context, which in turn helps to refine the roles and application of norms that govern relationships. Thus because principles are designed to guide ethical reflection and conduct, they admit flexibility and exceptions. To preserve the values, purposes and protection that they attempt to advance, the onus for demonstrating a reasonable exception to a principle should fall on those claiming the exception.... Beyond a keen appreciation for context, effective guiding principles also depend on procedures and policies for their implementation. Indeed, modern research ethics are premised on a dynamic relation between ethical principles and procedures. The relationship is implemented through a mechanism that has emerged in many countries over the last decades and which consists of the articulation of national norms that are applied through prospective ethics review of research projects. (Government of Canada, 2006)

A proportionate approach in a research ethics review holds that the more invasive the research, the greater the care should be in assessing its potential harm (Government of Canada, 2004b). The obligation of researchers to abide by the guidelines is contractual, meaning that the researcher voluntarily adheres to them as a condition for receiving funding. To further support these principles, academic disciplines (e.g., psychology, anthropology, medicine) also have their own particular sets of ethical guidelines.

PROFESSIONAL MEDICAL ASSOCIATIONS

Today, professional associations established under and regulated by provincial statutes govern most health care professions. The associations play a role in policing the ethical conduct of their members and maintaining standards of competence. Where it is believed that professional standards have been breached, the governing organization can take disciplinary action against incompetent or unethical conduct. An example of a professional code of ethics is the Canadian Medical Association Code of Ethics. This code guides physicians, including residents and medical students, and is based on fundamental principles and values of medical ethics, "especially compassion, beneficence,

non-malfeasance, respect for persons, justice and accountability" (Canadian Medical Association, 2008). The code is applied across the spectrum of core activities of medicine, including health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education, and research.

BIOETHICS

Professional bioethics plays an important and necessary role in the delivery of health care. As a subdiscipline of Western medicine, it has opened up a legitimated space to examine moral issues of illness and care (Klienman, 1995, p. 52). Ethical questions examined by bioethicists are for the most part associated with high-priced, high-tech, high-drama biomedical settings, such as neonatal intensive care units, surgical suites, coronary care wards, cancer clinics, and emergency rooms (Klienman, 1995, p. 51). Traditional bioethical principles include respect for personal autonomy, beneficence, nonmalfeasance, and (distributive) justice. The principles provide a framework for determining whether a particular action is ethically acceptable from both individual and community standpoints. However, while a broader range of perspectives are supposed to be considered by the bioethicist, for the most part the contextually rich experience of near illness narratives such as those of patients, their families, and traditional healers are not privileged within a bioethics lens (Klienman, 1995).

> The categories of patients and Indigenous healers are provided with only limited legitimacy; they are after all called 'folk,' a derogatory label. If they can be restated in the abstract terms of the standard bioethical orthodoxy, they are provided a place in the analysis. But if they cannot, then 'folk' categories lose their authoritative imprint to define what is at stake for patients and families. (Klienman, 1995, p. 50)

Klienman (1995) further argues that because medical morality is configured as crisis within bioethics, the mundane worlds of suffering and treatment (e.g., the primary care clinic, the public health nurse's office, local reserve health care centres, settings for traditional healing, front-line prevention, and treatment programming) are given less moral weight than the high-technology setting of the hospital or research clinic. While bioethics obviously plays an important and necessary role in institutional health centres, most illness episodes are experienced, interpreted, and responded to in the context of the family or community. Klienman (1995, pp. 50–51) argues that

> The family — the mundane, cultural setting of illness and care, where local social processes are so greatly influential — together with the workplace frequently disappear in bioethical discourse, to be replaced by the biomedical staging of more extreme, even exotic value conflicts.

Current discussions in Canada about the development of public health ethics reflects a bioethics focus on crisis, whereby a large part of concern is being directed towards responding ethically during a public health crisis, the most recent example being the 2005 SARS outbreak in Toronto. In that case, balancing the rights of the individual with a need to protect the health of the broader population was central. Ethical concern directed towards more mundane public health programs and services, including the experiences of clients, receives only minimal attention to that of widespread crisis situations.

A final point made by Klienman (1995, p. 47) is a critique of the primacy of the individual in Western ethics. He points out that, globally, few members of non-Western societies believe that

> the isolated individual is the locus of responsibility for therapeutic choice, or that therapy should work to maximize the individuation of the sick person, or that personal authenticity is fundamental to health and well-being. Rather, there is usually a paramount sociocentric consensus in which social obligation, family responsibility, and communal loyalty outweigh personal autonomy in the hierarchy of ethical principles.

From this point of view, ethical principles that employ abstract universal concepts of justice and beneficence in decision making appear suspect. Kleinman (1995, p. 48) writes:

> Yet there is also a failure to take into account the local worlds in which patients and practitioners live, worlds that involve unjust distribution of power, entitlements, and resources. It is utopian, and therefore misleading to apply the remote principles of justice and beneficence to ordinary clinical problems, unless we first take into account the brutal reality of the unjust worlds in which illness is systematically distributed along socioeconomic lines and in which access to and quality of care are cruelly constrained by the political economy.

Kleinman's point reflects the importance of cultural safety as it points to underlying reasons as to why mental health reform has failed to address the unique and complex concern of Aboriginal communities. Because mental health programs and services are designed to reflect the dominant cultural (biomedical) views of mental health and illness, they ignore the unique cul-

tural identities, histories, and sociopolitical contexts of Aboriginal peoples (Smye and Browne, 2002, p. 50).

ETHICAL GUIDELINES FOR RESEARCH WITH ABORIGINAL PEOPLES

In the past decade, Aboriginal leaders in health and research have driven the development of ethical guidelines specific to research involving First Nations, Métis, and Inuit peoples. This has largely been precipitated by the design and implementation in the late 1990s of the principles of OCAP.[5] As a political response to the marginalization of Aboriginal interests in the research process, including the interpretation of research data and management of information dissemination, the OCAP principles have become synonymously linked to national and regional arguments for Aboriginal self-determination and governance. The underlying premise of the principles is to assert a clearly defined and ethically sound approach to research that privileges the vested interests of Aboriginal peoples in ensuring accurate research concerning their communities. Collectively, the principles impose an ethical duty upon researchers with regards to cultural sensitivity, informed consent, confidentiality, conflicts of interest, inclusion, consultation, and collaboration. By asserting the principles at local, regional, and national levels, Aboriginal stakeholders have effectively shifted a degree of power from external authorities to their communities, thereby making the process and products of research more meaningful and relevant.

The impact of a shift in power relations has influenced subsequent initiatives focused on ethics and Aboriginal health research. For example, the TCPS guidelines specific to research with Aboriginal peoples fall short of being a definitive framework. Precipitated by attention to the OCAP principles, in May 2007 CIHR (2007) introduced the *CIHR Guideline for Health Research Involving Aboriginal People.* This is an attempt to acknowledge that, "Aboriginal peoples have rights and interests which deserve recognition and respect by the research community" (Canadian Institutes for Aboriginal Health Research, 2007, p. 10). The new guidelines are based upon an acknowledgment that, historically, Aboriginal peoples in Canada have been largely prevented, discouraged from, or punished for using their languages, traditional practices,

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5.   Cathryn George, a committee member from the Association of Iroquois and Allied Indians, is credited with coining three of the four principles (OCA) at a 1998 meeting of the National Steering Committee of the First Nations Regional Longitudinal Health Survey (RHS) (Schnarch, 2004).

and ways of gaining knowledge. The Western scientific research paradigm has predominated mainstream understandings of Aboriginal peoples' health, with First Nations, Métis, and Inuit peoples and their cultures largely being the subjects of university and government-based researchers. In adopting the new guidelines, CIHR is seeking to address past wrongs by reeducating researchers and fostering research that respects the interests and rights of Aboriginal peoples.

The politics of research in this context is a process of negotiation and conflict resolution in which support for a new way of conceptualizing the research process and its products is mobilized and maintained for a common purpose. Unlike the ideals of purported objective research, in this context the researcher/participant relationship is not viewed as being neutral. Rather, it is acknowledged that the relationship can, and most likely will, embody conflicting perspectives and interpretations, power, and prestige differences, as well as contrasting needs and interests (Brant-Castellano, 2000). The following statement by the Royal Commission on Aboriginal Peoples (1996, p. 4) highlights this point:

> The gathering of information and its subsequent use are inherently political. In the past, Aboriginal people have not been consulted about what information should be collected, who should gather that information, who should maintain it, and who should have access to it. The information gathered may or may not have been relevant to the questions, priorities and concerns of Aboriginal peoples. Because data gathering has frequently been imposed by outside authorities, it has met with resistance in many quarters.

The rationale for the development of specific guidelines for research with Aboriginal populations is to acknowledge that within the realm of research, broad historical understandings of European and Aboriginal relations, along with contemporary Aboriginal and Western scientific perspectives, greatly strengthen research outcomes (Royal Commission on Aboriginal Peoples [RCAP], 1996, p. 10). Furthermore, many Aboriginal communities and organizations in Canada are at various stages of creating independent ethical research guidelines and protocols based upon Aboriginal knowledge frameworks. In some cases, legislatures have enacted research requirements (e.g, the Northwest Territories' Scientific Act, which sets out the requirements for obtaining a license to conduct research for the purpose of gathering Western scientific knowledge and/or Aboriginal knowledge).

Legal Liability and Service Provision

An important dimension of health care delivery to Aboriginal populations is front-line prevention and treatment programming. The processes by which various levels of government provide funding and move forward prevention and treatment programming is best characterized as a system by which decisions about front-line prevention and treatment priorities are largely generated at the level of government ministries that then provide program funding to regional and local organizations (e.g. First Nation tribal councils, health authorities, Métis nations or locals, First Nation Band councils, Inuit government bodies) to carry out the work. While health care and paraprofessionals provide the skills and expertise needed to produce an outcome (successful prevention and treatment), government departments provide the funding needed to develop and maintain the process. Because the large majority of prevention and treatment programs are publicly funded, governments are key stakeholders with considerable decision-making power in how the process unfolds.

From a legal standpoint, provincial, territorial, and federal governments have traditionally not been liable in tort[6] for negative outcomes caused by their decisions, either intentional or negligent (Duhaime, 1996) However, this has recently changed somewhat, with the Crown now liable in tort, like any private person or organization. Nevertheless, the government's "Crown immunity" defense persists. For example, in *Just v. British Columbia* (1990), the Supreme Court of Canada distinguished between the policy and operational decisions of a public authority:

> The duty of care should apply to a public authority unless there is a valid basis for its exclusion. A true policy decision undertaken by a government agency constitutes such a valid basis for exclusion. What constitutes a policy decision may vary infinitely and may be made at different levels, although usually at a high degree. As a general rule, decisions concerning budgetary allotments for departments or government agencies will be classified as policy decisions. (Duhaime, 1996, p. 2)

By way of illustration, if a provincial government funds a substance abuse treatment service and later withdraws funding from the program, a client who is harmed by the withdrawal of service (e.g., he/she suffers a relapse) would have a very difficult time holding the government accountable. A government's counterargument to such a complaint might be that the with-

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6.   Tort refers to a wrongful act or an infringement of a right (other than a contract) leading to legal liability.

drawal of funding is a budgetary/policy decision, and should be free from tort liability. Notably, in this example service providers would also not be held accountable for harm caused to their clients because they have very little, and in most cases no, decision-making power as to how government funds are allocated.[7] Because service providers cannot assure a client that a program will continue indefinitely, they cannot be held strictly liable for all the consequences of their client's reliance on the service (Smyth and Soberman, 1983). Therefore, when a client seeks a service that addresses a substance abuse problem, he/she is accepting a certain amount of personal risk. Difficult cases are those that arise from the poor design and delivery of a service but which nevertheless are not of the type arising from alleged breaches of professional ethical standards or legal liability.

In the absence of legal responsibility, how are front-line prevention and treatment services, and the government ministries that fund, design, and evaluate them, held accountable to the clients to whom they provide services? As stated previously, a formalized set of ethical standards to ensure that clients are protected from undue harm from front-line prevention, promotion, and treatment services does not exist. While a client may assume that a government-funded front-line health service is designed and delivered according to professional standards and practices that have built-in mechanisms to minimize harm, funding cutbacks, an unskilled or poorly trained workforce, and inappropriate timelines can all significantly contribute to vulnerable clients being placed at considerable emotional and psychological risk.

Currently, a client possesses the legal right to hold a public health service liable only in cases where a serious breach of professional ethical standards occurs. However, when a service or program fails a client in ways that the harm caused is not considered significant enough to initiate professional or legal sanctions, this does not mean that the client did not suffer significant harm, personal loss, or injury. That is a situation with which most individuals and agencies that provide community-based programming to vulnerable populations are familiar. Contributing to this problem, in almost all situa-

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7.   Funding for programming is dispersed to government departments such as, at the federal level, First Nations and Inuit Health Branch. The funding is attached to a specific initiative with defined deliverables on which the department must report back to the Treasury Board. Contribution agreements are made between community authorities, such as a band council or a NGO like a Friendship Centre. The community stakeholder carries out the work and reports back to the department, as required by the agreement. The particular department still holds a certain level of discretion over how funding flows to the community. Disruptions in funding can occur if a project does not meet certain milestones or if the department or Treasury Branch decides to cut the funding.

tions a moral gap exists in the sense that there is no formal ethical framework to which to refer when designing, implementing, and evaluating public health programming and services. When a loss is serious enough, referral to the tort laws of negligence or to a profession's standard of competence can be made. However, for less serious harms or those that fall outside the gaze of professional, legal, or medical bodies, there is no documented policy framework to consult. Front-line service providers, community leaders, and government workers are left in a position where the shortfalls of public health programming at all stages lie outside the parameters of formalized ethical standards. If we accept that public health prevention and treatment programs and services of the same type may vary across geographical and cultural divides in their design and quality, so that different consumers may be required to "accept" varying degrees of risk, development of a set of formalized public health ethical principles will help ensure that Aboriginal clients, regardless of their place and circumstances, accept more or less the same amount of risk.

The ethical frameworks discussed earlier (e.g., TCP and OCAP principles) are intended to protect research participants from harm, and when administered consistently, participant risks are both minimized and relatively consistent from person to person, one research study to another. But these principles only apply to research; they do not apply to the design and delivery of public health programs and services. While there are ethical review processes for research, we need to ask why a similar process for the design, delivery, and evaluation of public health programming and services does not exist. This question is even more urgent when realizing that public health interventions targeting vulnerable populations are increasing in the area of mental health and addictions targeting Aboriginal peoples.

A Postcolonial Paradigm for Public Health Ethics

Good ways or good cultural ways is an Indigenous concept meaning that actions are congruent with core values. It means we walk the talk; we model ethical behavior. We are respectful to others, including all things of the Creator, and of the earth.
Bill Mussel, Native Mental Health Association of Canada (2007, p. 8)

A valid critique of the argument that I have put forward is to ask whether development of a code of ethics for front-line mental health and addictions pro-

gramming would, accepting good intentions, nevertheless serve to reinforce Western hegemony and further social control over the lives of Aboriginal peoples. Similar questioning arises throughout the writings of Aboriginal scholars who struggle to reconcile the positive elements of their respective Western disciplines with Aboriginal worldviews. Added to this is the challenge of achieving meaningful change against complex and entrenched government bureaucratic ideals and practices, including mechanisms for decision making, allocation and accountability of limited resources, and government mandates limited by the cycles of political change. In the current context, it is not surprising that the path for affirming Aboriginal knowledge as an essential goal of Aboriginal health policy appears to be a daunting, if not impossible, task.

In 1996, the Royal Commission on Aboriginal Peoples, under the direction of Aboriginal experts, proposed a range of solutions to problems that confront Aboriginal peoples and plague intercultural relations, including areas of health (Brant-Castellano, 2000). In its recommendations, the Commission called for Aboriginal peoples to be full participants in devising policy in political relations and governance, land use and economic development, family rehabilitation and community development, and health and education. Central to meaningful Aboriginal involvement was the incorporation, as deemed appropriate by Aboriginal peoples, of traditional knowledge and practices (Brant-Castellano, 2000). Marlene Brant-Castellano (2000, p. 23), Co-director of Research for the Commission, writes:

> For Aboriginal people the challenge is to go beyond deconstruction of oppressive ideologies and practices to give expression to aboriginal philosophies, worldviews, and social relations. For nonaboriginal people the challenge is to open up space for aboriginal initiative in school and colleges, work sites, and organization so that Indigenous ways of knowing can flourish and intercultural sharing can be practiced in a spirit of coexistence and mutual respect.

Consensus exists among scholars that a central difference between Aboriginal and Western ideas of health and wellbeing rests on differing concepts of illness and disease. For example, the Native Mental Health Association writes,

> Western thinking tends to define mental health problems as individual pathologies, e.g. brain disorders. For the most part therapies are applied at the individual level. Mental health disorders and mental health are not viewed as connected to broader issues such as spirituality, culture, and social conditions. Indigenous perspectives are more holistic in nature. The core foundation of these perspectives is

> spirit, which is intrinsic to nature, human culture, community and family, as well as individual human being. (Native Mental Health Association, 2007, p. 6)

Native American psychologists Bonnie and Eduardo Duran (2000) point out that Western practitioners view traditional Aboriginal health methods with skepticism, yet expect traditional healers to have absolute faith in orthodox Western-oriented therapeutic strategies. Duran and Duran (2000, p. 5) argue that if integration of the positive elements of Aboriginal and Western methods is to occur, an initial and necessary step is for Western practitioners and government health ministries to acknowledge that their beliefs and practices are deeply entrenched in a worldview that excludes all but rational empirical thought.

Cree ethicist Willie Ermine (1995, p. 103) suggests that in constructing the world through a language of fragmentation, Western science habitually reduces the world in all its complexity into neatly packaged concepts that permeate understanding of the external world. This fragmentation of the constituents of existence results in a "vicious circle of atomistic thinking that restricts the capacity for holism." He writes:

> The "fragmentary self-world view" that permeates the Western world is detrimental to Aboriginal epistemology. The Western education systems that our children are subjected to promote the dogma of fragmentation and indelibly harm the capacity for holism. The mind-set created by fragmentation impedes the progress towards inwardness that our ancestors undertook. Only through subjectivity may we continue to gain authentic insights into truth. We need to experience the life force from which creativity flows, and our Aboriginal resources such as language and culture are our touchstones for achieving this. It is imperative that our children take up the cause of our languages and cultures because therein lies Aboriginal epistemology, which speaks of holism. With holism, an environmental ethic is possible. (Ermine, 1995, p. 110)

For Aboriginal peoples, the restoration of individual and collective wellness involves taking back responsibility for health and wellbeing (Native Mental Health Association, 2007). Self-determination, cultural safety, and social justice are the building blocks for moving forward within the ethical space. Power relations are shared between government ministries and bureaucracies and local, regional, and national Aboriginal knowledge and practice foundations. This, however, does not mean a complete rejection of Western models of care, but rather seeks to incorporate what is valuable from these models, even while recognizing that they are embedded within colonialist structures and processes.

RETURNING TO THE COMMUNITY: A CASE STUDY OF KNOWLEDGE TRANSFER TARGETING VULNERABLE WOMEN AND CHILDREN

Empowerment comes from a secure sense of personal and cultural identity—
from knowing and valuing who you are. If this is not present, hopelessness
and despair can result. Empowerment is central to healing.
Native Mental Health Association, Ten-Year Strategic Plan (2007, p. 15)

In spring 2006, I undertook a postprogram evaluation of a fetal alcohol spectrum disorder prevention initiative for the Northern Inter-Tribal Health Authority (NITHA). The project, which was funded by First Nations and Inuit Health Branch (FNIHB) of Health Canada, included four pilot sites located in northern Saskatchewan reserve communities. The Northern First Nations Fetal Alcohol Spectrum Disorder Strengthening the Circle Program was designed as a community-based prevention program that worked directly with women with substance abuse and dependency problems. The program model placed female mentors from the community, many having training in social work or addictions, with women considered to be at high risk for giving birth to a child with fetal alcohol spectrum disorder (FASD).

Considered within the research literature to be a "best practice," the Parent-Child Assistance Program (P-CAP) is based upon data suggesting that women with substance abuse and dependency problems possess identifiable strengths that can be built upon in a positive and supportive environment of care in order to help reduce substance use and improve the quality of life of the women and their children (Basford and Thorpe, 2005). The goal of P-CAP is "to test the efficacy of a model of intense, long-term paraprofessional advocacy with extremely high-risk mothers who abuse alcohol or drugs heavily during pregnancy and are estranged from community service providers" (Ernst et al., 1999, p. 20). Incorporating harm reduction and relational theory, P-CAP supports clients along a continuum of change, from excessive use of alcohol or illicit drugs to abstinence (Basford and Thorpe, 2005).

The component of the P-CAP model that holds significant relevance for First Nations is the premise that paraprofessional mentors who have experienced adversity similar to that of their clients are uniquely able to connect with and inspire hope in women at risk (Basford and Thorpe, 2005). In describing the P-CAP model, Basford and Thorpe (2005, p. 150) write,

> This advocacy approach serves two major functions: the paraprofessionals serve as role models and provide practical assistance in the client's home as well as ensuring clients have access to various community services. Essentially, the P-CAP acknowledges the significant role of paraprofessionals working independently to support a generally non-compliant high-risk group of mothers.

They add that adaptation of this

> gold standard model speaks to the need for these programs in most, if not all, communities and to the desire of health care professionals to serve these women in ways that meet their needs and, ultimately, affording appropriate care for children to enhance their safe upbringing. (Basford and Thorpe, 2005, p. 152)

Basford and Thorpe (2005) document the key characteristics of successful home visitation based programs, such as the P-CAP model, including: (a) intensive level of service that is responsible to client growth; (b) first-year client/mentor interaction to be one-and-a-half hours or more per week (excluding transportation time); (c) second-year mentor visits to clients every other week; (d) third-year transition to monthly and as-needed visits; (e) lifelong community-based support for clients with FASD; and (f) appropriate addiction treatment and aftercare supports, preferably at the community level.

Based upon past successes of the P-CAP model, NITHA anticipated the following outcomes: (a) a decrease in the number of children born with FASD; (b) reduced rates of child apprehensions and children in child welfare care; (c) increased participation of women with substance dependencies in individual and family support programs, such as the National Native Alcohol and Drug Addiction Program (NNADAP) and parenting programs; (d) increased collaboration among community agencies and service providers; (e) improved linkages between community agencies with provincial services, such as regional health authorities; and (f) improved and sustainable health for children, parents, families, and community members over subsequent generations (Tait, 2006).

Research suggests that rates of FASD are elevated in some First Nations communities (Asante and Robinson, 1990; Asante 1981; Asante and Nelms-Matzke, 1985; Robinson et al., 1987). This indicates that implementation of P-CAPs in northern Saskatchewan First Nations communities, particularly those with high rates of substance abuse, will result in a decrease in long-term health, social services, and special education costs, while improving the lives of vulnerable and marginalized women and children. The estimated

average lifetime cost for an individual with FASD is $1.5 million (Grant et al., 2005, p. 485). The estimated cost of a P-CAP per client is approximately $15,000–$20,000 for the three-year program, including intervention, administration, and evaluation. Grant and her colleagues estimate that if a P-CAP prevents the occurrence of just one case of FAS, the estimated lifetime cost savings is equivalent to the cost of the P-CAP intervention for 102 women (Grant et al., 2005, p. 485). This does not factor into account the cost benefits to maternal health and wellbeing as a result of the program, as well as a decrease in the health and social service needs of this population. Therefore, even a minimal reduction in rates of FASD in northern Saskatchewan First Nations would save millions of dollars, suggesting that the upfront costs of the P-CAP would be recovered in a very short period of time.

The Pilot Project

In response to a funding call from FNIHB for development of FASD prevention projects, the FASD Mentorship Proposal Committee formed in October 2003. The proposal involved the creation of P-CAP pilot projects in four reserve communities in northern Saskatchewan, one in each NITHA Tribal Council partners' jurisdictions. The proposal was presented to FNIHB on 23 November 2003, and received funding approval for the three-year pilot in January 2004. Mentors were hired in early March and a manual for the pilot project was developed. An initial training session was held in early March 2004, and was attended by the four mentors, a community member from each of the pilot sites, and tribal council representatives. A second training session was held three weeks later and covered First Aid and CPR. Mentors and community support participants also began developing client intake and research data collection forms. A third training session was held at the end of April 2004, which covered addictions, including reviews of the transtheoretical models of change, harm reduction, and case management. By the end of the third training session, optimism had built within the project with mentors and their communities believing that the pilot project would be a great success in their communities.

The fourth training session was not held until November 2004, covering crystal meth use and pregnancy, cognitive disability, self-care, sexual transmitted illnesses, and gestational diabetes. In January 2005, a final training session was held, covering normal prenatal development. In February 2005, NITHA hired a childhood program specialist, who joined the pilot project's broader team. A project coordinator was hired by NITHA in March 2005 to

provide overall coordination support for the mentors, including collecting monthly reports, organizing meetings, and training opportunities for mentors, as well as other supports. However, the coordinator left her position in September 2005, at which time NITHA's addiction program developer reassumed the role of support and coordination for the project.

During the first year, the mentors reported having strong support from their local health directors and other community staff. However, they found that the P-CAP model did not directly fit with the profile of their client base (Simpson, 2006). A central challenge was the P-CAP model's overwhelming focus on individual clients. Unlike clients participating in urban-based P-CAPs, most clients accessing the pilot project were living with partners and/or extended family members who were commonly present during meetings with mentors. This meant that working exclusively with individual clients, specifically in a home-visit situation, was neither appropriate nor effective. Mentors found that they were interacting daily with partners and extended family members of their clients, which quickly extended the scope of their work in ways not experienced by other P-CAPs. However, because of the constraints of the mandate of the program, the mentors were unable to modify the pilot's approach to reflect the context in which they were working.

During the evaluation, mentors pointed out the difficulties in engaging individuals in small rural and/or remote communities to participate in programming that associates them with stigmatized behaviours, such as alcohol abuse, or with illnesses, such as FASD or alcohol dependency. However, by seeking to build trusting relationships with their clients, mentors sought to minimize the stigma associated with the program's focus, while simultaneously raising awareness within their communities of FASD and the risks associated with alcohol/drug abuse during pregnancy.

By the end of the first year of the program's operation, three of the four pilot sites had filled all or most of their available places. In two communities the demand for access to the program grew so that by the end of the pilot each had extensive waiting lists of women requesting access. Because of this demand, mentors and health directors became deeply concerned with providing supports that would offer long-term benefits to both their clients and their clients' children. However, short- and long-term uncertainty over funding meant that the communities were not only preoccupied with sustaining the project's work but were continually having to prepare clients and the broader community for the likelihood that the pilot's funding would end early or not be renewed.

The general psychological, emotional, and physical health of clients was of great concern to the mentors, who reported that combined substance abuse and high levels of mental distress characterized the profiles of most of their clients. Illnesses such as hepatitis C and HIV/AIDS were also reported among a subgroup of clients enrolled in the program. Clients typically had complex life histories often marked by past childhood sexual and physical abuse, alcoholic parents and grandparents, mental illness such as depression and suicide ideation, and deaths of close family members and friends. Client profiles, while similar to others attending other P-CAPs in Canada and the United States, were further affected by local histories involving government strategies of assimilation, specifically the residential school system, which actively sought to break up First Nations families and obliterate traditional languages and cultures. Added to the destructive nature of these policies is the history of physical, psychological, and sexual abuse that many First Nations children experienced while attending residential schools and the intergenerational impact upon First Nations families and communities. An added dimension that mentors dealt with regularly in their interactions with clients and which characterized their client base as a particularly vulnerable group of women and children.

The large majority of clients enrolled in the pilot projects were impoverished women receiving social assistance. Mentors pointed out that on days when social assistance payments or family allowances were received, there was a dramatic increase of binge drinking, either on- or off-reserve, among community members who used substances. In some instances, pregnant women or parents would forgo buying essentials such as food, instead spending their money on alcohol or drugs. Mentors spent considerable time with clients leading up to and on the days that the money was received to help them develop management skills so that they had food and other essentials. Building the level of trust required to work with clients around these issues takes considerable time and close one-on-one support. However, a limited timeframe, small local project budgets, and funding uncertainties undermined the efforts of mentors when they made strong meaningful connections with these high-risk clients. Mentors also reported that community histories of inconsistent government programming meant that the women targeted by the pilot project commonly held feelings of mistrust, betrayal, marginalization, and indifference about what was being offered to them. Unfortunately these feeling were reinforced as expectations were raised and then dashed for clients when the program closed prematurely. Important to note is that

many clients came to view the pilot project as a source of promise and hope that not only offered them assistance to change their life circumstances, but also simultaneously validated their citizenship within the community as being important enough to receive special attention and support. Mentors and health directors reported that once those expectations were shattered, clients, mentors and the local health care teams, experienced a collective sense of hopelessness, worthlessness, and defeat that is still felt today in the communities around the issue of pregnancy and substance abuse.

Timelines and Funding

An inadequate flow of funding from FNIHB to NITHA significantly altered the time period that the pilot projects were able to be fully operational. The program ran for just over two years (March 2004–May 2006), rather than the three-year cycle commitment required for each client. Because of the need to train mentors and set up the program in each community, the actual duration that the pilot sites were operational was under two years. Recruitment of clients also took place over the first year, which meant that many clients were enrolled in the program for under half the promised cycle of support. This greatly hindered the ability of mentors and their broader support structure to successfully carry out the mandate of the P-CAP "best practice" model. Most importantly, the flow and timing of funding, or lack thereof, made it impossible for the programs to offer the type of long-term client support promised by the program's model. This contributed to client feelings of mistrust, anxiety, and apathy, and was a great point of frustration for mentors and the broader health and social service supports serving this group of clients.

The delayed flow of funding from FNIHB also inhibited the ability of mentors to reach those who were the central focus of the P-CAP model — chronic alcoholics, the women most at risk of giving birth to a child with FASD. These women are often unwilling or untrusting of the very services designed to help them (Poole, 2000; Tait, 2000). Developing trusting and meaningful relationships with this group generally takes much more time than with those who are not substance dependent. Mentorship programs have been found to be more successful if they can demonstrate ongoing consistency and commitment through their service delivery to this particular "high risk" client base (Grant et al., 2005). This was very difficult for the mentors to achieve and sustain because of the uncertainty and limitations surrounding available funding, as well as the delays in program operation in each community.

    Reasons for delays in funding and funding uncertainties appear to be directly related to fiscal time constraints set out by FNIHB. For example, the initial month that funding became available was January 2004, which meant that the first fiscal year was almost over by the time funding was in place. In year two, the project was required to resubmit a proposal for the second year of funding, then was told that only six months of funding was available. This created significant uncertainty at regional and community levels, resulting in a notice to mentors to begin to prepare their clients for the project's closure. Change in personnel at the regional FNIHB office also delayed allocation of funding in 2004. When this funding was finally received it was followed by notification that the remainder of the year's funding would be forthcoming. This meant that mentors had to re-engage with clients in the program. A second renewal proposal was submitted in March 2005, which was funded for the full year. This brought the pilot project up to the end of the third fiscal year, although in practice the pilot ran only twenty-six months, which included establishment of the program, training of mentors, and recruitment of clients.

    Each pilot site was characterized by a number of limitations that inhibited mentors from meeting the mandate of their program. My evaluation found that inadequate prior assessment of the pilot sites, the short time period given to the development and implementation of the project, and inadequate reporting and tracking mechanisms to ensure the cultural safety of clients meant that clients were placed at greater than acceptable levels of risk than would be allowed had the pilot been governed by Tri-Council ethical guidelines. Furthermore, it is unknown whether the positive gains made by the pilot project have been sustained since the closure. It is possible that despite the significant efforts by mentors and others in the communities to make this pilot a success, the abrupt closure of the program after such a short period of operation diminished many of the gains made, and reinforced a lack of trust within the community of government integrity and support.

    The Strengthening the Circle project is a typical example of a public health prevention initiative found in First Nations communities in northern Saskatchewan. Despite the number of shortfalls of the project, local mentors emerged as an undeniable strength and their commitment speaks to the resilience and determination of First Nation communities to overcome adversity. However, the postprogram evaluation found that from the outset the pilot project was poorly conceived and would have benefited greatly from local community input and assessment to determine the scope of the prob-

lem being addressed, the readiness of each community for such an initiative, and the feasibility of imposing an existing program designed for urban-based non-Aboriginal clients onto rural and remote First Nations communities. The half-hearted funding commitment made by FNIHB further suggests a failure and possible naïveté on the part of Health Canada as to what NITHA envisioned in their proposal, including a failure to recognize the complexities associated with maternal substance abuse and dependency, and how best to address it. Engagement of women who are experiencing substance abuse problems and high levels of mental distress in a program involving intensive one-on-one support aimed at producing life altering outcomes (e.g., addiction recovery, support to have a healthy pregnancy and baby) will no doubt raise expectations among clients and the community. If proper handling of these expectations does not occur, especially when programs fail to deliver the support that they promise, the outcome can be added mental distress and substance abuse among clients, fetal development and children being placed at risk due to the mother's distress, and increased mistrust by front-line workers and communities about the true commitment of government ministries. In this example of knowledge transfer, the communities all felt that they had been set up to fail, and that the failure that occurred caused more harm than benefit to their clients and community. As one health director expressed, "we were duped by FNIHB to participate in this project, never again!"

Health Canada (2002) and the Public Health Agency of Canada (2008), ascribe to the benefits of evidence-based policy and programming and "best practices" based upon the best available scientific evidence. As such, it is surprising that the federal government would purposely underresource a pilot project that directly sought to apply a "best practice" model as a form of knowledge transfer.[8] Even more surprising is the lack of awareness and sensitivity on the part of the government about the detrimental impacts that such underresourcing could have upon vulnerable women and children, front-line services providers, and First Nations communities. Based upon scientific evidence, three-year P-CAPs have successfully reduced rates of FASD, improved maternal health among substance dependent women, and reduced

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8.   Important to note is that at least some of this problem is a function of the machinery of government, for example, the timing of when Parliament approves Main Estimates which makes it possible for departments to access new funds. Placing public servants in a position to do a better job in forecasting the amounts and timing of funding needed to support new programs would be one way to address this.

health and social services costs in the form of services for children with FASD and women with substance dependencies (Grant et al., 2005; Poole, 2000). However, my evaluation found that without appropriate levels of support — financial, time, and human resources — these benefits were reduced to a minimum, despite the committed efforts of local mentors and their communities. Without a formalized avenue, such as ethical guidelines, to which community leaders and NITHA could refer when critiquing the government's handling of the project's portfolio, the experience of the program's clients, mentors, and the broader community is silenced. Further, the evaluation suggests that no one's expectations about the project's benefits — FNIHB, the First Nations communities involved, and the clients who were recruited into the pilot — were met. However, a valuable lesson gained from this project is that both theoretical and structural changes to the ways that front-line prevention and treatment services are conceptualized and delivered to Aboriginal peoples is long overdue. The first of these being the greater empowerment of local, regional, and national Aboriginal stakeholders, including acknowledgement of Aboriginal knowledges, practices, and moral frameworks, within the design and delivery of frontline prevention and treatment services, as well as appropriate commitments by government ministries and Treasury Branch to knowledge transfer initiatives.

Conclusion

The challenge is fundamentally ethical. We must speak, listen, choose, and act in ways that work for the health of ourselves, our communities, and our society. As we work to unfold the next phase of medicare it is natural to think of public policy as a contested arena. It may be useful to think not always of arena, but also of ethical space that calls to us in the words of the elder, "to put our minds together and see what kind of world we shall make for our children."
Willie Ermine and Eber Hampton (2007)

The task of developing an ethical framework to guide public health policy that can be appended to existing conventions guiding evaluative research and public health practice will require consideration from various stakeholders, particularly Aboriginal health leaders, mental health care policymakers, and community stakeholders. The development of public health ethical guidelines that can both inform and guide the design and delivery of front-line community-based programming and services will close some of the gap between those who use a service and those responsible for designing, deliv-

ering, and evaluating it. Furthermore, a formalized ethical process will provide communities and front-line service providers with a moral framework grounded in Aboriginal values to invoke when they believe that the quality of service that they provide is violating certain ethical principles of public health design, delivery, and evaluation.

Of course, designing, developing, and applying formalized ethical guidelines to Aboriginal mental health and addictions programming will be no small effort. However, while the task appears to be daunting, there is a pressing need, as illustrated by the case study above, for ethical standards to be applied beyond the narrow confines of research and clinical practice, and to guide the design, delivery, and evaluation of public health initiatives. By operationalizing the ethical space we are provided with an opportunity for knowledge exchange, including the back and forth flow of creative ideas from Aboriginal and Western knowledge keepers, that can replace outdated policy and funding practices with a framework for cultural safety and moral governance that is client and community centered.

The following recommendations describe initial steps that could be taken to ensure that early development of the guidelines are grounded in Aboriginal epistemologies and worldviews as to what is moral and ethical, and reflect the strengths of both Aboriginal and Western scientific knowledge bases.[9]

1. Seek and obtain a mandate from First Nations, Métis, and Inuit health leaders to undertake the development of national ethical guidelines for program delivery.

2. Seek advice from a diverse group of Aboriginal peoples (e.g., First Nations, Métis, Inuit, reserve, urban, rural, including Elders, healthcare leaders, mental health and addictions workers, and traditional healers), about the types of ethical problems that arise in program and service delivery.

3. Survey the literature written by Aboriginal scholars on ethics and health care.

4. Survey the medical and government literatures (bioethics, public health ethics etc.) discussing ethical standards and their application.

5. Work with an advisory board of Aboriginal and other key stakeholders to synthesize and analyze data from Indigenous, biomedical, and government sources.

6. Draft ethical principles.

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9. Since submitting this paper a consultation process has begun with First Nations in Saskatchewan. A grant has also been submitted to CIHR to fund the development of the guidelines.

7. Once the principles are drafted, undertake a review process where the draft principles are distributed to key stakeholders (community, policy) for review and feedback.

8. Incorporate suggestions from the above review process, prepare a second draft of the principles, and then undertake review process again.

9. Present final draft of principles to Aboriginal health stakeholders and research participants.

10. Pilot ethical guidelines in Aboriginal community and regional settings.

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