MAT Medicine Anthropology Theory

THINK PIECES

Longing for evidence-based traditions

Addiction treatment in Canada's Northwest Territories

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Abstract

In Native North America, clinical/healing spaces are caught up in political struggles for autonomy. In Canada's Northwest Territories, where rates of alcohol consumption are substantially higher than national averages, there are ongoing attempts to align therapeutic practice with traditional Aboriginal modes of healing and well-being. This Think Piece traces the 'therapeutic trajectory' of alcohol treatment in and out of this subarctic region. I show how the language of 'evidence-based practice' affords both gains and losses with regard to the assertion of collective identity and values vis-à-vis the state. Against the backdrop of the closure of the region's sole residential treatment program, I contrast a conversation with a clinician responsible for implementing culture-based programs with the experiences of Destiny, a young Dene woman who, in the absence of local treatment options, spends time in clinics some one thousand kilometers away from her home community. In her movements away from the place to which she is indigenous, Destiny activates different forms of Aboriginal care than those intended by state and community actors. These divergent perspectives speak to the enmeshment of addiction with the perils and politics of liberal forms of recognition.

Medicine Anthropology Theory 3, no. 1: 55–67; https://doi.org/10/17157/mat.3.1.252

Keywords

addiction, evidence, care, Canada, indigeneity

Closure

In 2013, the territorial government closed the Nats'ejee K'eh Treatment Centre, the only addiction-treatment facility in Canada's Northwest Territories (NWT), a move that came as a shock to local people. The population of the Northwest Territories is forty thousand people, and just over half are Aboriginal or Metis.[1] According to national public health surveys, alcohol consumption rates in this sparsely populated region are substantially higher than in any other part of the country (Collin 2006; GNWT 2010).[2] Locally, alcohol addiction is often cited as the most urgent social problem. While rates of alcohol consumption are equal among the NWT's Aboriginal and non-Aboriginal populations, poor Aboriginal families and communities disproportionately experience the burdens of addiction – loss of housing, loss of paid work, and the loss of life itself.[3]

In Canada's northernmost regions, Aboriginal life (and death) acts as a barometer of bureaucratic success or failure (Stevenson 2012, 2014). Addiction as a possible, yet preventable, path to death is therefore a governmental problem and not merely the concern of individuals afflicted by addiction. Forms of bureaucratic care and governance that emerge in response to addiction can be characterized as 'biopolitical' in the sense that they are

1 The term 'First Nation', which is used widely throughout other parts of Canada, is not common parlance here. The Northwest Territories is multiethnic and recognizes eleven official languages. Locally, the term 'Aboriginal' encompasses both Dene and Inuvialuit.

2 'Heavy drinking' is defined by Health Canada, the national health ministry, as consuming more than five drinks on a single occasion. In public discourse, heavy drinking is often considered analogous to addiction. Health Canada data concerning consumption rates were gathered by telephone surveys and depended on self-reporting. The Health Canada study cited here excludes the three northernmost territories for unspecified methodological reasons. The government of the Northwest Territories repeated the national alcohol and tobacco survey, although telephone surveys were replaced with in-home visits in smaller Aboriginal communities (populations under four thousand). The survey found, among other things, that rates of use and reported alcohol-related harms were higher in the NWT than national averages.

3 In 2009, national and regional surveys began asking respondents about harms people experienced in the past twelve months due to someone else's alcohol use. Types of harm included being verbally abused, feeling threatened, being emotionally hurt or neglected, and being physically hurt. The national average (excluding northern NWTs) for self-reported harms was 14 percent; for the NWTs this rate was 51 percent. Alcohol-related deaths were not part of the survey (GNWT 2010; Health Canada 2012).

devoted to the maintenance of life itself and are directed at populations rather than individuals (Agamben 1998; Foucault 2009). In northern Canada, policy makers and community advocates often frame addiction as an Aboriginal problem in need of distinctly Aboriginal solutions.[4]

The closure of the Nats'ejee K'eh Treatment Centre, located in the community of Hay River, was a first step in a joint effort by the government and the community to completely redesign addiction treatment in the NWT. [5] In line with broader therapeutic trends in Native North America (Gone 2013; Kirmayer 2007; Kirmayer and Valaskakis 2009; McCormick 1996), the main objective of this new plan is to put Aboriginal culture[6] at the center of therapeutic practice. This turn in the 'therapeutic trajectory' (Raikhel and Garriott 2013) of alcohol treatment in the NWT raises the following questions: What are the perils and promises of liberal forms of recognition – enacted within a framework of multicultural politics – when it comes to addiction? How do notions of culture, sanctioned within the context of a postcolonial state, produce epistemological frictions with regard to what constitutes care? How do the intended targets of care fashion a life within and against the ideas and institutions created in their imagined image?

This Think Piece explores notions of evidence, expertise, treatment success, and indigeneity in the configuration of postcolonial forms of care.[7] In the larger context of the closure of this center, debates about addiction treatment pivoted around questions of evidence, or effectiveness. Standard twenty-one-day programs like those offered by the center seldom produce 'clean' subjects. The absence of evidence of such programs' effectiveness enabled northern Aboriginal people to make claims that current treatment offerings were insufficient

4 My focus here on addiction and indigeneity is not intended to reinforce pathologizing accounts of Aboriginal people so often used to legitimize state intervention. My objects of analysis are the contradictions that emerge in postcolonial societies and the social conditions that my interlocutors then must endure.

5 The center's funding and complex ownership regime were also part of the closure issue, although this was less public until years later. Essentially, the government built the center on the region's only reservation and then rented it from the First Nation. This enabled some, albeit very little, local control over the facility while absolving the state of full financial responsibility for the facility. The state did not renew its contract with the First Nation to use the facility.

6 Here, I use the term 'Aboriginal culture' as a practical category and not an analytic one.

7 Following the editors of *Postcolonial Disorders*, I use the term 'postcolonial' to indicate 'an era and a historical legacy of violence and appropriation carried into the present as traumatic memory, inherited institutional structures and often unexamined assumptions' (Good et al. 2008, 6; see also Garcia 2010; Stevenson 2014).

and should be replaced with locally developed and delivered programs. However, as my conversation with one clinician reveals, promises to make treatment reflect local norms and values are expressed always in a conditional tense: Aboriginal treatment programs will be put in place, *so long* as they are effective and *so long* as they produce the kind of evidence base demanded by state funders and health professionals. The aim of postcolonial biomedicine is not to eliminate Aboriginal traditions, but rather to cultivate an evidence base for them.

In attempts to nudge theory into rough alignment with everyday life (Stewart 2012), I contrast treatment debates and conditions with the experiences of Destiny, a young Dene woman whom I have known for many years through my fieldwork in the NWT related to the boom and bust of industrial diamond mining. Given the absence of local options, Destiny travels a thousand kilometers to receive treatment. Her movements highlight different forms of Aboriginal care than those envisioned by those working to reform therapeutic programs. Focusing on 'the incoherence of the ordinary' (Das 2014), I attend to the moral, political, and epistemic orders that form the basis of state violence in and out of Canada's north.

Evidence

In 2012, the NWT's minister of health formed a Task Force on Addictions and Community Wellness, which traveled to twenty subarctic and arctic Aboriginal communities to seek input from residents and clinicians about possible new directions in addiction treatment and prevention. Over the course of four months, the task force spent one or two days at each location, holding open community forums to gather perspectives from those working in public health and social services as well as community leaders and elders.

Since the 1970s, across settler colonial states such as Canada, Australia, and New Zealand, the burden of governance has increasingly been shifted onto the governed (Povinelli 2002, 2008, 2011). Aboriginal communities are now partially responsible for the task of eliminating forms of social harm they did not and do not author. Community consultations, like those conducted by the task force, are a hallmark of northern life today. Whether they are about potential mines or matters of wellness, they aim to include Aboriginal people in decision-making processes. The state's shift – from imposing programs to seeking community input – was a response to vivid harms caused by earlier centralized models for health. High rates of tuberculosis in the 1950s and 1960s led to many northern people being removed from their home communities, placed in faraway hospitals and sanatoriums, and subjected to paternalistic and assimilative health care. Many never returned (Stevenson 2014). New, more inclusive modes of governance, such as the addiction task force, are an attempt at 'co-management', meaning shared responsibility between the state and community governments. The move to co-management, and liberal recognition more generally, has resulted in both

gains and losses with respect to the assertion of collective identity, ownership, and values vis-à-vis the state (Barker 2011; Coulthard 2014; Cruikshank 2005; Nadasdy 2003; Slowey 2008).

Following the community consultations, and many Styrofoam cups of coffee, the task force concluded that state efforts should be directed towards developing community-based treatment options. Concretely, this means replacing residential treatment with on-the-land programs, thus highlighting a definition of indigeneity as tied to territory. As the report by the Minister's Forum states:

> People made it clear they want on-the-land programming, and lots of it. Reconnecting with their spiritual and cultural identities – so closely tied to nature – was for many communities a necessary component to all six pillars of healing: Prevention, Intervention, Treatment, Outreach, Aftercare and Enforcement. As such, the Forum has identified community-based and operated, on-the-land programming, to be the peoples' top priority. (GNWT 2013, 3)

'On the land' refers to time spent out of community settlements checking trap lines, fishing, collecting berries, or hunting large game. The procurement of these subsistence foods has, for many, a larger sociospiritual significance.[8] In terms of addiction treatment, what an 'on-the-land' approach would look like in practice is somewhat unclear to many involved with establishing such programs. To date, the focus has been on prevention activities that involve young people being on the land with community elders for several days at a time.

Susan is a public health clinician and she was one of the few non-Aboriginal people on the task force.[9] While Susan agreed with her public health colleagues that there was a need for improvement in addiction treatment, she was skeptical of their advocacy of on-the-land programs. Despite a recent move to a new office in the capital city, Susan made time to meet with me among boxes of books and office materials to express her concerns:

> They want 'on-the-land', and I get that, but where's the evidence for it? I think the focus needs to be on things that are evidence-based. Things like CBT [cognitive

8 'On the land' is a local shorthand expression used to refer to practices of harvesting fish, game, and plant life. Its meanings are far more complex than simply acquiring food or spending time outdoors. For more discussion of human–nonhuman relationships see Nadasdy 2005; Todd 2014; Todd 2016.

9 All personal names used herein are pseudonyms.

> behavioral therapy]. There is evidence for that. If they are going to go this way, then they have to be sure they are getting evidence.

Susan's 'they' is a direct index of the task force and likely an indirect index of Aboriginal people more generally. Employing the phrase 'evidence-based', Susan demanded that new culture-based treatment programs be commensurate with Western biomedical and public health benchmarks.[10] She wasn't the only one with these expectations. In order to access government funding for programs, communities must have evidentiary accounting practices and state-validated licensure processes in place. These demands are no small order for communities with limited resources. A year later, no recurring on-the-land program existed.

Referring broadly to addiction treatment in the Western world, Klingmann and Bergmark (2006) argue that modernity imposes on people an expectation of living an evidence-based life, as opposed to one based on traditions. Community workers and clinicians in the NWT aim to cultivate and document an evidence base for traditions, to answer the question posed by Susan and so many others: 'where's the evidence?' Asking for evidence doesn't immediately discredit tradition, but this shift does attempt to discipline tradition and render it legible within existing colonial and biomedical frameworks. In the NWT, healing practices are increasingly subject to state forms of regulation, evaluation, and accounting. While the gesture toward local and land-based treatment is, in part, a response to the assertion of Aboriginal rights, and the outcome of the hard work of many, aspects of the planning and funding of indigenized health care can still carry the weight of colonial history, its civilizing mission, and a nation's intentions and desires to improve its 'others' (cf. Cowlishaw 2003, 108; Lea 2008). This makes the work of developing on-the-land programs all the more complex, but not any less meaningful to those invested in them coming to fruition.

It is important to mention the work of indigenous scholars, such as Joseph Gone (2012, 2013), who points out the limitations of Western definitions of evidence. Gone's work has been dedicated to codifying the evaluative aspects of indigenous traditional knowledge (ITK), emphasizing its personal and experiential dimensions. He writes that 'intervention scientists are skeptical of personal inference as a basis for efficacy evaluation' (Gone 2012, 493), and urges intervention scientists who work in native North American communities to

10 Susan's skepticism about the effectiveness of culturally based treatments exemplifies the beliefs of many health and social service workers I have encountered over the past ten years.

'remain open to the legitimacy and role of ITKs in investigations of substance abuse treatment' (493).[11]

Rather than pertaining only to what has already happened, the notion of 'evidence-based' can involve a projection of what is possible in the future. The Nats'ejee K'eh Treatment Centre, much like most North American residential addiction programs for the poor (Carr 2011; Garcia 2010), produced graduates with a high rate of relapse. In the absence of 'positive' results, it was easy for the state to argue that there was no reason to keep the center: a lack of positive evidence opened the door to question its potential future achievements. Rather than jeopardizing the proposals for new culture-based forms of care, the language of evidence in fact bolstered arguments for closing the existing residential program and replacing it with a local program – one that might succeed. For on-the-land advocates, the legitimacy of local programming lay precisely in its potential: it could be more effective, could produce results, could be backed by evidence. But this view conflicted with that of health and social service workers like Susan, who imagined 'evidence' as located in the past, in 'what we know works' from already-trialed interventions. Ultimately, the future-oriented projection of 'evidence' won out and the center was closed in favor of on-the-land programs. In the meantime, while communities develop the plans for local programs, those with addictions are sent south for treatment.

Movement

When twenty-four-year-old Destiny was found unconscious in a bus station in Edmonton, Alberta, in the summer of 2014, she was taken to a local hospital, stabilized, and then transferred to a detox clinic to manage her alcohol-withdrawal symptoms. She had hitched rides from her home in the Northwest Territories to the city some 1,000 kilometers away to, in her words, 'get away from all the bullshit and have a good time'. She returned to the same detox clinic three times before being sent to a twenty-eight-day program for women. In the summer of 2014, over greasy Chinese food in a small northern Albertan town, Destiny recounted her trajectory through a variety of clinical spaces. What she emphasized was not the content, location, or efficacy of the programs. Rather, she wanted to give me a clear sense of the romantic dramas that punctuated her experiences of treatment. She described the lover who got her from that bus station to the hospital: 'I seen him before in the bus station. Thought he was hot. We never talked before. Always looked at each other. Just kept

11 There could be a valuable consideration of how this framework mimics some of the traditional ecological knowledge infrastructures and its limits, as explored by anthropologist Paul Nadasdy (2005).

seeing him and then, like that', she snapped her fingers, 'he was right there, seeing that I was really messed up and took me to the hospital. He stayed. He stayed beside me for the days I was there'.

Chasing fried rice around my plate with a fork, I tried to get Destiny to join in my lament that the NWT no longer offered any local treatment options. My righteous indignation fell flat. She assured me the programs she attended had all been 'pretty good'. The twenty-eight-day residential program outside of Edmonton was her favorite. There, she was given the nickname 'Desert Rose' and the personal mantra 'I am a powerful and free woman'. (Having known her now for eight years, I can attest that these two descriptions suit her well.) Destiny quickly brought our conversation back to romantic relationships. 'There are way more men down that way', she said before going on to describe in detail the locations of each of the programs and the good places nearby to meet people and 'chill' or 'party' once you are out (street corners, bus stations, reservations).

For Destiny, treatment programs aren't stand-alone events, locked into the travails of 'recovery'. Rather, they are threads woven into a larger life project that hinges on romantic partnering,[12] which is better achieved far from home, where there are 'way more men'. Alcohol-linked harms allow for romantic expressions of care to emerge ('he stayed beside me'). In this scenario, cases of overdose, like that at the bus station, are reframed as enactments of a partner's care.

Destiny's other accounts showed me how harms could activate collective forms of care, as well as individual romantic ones. When a bootlegger's dog attacked her at sixteen, she was flown to Edmonton to have skin-graft surgery to repair wounds on her face and leg. In telling the story, she stressed not the physical duress of the dog bites, but that her First Nation had paid for her family to come down and be with her. 'My whole family, my whole family, they paid for', she repeated. Traveling safely from Destiny's home community to the nearest urban center of Edmonton is a privilege many people in the region take for granted. Destiny's family could not have traveled at their own expense. The pride Destiny expressed was not only about having her mother and sisters with her, but equally about the sense of community that came from having the limited finances of her First Nation spent on her well-being.

12 Destiny's search for a partner is easily connected to her lack of stable housing in the NWT, which I have described elsewhere (Bell 2013). Subsidized housing is prioritized for families over single individuals. This is not state policy per se, but there are limited units for single people. The priorities for those units are elders and those on permanent disability. Larger units are prioritized for women or couples with children.

In the absence of local programs, Destiny took part in several distant treatment options. She went through detoxification, residential treatment, and in-house therapy while incarcerated in the south. Well-meaning program planners and community activists commonly believe that it is burdensome, and perhaps even traumatic, for NWT residents to have to 'go down south' for these options. However, Destiny's experiences of 'going down south' reveal that, despite the difficulties they bring, her addiction-entangled travels are important modalities of sociality and subjectivity. She appropriates elements of her far-reaching addiction trajectory to experience herself as an independent, feminine, and desirable Aboriginal woman.

With the closure of the Nats'ejee K'eh Treatment Centre, the comingled terrains of addiction and indigenous citizenship produced a gap in local forms of institutional care – and they also shaped Destiny's caring connections. Destiny does seek and value care that is indigenous, however, for her, neither care nor indigeneity function in the ways debated by people like Susan or by 'on-the-land' treatment advocates. And while there is no evidence that Destiny's patterns of treatment are effective at reducing her alcohol consumption (they aren't immediately), I hope it is clear that, in unexpected ways, they are life enhancing. They enable connections and a sense of self that interrupt the complacent façade of Canadian national solicitude (cf. Cowlishaw 2003, 121).

The cultural turn in addiction treatment and Destiny's experience of alcohol-related social harm emerge out of the same conditions. An important part of this context is the struggle over land between Aboriginal communities and extractive industries. Recognition of Aboriginal rights in Canada and elsewhere has been coupled with policies intended to expedite large-scale resource extraction (Bell 2013; Dombrowski 2001).[13] While legal battles have concentrated on Aboriginal people's rights to territory, their success co-occurs with socioeconomic changes (in-migration, increasing rents, and a shrinking social safety net) that make it difficult for people to remain in the places to which they are indigenous. For Destiny, indigenous forms of care are activated across and outside the legal-political boundaries used by health officials. Yet, for those involved in designing local forms of treatment, 'being in place' is the imagined ideal. The incoherence between institutional and everyday forms of care is not simply an incommensurability of ideology, but instead exemplifies the politics of life in and out of the Arctic today.

13 Dombrowski (2002) uses the term 'praxis of Indigenism' to aptly illustrate how in Alaska the US government used the notion of 'indigenous' to alter its own relationships to 'nonindigenous' national populations in order to simultaneously improve market conditions for the exploitation of natural resources (timber) and to reduce the responsibilities of the welfare state.

Acknowledgements

I am most grateful to those whose shared pieces of life form the basis of my writing. An earlier version of this piece was presented at the 2014 meeting of the American Anthropology Association as part of a panel titled 'Indigenous Experts: The Technopolitics of Recognition in North America'. I am grateful to panel organizer and colleague Tom Özden-Schilling for his close reading of the text and to discussant Paul Nadasdy for his helpful feedback. I would also like to thank Sara Komarnisky, Khadija Coxon, Joshua Moses, Olga Fedorenko, and the editors of *Medicine Anthropology Theory* for their comments.

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