AN AMERICAN INDIAN WAR ON DRUGS: COMMUNITY, CULTURE, CARE, SURVIVANCE

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ABSTRACT

AN AMERICAN INDIAN WAR ON DRUGS:
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The work presented here is the story of an American Indian Tribe in the United States as told to me in pieces by community members, Elders and employees of the Tribal government. I am responsible for taking up the stories shared with me in a good way. While this story includes sadness, trauma, and continuing oppression that are hallmarks of systemic settler colonialism, it is a story of survivance. In Gerald Vizenor's (1999) words, "Survivance is an active sense of presence, the continuance of native stories, not a mere reaction, or a survivable name. Native survivance stories are renunciations of dominance, tragedy and victimry."

Ethnographic research methods were used in this work, including semi-structured interviews, participant observation and one focus group; all centered on drugs, alcohol, addiction, and related service provision. Within this context, the habits, residues, and lingering structures of colonialism emerged as causes of significant problems. I use Brian Noble's (2015) two-pronged definition of coloniality to express these ongoing effects in the contemporary world. In opposition to coloniality, American Indian community members and Elders expressed survivance. Through the framework of survivance in the face of coloniality, I identify key challenges the community confronts, as well as ways they are addressing drugs, alcohol, addiction, and coloniality.

I present three related chapters that support this. First, durable racism against American Indians and stigma against drug users compound to perpetuate and justify stereotypes and racism against all American Indians in the area. This shifts blame for perceived disparities in drug use,

propagates shame among American Indian drug users, supports racial profiling, and interferes with services. In opposition to false narratives, stories from the community express survivance through community closeness, caring and compassion, and desire to foster these things within service provision. Second, community members, Elders, and employees drew clear connections between Historical Trauma, childhood trauma, and drug and alcohol use. These connections were also used to highlight colonialism and coloniality, counter narratives of personal responsibility/blame for addiction, refute stereotypes, and secure resources for services. These terms have become tools of survivance. One reason these efforts have been successful is because of the association of trauma with western medical/psychological establishments. I term the community redeployment of these ideas as post-medicalization. Finally, operating at the nexus of Tribal Sovereignty, U.S. criminal justice policy, increasingly medicalized ideas of addiction, and the rising influence of MAT (Medication Assisted Treatment), Tribal drug court service provider and participant choices are limited by coloniality. For example, service providers who express exemplary dedication and caring for program participants often resort to putting participants in jail to "save lives." In the face of these limitations and regular setbacks, both service providers and participants express optimism and hope for the future of individual drug users, and for the Tribal community as a whole. This has important implications for the Tribal community, but also for the study and treatment of addiction more generally.

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This dissertation is dedicated to survivance.

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I would not be here without the survivance of my parents, grandparents and all of my ancestors, and this research would not have been possible without the support of a huge number of people. First and foremost are my husband, parents and family who supported me in all facets of my life during this (long) journey, and continually inspire me to do good in the world. My dissertation committee at Michigan State University guided me through the academic world with admirable patience and superior mentorship in a number of important areas. The research presented here was partially funded by the Wenner-Gren Foundation. Most of all, it would not have been possible without the generosity, sharing and support of the American Indian community who allowed me to work and learn with and from them in undertaking this work. The Community Advisory Committee and all of the Elders, community members and employees I learned from during this research are the real sources of the knowledge shared here.

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Introduction

EVOCATION: From the Wisdom of the Forbears to the clean clear northern streams, among Mississippi Band mothers and Otter Tail Pillager fathers, farther back beyond the current conventions of names and numbers, beyond the skins and skeins of dark heavy liquid, let me be in honor of those who came before, of the first bringer of light, of the charge of creation and the spark of Creator, let me live in a good way with the gifts of creation.

--Gordon Henry Jr.

Entries into the Autobiographical I
from *The Failure of Certain Charms*
(2007: 22)

Stories as Survivance

Stories are recognized, remembered, honored and told within American Indian communities, because they are part of who American Indian nations and individuals are, and who we will be in the future. They express our past, our relationality, and our futures.

The work presented here is *one* story. It is the story of an American Indian Tribe in the United States as told to me in pieces by community members, Elders and employees of the Tribal government. I am responsible for taking up the multiple stories shared with me and forming one coherent account; any mistakes or errors here are mine. This story is complex, elaborate, and a very small part of the infinite number of other important and powerful stories it is connected to. It is beyond any one person's ability, time, and space to know or tell all pieces. While this story includes the sadness, trauma, and continuing oppression that are hallmarks of systemic settler colonialism, it is a story of *survivance*.

Gerald Vizenor weaves his (re)definition of survivance slowly, and through hazy, complex, and evocative words and stories, making clear that survivance is the lived stories of contemporary American Indian peoples. Survivance is reframing false and damaging images of American Indian peoples. Survivance is expressing American Indian ways of thought and relationality and ways of being in the world in resistance to colonial and neo-colonial framings

and systems. It is complex and as a trickster's framing is sometimes contradictory. Or in Vizenor's own words, "Survivance is an active sense of presence, the continuance of native stories, not a mere reaction, or a survivable name. Native survivance stories are renunciations of dominance, tragedy and victimry" (Vizenor: 1999). While I will not live up to all of Vizenor's hopes, imperatives and calls for vivid and powerful storytelling, I do my best to document and express survivance as I experienced it in this Tribal community.

A significant number of community members shared their stories with me in order to build this story, and will continue making and living their own stories. They shared their challenges, traumas, grief and anxieties. More importantly, they shared their hopes, dreams and visions of a future for themselves, their relations and their community. I cannot do justice to the amount of love, blood, sweat and tears that the community as a whole have invested in addressing the issues of drugs, alcohol and addiction, and many other issues that affect the community. Because of the very sensitive nature of this research, the Tribal community has chosen to be deidentified, and so American Indian community, the Tribal community, the community, and the Tribe are all used here in lieu of the official name of the Tribe. The reasons for this choice will become clearer in Chapter 1. While this work does focus on the "The War on Drugs," which encompasses issues that are devastating, stigmatized, heart-wrenching, and difficult to address in any community, my greatest hope is that if I convey anything in telling this story, it is that the community has gone above and beyond in their pursuit of a healthy community. Their stories are *survivance* in action.

Community, Relationality, Responsibility & Refusal

My dad has always been a source of stories, strength and vision in my life, and I opened this story with words from his beautiful book of poetry to properly express my relationality to

this work, and that this story is intended to be used and shared in a good way (Henry 2007). I also come back to his work and his words to open or close some of the following chapters. Many American Indian and other Indigenous scholars have expressed the importance of relationships to their work and more importantly to the communities they work with and for. Anthropologists and other social scientists have framed their relationships to their work as positionality, but in the context of this American Indian community, *relationality* is a more cogent term. Relationality is about connections to our families, ancestors, and the world around us. It is about mutual responsibility, respect, and reciprocity (McGregor, Restoule & Johnston 2018: 11-19; Howard 2018a: 271-272).

Because of my responsibility and respect for the community, I will not describe my relationality to the community in full. However, because of relationality and responsibility, separating ourselves as researchers from the communities and ideas we work with, does not make sense in many American Indian communities. Our connections and experiences frame our work, and give perspective, as well as define our responsibilities and possible biases. This aligns with changes in anthropological thought set off by significant criticism over framings of culture, researcher positionality and objectivity throughout the 1960s and 1970s—from both within and outside of the discipline. A considerable amount of this criticism came from scholars belonging to communities and nations that were previously over-studied and often exoticized, including Talal Asad (1973), Beatrice Medicine (1978), and Vine Deloria Jr. (1988[1969]). These critiques, and the significant and lengthy internal debates that followed, led to the increased recognition that anthropologists all have their own cultures, and since everything is thus mediated by cultural bias, objective assertions and observations are not possible (Marcus & Cushman 1982, Clifford & Marcus 1986; Abu-Lughod 1991).

Many American Indian and other scholars who belong to communities that have been historically and contemporarily oppressed have outlined the ways in which research and scholarship has been harmful to their communities (for example Medicine 1978, Simpson 2007, Atalay 2006, Brayboy 2005, Tuhiwai Smith 1999.) While some have offered alternatives to Western/Euro-American theory, a significant number still recognize the utility in using Western theory to identify and address issues affecting their communities, while also critiquing and expanding those theories to be relevant, and I will do the same. I seek to illustrate community vitality and survivance that persists despite historically oppressive external institutions, and the significant impacts they have at the local level. The community's continual exercise of sovereignty and self-determination have been at times in alignment with and at times in opposition to the goals and actions of those institutions. In addition, while I am in awe of Indigenous Knowledge, theory and methodologies, I in many ways feel that academia may not be properly prepared for, or may simply not be the place, to know or theorize on some Indigenous Knowledges. While Shawn Wilson (2008) does not argue for limiting the sharing of certain knowledge in his work, "Research Is Ceremony," in thinking of research in this light, I do. Like many Ceremonies, some research data, findings, and knowledge of communities is simply not for academic spaces or to be shared with non-community members out of context. Like Ceremonies, these things must be used thoughtfully, carefully, when appropriate and with sufficient preparation.

Audra Simpson (2007) demonstrates the relationship between colonialism, representation of Indigenous peoples through academic writings, and the construction of indigenous belonging/citizenship. In theorizing "refusal," Simpson asserts that knowledge is a prime tool used in governance over Indigenous peoples and argues that even Indigenous scholarship rests

on Empire (Simpson 2007). In Simpson's view, refusal to share information—by both Indigenous peoples who are participating in research and Indigenous scholars conducting research—is important because it offers a way to limit the appropriation and use of knowledge. Furthermore, refusals "tell us something about the way we cradle or embed our representations and notions of sovereignty and nationhood" (Simpson 2007: 78).

Representations of Indigenous peoples and what citizenship means to Indigenous peoples can thus be shaped not only by what is known and said, but also by that which is not known or shared. Refusal then is an important tool for both Indigenous scholars and Indigenous peoples' articulations of sovereignty and self-determination, and for thinking through the appropriateness of including particular Indigenous or community Knowledge(s), data, and information more broadly in academic and other institutional spaces. In short there are ideas and things not shared with me, things and ideas I will not say here, and ways in which some of the stories shared with me could be weaponized against the community I have been working with. I do not have the right, the desire, or tools to share some things in an appropriate way while living up to my obligations.

What I can say about my relationality is that I am a descendant of the White Earth Nation, so I am an American Indian woman working with an American Indian community but am not an enrolled member of the Tribal Nation described here. I am lucky enough to have storytellers on both sides of my family. My Anishinabe[1] (American Indian/Ojibwe) ancestors and Czech ancestors (and assuredly other ancestors) shared, created and lived stories during my lifetime. I tell this story in this way, because of my experience as an *Anishinaabekwe* (Ojibwe Woman) with mixed heritage growing up with connections to both Native and non-Native ancestors and communities; an experience both different from any other, and with much in common with

others' experiences. I am a product of both of my amazing parents. In addition, I seek to frame this work within relationality as a way to express my sense of responsibility and commitment to American Indian peoples and issues. In addition to my father's work and writing, I also claim kinship with Gerald Vizenor, the literary and theoretical trickster who (re)defined *survivance.* My Grandma is a Vizenor, some distant cousin to Gerald, and a paragon of fighting for what is right, centering relationality, and *survivance*. My responsibility and relationship to this work is even further extended and expressed through this bond of kinship. This is not to be taken in the traditionally anthropological, or genealogical sense—I mean kinship explicitly in terms of relationality, responsibility, and social connection.

With the guidance of my relationality and experience, and Indigenous scholars and their works, I sought to undertake community-based research with community oversight to the greatest extent possible. I have done as much as possible to prioritize the wants, needs, and concerns of the community discussed here. As Native communities have long expressed, and anthropology has also so thoroughly demonstrated, no community is homogenous or without internal disagreement or diversity of opinion. For the purposes of this work, community membership was loosely defined as those who self-identified as community members, whether they be Tribal members or descendants, members of other Tribes who live in the area, relatives or friends of Tribal members, Tribal employees, or anyone else who defines themselves as part of the Tribal community. The majority of participants were Tribal Members. Tribal Members are individuals recognized by the Tribal Government as members of the Tribe according to their own rules, laws and regulations. Tribal descendants are those who are not recognized as members by the Tribe, but whose parents or grandparents are members.

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[1] Ojibwe/Chippewa, Odawa/Ottawa and Bodewadomi/ Pottawatomi are related, and use this to describe ourselves

My research was reviewed, revised, and vetted through channels appropriate to this community, which included approval from the Tribal Council before the project began, and oversight and guidance from key Tribal governmental employees throughout the research and writing process. In order to protect the community, we agreed to not specifically identify the community in this writing. This means that the history, culture, and specific lived experiences of the community cannot be fully acknowledged or honored. Because this work is on a very stigmatized and contentious set of topics—drugs, alcohol, and addiction—parts of this work and its findings could have negative effects on the community as a whole if misinterpreted or taken out of context. In light of this, I humbly request that if as a reader you recognize the Tribal community that is at the center of this research, that you choose to hold that knowledge close.

Community Overview

The American Indian community at the center of this research is a federally recognized American Indian Tribe with a few thousand members. The history of this Tribal community is distinct and important, but also aligns with the histories of many other Tribes in the United States. Treaties were made with European and American colonial governments. Treaties and promises were broken by the United States. Non-Natives encroached on the lands, and swindled allotted lands from community members. Tribal children were taken and forced to attend assimilative boarding schools. But the community persevered, thrived, and continues to build for the future together.

American Indians in both Canada and the US are very diverse and have their own distinct histories and relationships with federal (and state or provincial) governments, however all Indigenous groups experienced the broader processes of colonization, disease epidemics, forced relocation, boarding/residential schools, outlawing of American Indian ceremonies and religions,

and ongoing oppression, and these processes have resulted not only in common experiences, but also in common issues relating to their health, wellness, illness and healing (Yellow Horse Brave Heart & DeBruyn 1998: 57, Wexler 2009: 268, Kirmayer et al. 2008 5-6). Refusal in this case means I cannot share the robust reality of the Tribal community that paints a story of survivance (in Vizenor's terms). I argue that the individual pieces of stories and theories of community members and Elders that come later in this document, will render tales of survivance that transcend this framing.

The Tribal Government is headed by a popularly elected Tribal Council, and provides a significant number of services to Tribal Members, descendants (children of Tribal Members), and members of other Federally Recognized Tribes who live in the area. The Tribal community is located in close proximity to a small city, and a significant number of Tribal youth attend public schools in the area, so there is substantial interaction between the Tribal and Non-Native communities. Like a large number of Tribes across the United States, this community operates a casino that serves as a source of income supporting the Tribal Government and services to community members. As in many other places in the U.S., the Tribe's businesses make it one of the largest employers in the area.

The Community's War on Drugs

There is a lack of readily available data on the rates of drug and alcohol related deaths, illness, arrest and incarceration in the American Indian community, but based on data pieced together from various programs and years of living in the community, both service providers and community members recognize these issues as primary threats to the health and well-being of the population. These issues are consistently a problem across Indian Country (American Indian communities in North America), and have been identified as a concern for Tribes across the

nation since at least the 1990s (Noe et al. 2003). The Opioid Epidemic has risen to the forefront as a concern for Indian Country over the last several years, and this Tribal community is no exception (Tipps et al. 2018; Venner et al. 2018). The Tribal government and administration have devoted a substantial amount of resources to these issues and have developed a number of programs that address drug and alcohol prevention and treatment across Tribal departments. In light of sustained concern over drug and alcohol related institutionalization, criminalization, illness, and death of community members, the Tribal Council declared an official "War on Drugs," within the past decade. Drug and alcohol use and addiction were chosen as the topics of this study, in large part because of its place at the forefront of Tribal concerns.

Anthropologists studying drugs, alcohol, and addiction have decried the US government's War on Drugs as a resounding failure that targets poor and otherwise marginalized individuals in ways that perpetuate inequality and benefit certain elite sectors of society (Singer & Page 2014, Calabrese 2013, Bourgois 2003[1996], Garcia 2014, Leons & Sanabria 1997). The Tribal government and community's War on Drugs has been framed much differently. In the community at the center of this study, discussions of the Tribal War on Drugs focus on healing individuals, family, and the community, and include assertions that part of being a warrior against drugs is exercising love and caring for the community. This may be a reflection of the closeness of the community as a whole, and of the fact that many of the Tribal policy makers and enforcers are deeply connected to drug and alcohol users through familial ties and friendships. The alcoholics and drug addicts of the community are parents, brothers, sisters, children, and friends to Tribal leadership, employees, and community members, and the impact of these connections are key to understanding the Tribal drug policies, and the extent of the drug and alcohol issues in the community. This connectivity and caring for the community stand in direct

opposition to the overarching hegemonic narratives of addiction that reign at a national level, and at a local one.

On the other hand, Tribal institutions including the behavioral health, Tribal police, and Tribal court programs also employ policies and practices that mirror federal and state models in dealing with drug and alcohol related issues. For instance, the Tribal behavioral health services include programs promoting American Indian culture as treatment and prevention, but still operate primarily in terms of Western psychological and biomedical norms and standards. In addition, federal, state, and city institutions also affect the lives of American Indian community members, as in the case of some individuals who may be dealing with drug related charges from the Tribal, city, and county police and/or various court systems simultaneously.

The Tribe's sense of community extends beyond the few thousand enrolled tribal members and descendants, and at times includes Tribal Members and descendants of other Tribal nations, Tribal employees, and residents of the city that sits within the historic reservation boundaries of the Tribe. The word community itself is problematic, but I have chosen to use this term because it is commonly used in this specific context to name the group that this study focuses on. Or in other words, community members frequently use it, and refer to "the community" or "our community." While community membership is inevitably shifting and defined in different ways by different people at different times, I will not comprehensively address this here, and included anyone who considered/identified themselves to be part of the Tribal community in the study. I also define community events as events sponsored by the Tribal Government or Tribal Programs, or that were primarily planned and/or attended by Tribal members and their families.

Tribal Sovereignty & Jurisdiction

Tribal Sovereignty and Tribal jurisdiction are poorly understood by the general public, but are key to understanding the ways in which Tribal nations are situated both in opposition to and within the boundaries of coloniality. I will not cover these ideas in great detail as they have already been more thoroughly and expertly explained by others than any description I could offer. This account focuses primarily on the ways in which one Tribal nation and its community members critique, resist, and are in many cases limited and restrained by coloniality; particularly in service provision related to drug and alcohol use. The ways in which Tribal sovereignty and jurisdiction affect these issues are significant.

American Indian Tribes are sovereign nations, and their recognition as such by colonial powers goes back to interactions with European governments before the establishment of the United States of America (Nesper 2004: 305-311). In addition, the U.S. constitution enshrines Tribal sovereignty and rights to enter into treaties, by outlining that Tribal Nations are in many ways similar to foreign nations in their relationships with the federal government, and that their affairs are not concerns of the states (Nesper 2004: 306). Over the years, this has resulted in a vast number of treaties that have defined Tribal ownership of lands, rights and relationships, as well as obligations of the U.S. federal government to Tribal nations. While some in the non-Native community assume that "Indians get free stuff" from the government, in fact the government is obligated to provide certain things to Tribal nations because of these treaties and established relationships. Some examples are health care and education (Littlefield 2004, IHS 2019, NCAI 2019).

Because Tribal Nations are sovereign and have unique relationships with the federal government, they also have unique jurisdiction and unique challenges surrounding criminal

justice issues. Rules and laws around Tribal jurisdiction are not the same for every Tribe, but Tribal jurisdiction is in many cases very complex, and can cause issues of both under- and over-policing in Tribal communities (Perry 2006, Poupart 2002, Amnesty International 2007: 27-30). For example, in 1957, Public Law 280 (PL 280) gave some states jurisdiction over what was previously federal jurisdiction regarding criminal cases involving American Indians, and gave other states the option to take over jurisdiction (Amnesty International 2007: 29). This means that both Tribes and states have jurisdiction in these cases—an erosion of Tribal sovereignty—and in some cases it has resulted in reduced BIA (Bureau of Indian Affairs) funding for the Tribal Law Enforcement agencies in those states (Amnesty International 2007: 29). The following summary from Amnesty International gives a general sense of some of these complications:

> ***Tribal police, prosecutors and courts***
> - *Tribal police and prosecutors can investigate and prosecute all crimes committed by Indian individuals in areas including but not limited to Indian Country.*
> - *Tribal police and prosecutors have concurrent jurisdiction with federal police and prosecutors (or state police and prosecutors where Public Law 280 is applied) over major crimes by Indians on tribal land.*
> - *Tribal police and prosecutors cannot investigate and prosecute crimes committed by non-Native perpetrators on tribal land.*
> - *Tribal authority to sentence offenders is limited to a maximum of one year's imprisonment and a US$5,000 fine for each offence.*
>
> ***Federal police and prosecutors***
> - *Federal police and prosecutors have exclusive jurisdiction to investigate and prosecute crimes committed by non-Native perpetrators in Indian Country (except where Public Law 280 is applied).*
> - *Federal police and prosecutors have concurrent jurisdiction with tribal police and prosecutors to investigate and prosecute major crimes committed by Indigenous people in Indian Country (except where Public Law 280 is applied).*
>
> ***State police and prosecutors***
> - *Where Public Law 280 is applied, state police and prosecutors have exclusive jurisdiction to investigate63 and prosecute crimes committed by non-Native perpetrators on tribal land.*
> - *Where Public Law 280 is applied, state police and prosecutors have concurrent*

jurisdiction with tribal police and prosecutors to investigate and prosecute crimes committed by Indigenous perpetrators on tribal land.

- *If a crime takes place on state land, state police and prosecutors have exclusive jurisdiction to investigate and prosecute.* (Amnesty International 2007: 31)

In the community at the center of this study, jurisdictional issues are extremely complex and have resulted mostly in over-policing of the American Indian community, which will be discussed more in chapters Two and Three. However, some community members and Elders also complained that in some cases they were under-policed. For example, police did not follow up appropriately on reports, or go after people who "everyone knows" are drug dealers. Because the community overlaps with a city, and county and state police have jurisdiction in the surrounding area, navigating the criminal justice system(s) can be complicated and demanding. For instance, an American Indian drug-user could have gotten drug charges on the reservation and be involved with the Tribal court, and charges off the reservation and be involved in county court. In addition, there are city and state police in the area, which further complicates matters when people cross reservation boundaries multiple times per day.

Methodology/Methods

The main purpose of this research study was to better understand drug and alcohol use in the community, and the "War on Drugs." Addiction is a main concern in the community, and I did my best to devote significant attention to issues the community wanted to know more about. Examination of how the non-Native community, service providers/organizations and discussions surrounding this war represent drug and alcohol users, as well as the effects of these representations was key in guiding analysis. This includes consideration of how individual, community, and institutional ideologies of drug and alcohol use affect the lives and well-being of drug and alcohol users and the community. In addition to community guidance, I was guided by Indigenous authors and research methodologies in developing this project. In an unpublished

paper produced for a graduate course, I did a literature review of existing writings on Indigenous methodologies and methods, and identified six main themes supported by those authors and works.[2] These themes guided my conceptualization of this work, and how to proceed in undertaking it in the best way possible. The themes identified (in their most simple forms) are:

1. Highlight, change or revolutionize the traditional research process itself
2. Privilege Indigenous ways of knowing; Include Indigenous Worldviews and /or Traditions
3. Address history and/or continued oppression
4. Practice reciprocity and develop/foster/grow relationships with community and individuals
5. Be relevant and practical for American Indian communities
6. Be community specific

In order to have as much community oversight as possible I volunteered in a Tribal department, held office hours for Elders and community members (with admittedly low attendance), and worked with a Community Advisory Committee of six members who primarily guided, contributed to, and oversaw the writing process of this dissertation. In addition, I completed research progress reports every other month that were submitted to the Tribal administration department and Elders board to keep them updated on the status of the research. I also spoke to a number of key employees about the project to gain their input and guidance.

[2] Works considered in this analysis include: Atalay, Sonya. 2006; Ball, Jessica and Pauline Janyst. 2008; Brayboy, Brian McKinley. 2005; Caldwell, Joyce with Jamie Davis et al. 2005; Garroute, Eva Marie. 2003; Jacklin, Kristen and Phyllis Kinoshamig. 2008; Menzies, Charles R. 2001; Speed, Shannon with Renya Ramirez et al. 2009; Steinhauer, Evelyn. 2002; Tait, Caroline. 2008; Tuhiwai Smith, Linda.1999 ; Walters, Karina L. with Antony Stately, Theresa Evans-Campbell, et al. 2008.

While it is necessary to balance Tribal needs with academic ones in order to achieve a PhD, I have also done my best to gather information that will be useful, relevant, and productive for the Tribal community and Tribal programs, and will complete reports on this research tailored to particular Tribal programs that may find them useful. Although Indigenous worldviews and traditions will not be comprehensively covered here to protect Tribal identity, they were part of this work, and guide the ways in which I have understood and represented the stories, experiences, and other "data" collected. I have also retained and included a significant number of direct quotes in each chapter to ensure people's stories are represented in their own way, in their own words. I have changed some details that did not affect the spirit and intent of the stories shared with me to protect participant and community anonymity, such as the names of programs, the names of individuals, the names of local media, the gender of some family members/friends mentioned, the exact ages of individuals, descriptions of participants, and other factors.

A number of ethnographic research methods were used to undertake this study. The bulk of data collection was conducted between August 2016 and September of 2017. This included semi-structured interviews, participant observation and one focus group with around 20 community members. Participants were self-selected; they contacted me through flyers and ads I posted in the Tribal newspaper. Distribution of flyers for employee interviews were targeted to service providers and first responders who are on the front lines of dealing with drug and alcohol use and their effects on a daily basis. Table 1 below outlines the interviews and participants:

Table 1: Interviews

	# of Interviews	# of People Interviewed
Elder Oral History	13	15
Community Member	21	28
Employee	17	17
Tribal Drug Court (Employees & Participants)	16	16
TOTAL	**67**	**76**

Figure 1: Community Members

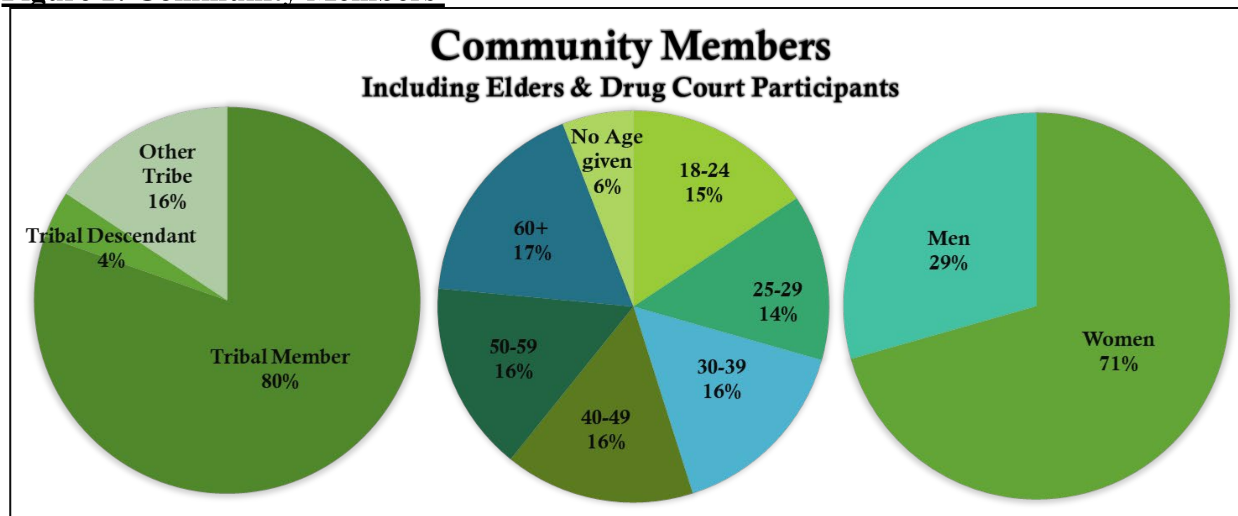
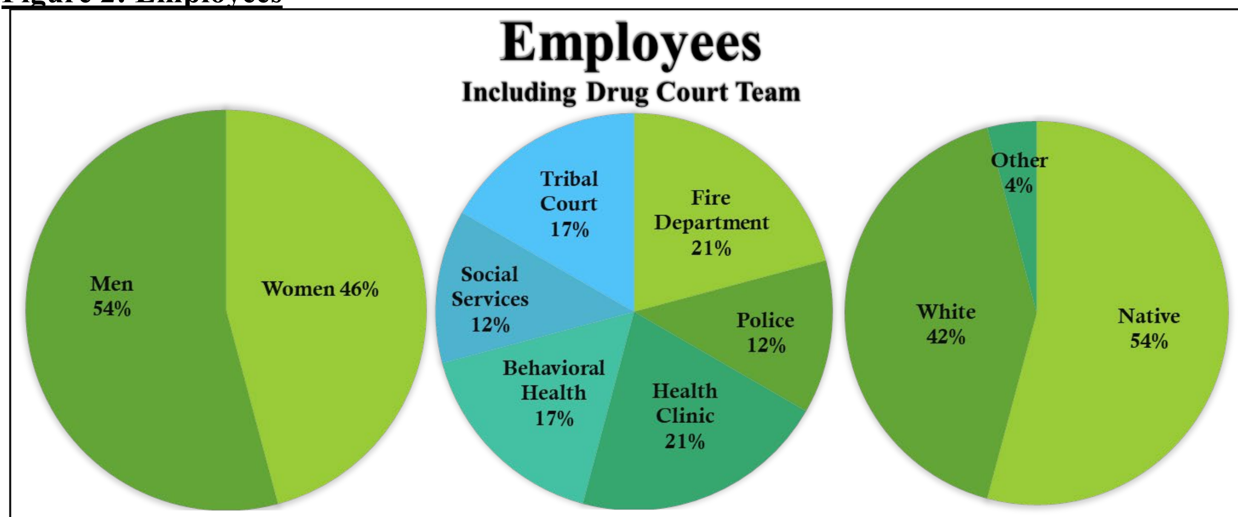


Figure 2: Employees



Five separate yet overlapping interview guides were used to conduct semi-structured interviews with participants. Elder oral history interviews were the most open-ended with just eight questions focusing on Elder experiences in growing up, what they saw as main issues with drugs and alcohol and their effects on the community, how these issues changed over time, and how they thought these issues should be addressed. Community member and employee interviews also included these areas of inquiry, as well as questions about specific topics, Tribal programs and efforts to address drug and alcohol use. Additionally, community members and employees were asked how much impact particular factors have on drug and alcohol use, such as the influence of friends or family members and religion/spirituality. Tribal drug court interviews included a number of the same questions as community and employee interview guides, but also focused on participant experiences and their perceptions of the specific program and its components.

While participant demographics were fairly balanced overall in terms of age, young women between the ages of 18 and 36 were disproportionately represented in community member interviews. I originally theorized that this may have been in part because I am a woman in my 30s, but a few Tribal Elders that I spoke to (both during interviews and in more informal discussions) had a different hypothesis, and one told me:

> *Well, I don't know. It's a weird thing, especially around here, because I seen the—because a long time ago we had—the men had to go out and find jobs and work. And then the women stayed on the Rez. So, a lot of women started running the programs. You know, and then they all go into the programs and then—and then—so, they were actually kind of running the Tribal Programs and things while the men were out—when it first started all the men had to work…in different areas. And so, uh—so the men—the women did all the talking here on this Rez. That's what I've seen. You know, and so…so the men don't say much…*

The story about women being in leadership roles within the Tribal Government was repeated to me by a couple of other Elders. This was framed as a loose community norm in which women

tend to be (but are not always) more outspoken, and many men (especially younger men) are less likely to talk about particular issues publicly, or with someone they don't know. There was not a big difference in the numbers of male and female participants in the Elder oral history interviews, and more men actually participated in employee interviews.

I carried out participant observation at the Tribal drug court program, between August 2016 and July 2017. This consisted of 27 days of observation at drug court team meetings, and 27 days of drug court itself, as well as 9 "check-in" days, when participants met with drug court coordinator(s). Team meetings and court typically ran between 45 minutes and two hours, while check-ins were typically 3-4 hours. There are a large number of drug courts across the country, and there are over 100 documented Tribal drug courts in the United States (Tribal Law & Policy Institute Website 2019). The Tribal drug court model is essentially a jail diversion program. Participants of the program in this community are all Tribal members, descendants of the community, or members of other federally recognized Tribes. In addition, participants must be individuals with drug or alcohol related charges and no violent offenses on their criminal record. Participants who are eligible are given the choice to join the program, which includes additional conditions and requirements that they would not have to adhere to if placed in jail or on regular probation, as well as additional services. If they successfully complete the drug court program, they have the opportunity to have their original charges reduced, or completely dropped/expunged from their record.

Drug court team meetings are held weekly, and are made up of Tribal employees and a few outside representatives (as needed/invited) who come together to discuss each drug court participant, assess their progress, and determine if they are adhering to program requirements. If participants are not adhering, the drug court team also makes decisions about what the

consequences should be, or in the language of the program, if they should be "sanctioned." Sanctions include anything from a stern talking-to from the Judge, being required to write about why they are not adhering, additional check-ins with the drug court coordinator or case manager, additional community service requirements, serving jail time, or being kicked out of the program. Those who are adhering to the program may also be rewarded (or given "incentives") through gas cards, candy bars, praise from the Judge/group, reduced check-ins with drug court staff, or other rewards. The drug court session itself is when the participants stand before the Judge to give updates on their progress, and receive their incentives or sanctions. Check-in days include participants meeting with the drug court coordinator(s) and/or case manager on their progress, taking drug tests, receiving information/classes on various topics, etc. In addition to observation of the drug court, I also attended some community events focused on drug and alcohol use, and undertook participant observation in the community more generally.

Finally, one semi-structured focus group was conducted with around 20 participants who have been at the forefront of addressing drug and alcohol use in the community at a grassroots level. They were asked about main issues surrounding drug and alcohol use, and what they see as the best ways to address these issues.

Grounded theory was used as a framework for undertaking this work, and in analyzing research data (Charmaz 2006, Bernard 2011: 435-439). Interviews and new articles were transcribed and coded to identify major and minor themes, and in some cases themes were further analyzed in relation to demographic characteristics of interview participants. In addition, as mentioned above, a six-person Community Advisory Committee reviewed findings of the study, and the actual text of this dissertation. Their work ensured that the Tribal community and individual anonymity was protected, and helped me make decisions about what to share with the

general public. We also had a number of discussions around early chapter drafts, mostly about complex issues that came up in the research findings, and the way I framed particular issues. For example, they really encouraged me to link this work to the importance of stories in American Indian culture. Two Advisory Committee members provided more intensive oversight and guidance, by reviewing multiple drafts and pieces of this dissertation, as well as abstracts, presentations, and other writings, and by giving me edits and/or approval to submit/present information outside of the Tribal community. Permission to undertake this study was granted by the Tribal Council, and approval of this dissertation also received Tribal Council approval before it was cleared for publication.

Survivance in the Face of Manifest Manners and Coloniality

Vizenor's *survivance* is the main organizing principle that emerged during this research, because of the multiple ways in which the Tribal community, and individual people within the community, have exhibited strength, hope, love, caring, conscientiousness, and dedication in addressing drugs and alcohol in the community (Vizenor: 1999). This overlaps with and differs from more commonly used terms like "lived experience," or "resilience," in that Vizenor situates survivance in the context of both communal history and contemporary living, and not necessarily as a reaction to colonialism and misrepresentation, but an opposite force to both of these. While there were sad and tragic parts of stories shared with me, taken as a whole these stories show that the community is proactive, progressive, and powerful in their connectivity and care.

Furthermore, I have used survivance as an analytical framework. As Chapter One covers, much of the scholarship has painted American Indian communities as dysfunctional or deficient, with little attention to the effects of colonialism and coloniality. By using survivance as a unit of analysis—or more simply put, as a point of focus—the ways in which Tribal peoples are living

and thriving within and against coloniality shift to the forefront, and demonstrate some of the points of tension community survivance creates within systems of coloniality. Instead of focusing on deficit, survivance allows for recognition of the exceptional, the remarkable, the strengths of communities.

Vizenor describes survivance in the face of, or in opposition to, what he calls *manifest manners*; essentially the ideas, representations, and mechanisms that erase Native peoples as distinct Tribal Groups and continue to misrepresent and foster oppression of individuals and communities (Vizenor 1993). Thus, many governmental policies and practices, as well as continuing stereotypes and false tropes concerning American Indian peoples are encompassed in this definition; "Coloniality as oppositional encounter of self & other" encompasses all of the "territory, knowledges, categories, normative practices" that differentiates a "self" from an "other", in ways that justify and rationalize the dominance of "self" and dispossession of "the other." The second dynamic, "Coloniality as Apparatus and Milieu," encompasses all of the ideologies, norms, and definitions that work to shape, constrain and assimilate individuals and groups into the systems and categories of coloniality (Noble 2015: 429-430). Noble argues that this is comparable to Foucault's governmentality, or "the conduct of conduct" (Noble 2015: 430; Foucault 2004 [1978-79]: 186). Both manifest manners and ongoing coloniality are clear and present in the context of addiction in this American Indian community—especially when considered in the context of service provision—and will be the primary framework used to describe and address the challenges faced in the community's War on Drugs. Medicalization is one important anthropological framework that is crucial to understanding coloniality in this context. Framed simply by Peter Conrad (1992, p. 209), "Medicalization describes a process by

which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders."

This dissertation is organized into three chapters focused on closely related issues surrounding drugs, alcohol, addiction, and treatment in the American Indian community. Chapter One outlines the ways in which manifest manners and coloniality as encounter of self and other operate in stereotyping, stigmatizing, and seeking to subjugate American Indians. I first briefly outline the state of the opioid crisis, and then move on to summarize the anthropological literature on the history of racism and stereotypes against American Indians, particularly in terms of medicine and illness, and the history of addiction and the stigmatization of drug and alcohol use. By recounting stories from community members, Elders and Tribal employees it is clear that the durable racism against American Indians and stigma against drug users compound to perpetuate and justify stereotypes and racism against all American Indians in the area. In addition, these narratives work to shift blame for perceived disparities in drug use, propagate shame among American Indian drug users, support racial profiling, and interfere with service provision to American Indians. In opposition to these false narratives, stories from the community show lived survivance through community closeness, caring and compassion, and the desire to grow these things within service provision.

Chapter Two focusses on the links between drug and alcohol use and historical and childhood trauma as outlined by community members, Elders and employees. Despite some lingering questions and concerns about the validity of Historical Trauma as it has been theorized and used over the past few decades, the term is very relevant and meaningful to the Tribal community. People I spoke to outlined clear connections between Historical Trauma and both childhood trauma, general trauma, and drug and alcohol use in the community, and used these

connections to highlight both historical experiences of colonialism and ongoing oppression and coloniality. Tribal community members, employees and programs also used the ideas of historical and childhood trauma to counter narratives of personal responsibility and blame for drug and alcohol use, and lasting stereotypical representations of American Indian peoples, as well as to secure further resources to address drugs, alcohol, and related issues in the community.

In part, the use of these terms has been successful within the Tribal community because of their medicalization over the past few decades. Deployment of "trauma," "Historical Trauma," and other related terms and ideas is powerful because they hold weight in biomedical and psychological circles and institutions (including federal agencies). I term this taking up of medicalized terms in new ways for community benefit as *post-medicalization*. In essence, the deployment of these terms has been used as a tool of survivance and has implications for the importance and utility of Historical Trauma as an organizing framework to discuss ongoing issues and oppression. Efforts to heal Historical Trauma, are not focused on the past but on the present and future.

Finally, Chapter Three addresses the ways in which the Tribal drug court works to affect drug and alcohol use in the community, and the individual lives of drug and alcohol users. Medicalization is an essential concept in medical anthropology and has been increasingly discussed in relation to addiction and drug use over the past several years. Over the time I worked with this American Indian community, there was a significant increase in medicalized explanations of addiction (and opioid use in particular).

Operating at the nexus of Tribal Sovereignty, U.S. criminal justice policy, increasingly medicalized conceptions of addiction, and the rising influence of biomedicine and MAT (Medication Assisted Treatment), drug court service providers and participants are faced with

choices limited by ongoing coloniality. Because of these limitations, service providers who express exemplary dedication and caring for program participants often resort to putting participants in jail to "save lives." This is particularly ironic because drug courts are diversion programs—explicitly meant to divert participants from incarceration. In the face of these limitations, and despite the disproportionally high number of overdoses in the Tribal community, both service providers and participants express optimism and hope for the future of individual drug users, and for the Tribal community as a whole. This not only has important implications for the Tribal community in which the drug court operates, but also for the study and treatment of addiction in a criminal justice context more generally.

While some parts of this work may seem to criticize individual actions, or people, that is not my intent. Because we all live and work within the framework of coloniality, we are all limited by its rules, parts and pieces in various times and places. The primary goal in pointing out frictions and fractures in service provision is to highlight the problems with coloniality and working within such a system. These problems are primarily a result of the ways in which our systems are set up and shaped through ongoing colonial mechanisms and mentalities, and not due to any individual person or group. It is my belief that every service provider I spoke with or observed, acted in good faith and with true desire to do the right thing. Although there are no easy answers for combatting addiction and ongoing oppression, the strengths of the community are clearly demonstrated in their love, caring, dedication, and connectedness.

Overall, this study demonstrates how the Tribal community faces coloniality and manifest manners in a multitude of ways, on multiple scales. Individual community members and the community as a whole are stigmatized and stereotyped, and are deeply affected by the ongoing structures, ideas, and facets of coloniality. Individual community members, Elders and

employees reframe dominant narratives to identify these ongoing injustices, and more accurately represent the Tribal community, and Tribal programs work creatively to mold imposed policies and practices to fit community needs. The community lives survivance every day.

Chapter 1:
Representational Politics of Drug Use & Survivance in the face of Manifest Manners

This chapter examines ways in which historical and ongoing racism combine with the stigma surrounding drug use to entrench American Indian drug users in a double jeopardy of stigma and discrimination. Both American Indians and drug users have been historically dehumanized and oppressed, but as this chapter reveals, American Indian drug users are doubly subjugated. These processes demand examination in the context of coloniality, where ongoing overarching narratives of race combine with those articulating moral perils of drugs and alcohol. These narratives not only shape views of American Indian drug users, thus perpetuating and justifying stereotypes and racism, but also work to shift blame for perceived disparities in drug use. In effect, these perceptions propagate shame and reasons for continued drug use (e.g. as a coping mechanism). These processes are a clear expression of coloniality, and an example of Gerald Vizenor's description of *manifest manners*: the ideas, representations, and mechanisms that erase Native peoples as distinct Tribal Groups and continue to misrepresent and foster oppression of individuals and communities (Vizenor 1999).

I outline the development of perceptions of race and drug use, and connect the resulting narratives to the everyday lives of community members through data collected in interviews and participant observation. Community members and Tribal service providers demonstrate that these negative views interfere with provision of mental health and other services, and result in racial profiling and differential treatment throughout the criminal justice system. In the face of these manifest manners, American Indian community members stress ongoing connectedness and coming together in times of need and strife as a key strength and way of being in the world. This highlights the ways in which Native understandings and community members combat these issues in their own way. Community members enact survivance in the face of ongoing

coloniality and manifest manners through articulations that run counter to false narratives, community support, and relationality. They also seek to increase love, compassion, and caring for those struggling with addiction. Community member experiences complicate racist and stigmatizing framings of American Indian drug users, and point to important ways in which representations of, and services provided for, community members may be improved.

The War on Drugs & Rise of the Opioid Crisis

President Nixon officially implemented the "War on Drugs" in 1971, and although President Obama discarded the official name of the movement, the heavy-handed criminalization of drug users and demonization of drugs has continued for almost fifty years. This has had devastating effects, especially on poor minority populations; a fact that a large number of anthropologists have critiqued and drawn attention to (Singer & Page 2014: 169-176, Calabrese 2011: 10-13, Bourgois 2003[1996]: xxi-xxiii, Gilliam 1992: 19-22, Garcia 2014: 56). On October 26 of 2017, President Trump declared the Opioid Crisis a national Public Health Emergency, (The White House 2019) and has recently threatened to sue opioid manufacturers (Fritze 2018). At first glance both moves seem to run counter to the previous tactics of the War on Drugs that focused on penalizing individuals. However, Trump has also advocated for mandatory minimums for certain drug related crimes and the death penalty for drug dealers (Lopez 2018). In addition, President Trump recently (October 2018) signed a bi-partisan package of bills aimed at addressing the Opioid Crisis, but a number of politicians, health officials and others have expressed skepticism on the bill and the extent to which it actually expands funding and services, or can address addiction as a whole (Drash 2018).

The current labels of "Opioid Epidemic" and "Opioid Crisis," are the result of soaring rates of opioid related hospitalizations and deaths. While opioid death rates plateaued over the

second half of 2018, their exponential growth over the past 20 years is alarming, and it is difficult to know if this trend will hold (Drash 2018). From 2001 to 2016, the number of opioid-related deaths in the US jumped by 345%, from 9,489 to 42,245 deaths (Gomes et al 2018). This trend worsened in 2017, with more than 72,000 deaths due to (all) drug overdoses, meaning that from 2016 to 2017 the overdose death rate increased by 30% across the US; by 16% for overdoses involving Opioids (NIDA 2019a; Drash 2018). The Northeast and Midwest led the rise in overdoses resulting in hospitalization, with both regions reporting over 20 overdoses per 10,000 hospital emergency room visits in the last two quarters of 2017 (Stein 2018; Drash 2018). In addition, young people have faced the highest proportions of Opioid related mortality. In 2016, 20% of deaths among 24 to 35-year-olds and 12.4% of deaths among 15 to 24-year-olds were attributable to opioids (Gomes et al. 2018). Despite the origins of the opioid epidemic now being widely and directly attributed to big pharma and prescribing practices, individual drug users still shoulder significant criticism and accusations (direct or indirect) of immorality (Dasgupta et al. 2018, NIDA 2019b).

The racial tenets of the drug war identified by a multitude of scholars are true to form in the increasingly publicized “Opioid Epidemic,” as it is consistently termed on the Department of Health and Human Services website and across media outlets. For example, Netherland and Hansen (2016) demonstrate that the media perpetuates the idea that white and black drug use are different and separate; humanizing white drug users while reinforcing an association between black and Latino drug use crime and violence. Even within the opioid drug scare coded as white, media and policy makers continue to target black and Latino users and dealers. In part, this is made possible through overreporting on routes which link heroin from largely black and Latino inner cities to white heroin users in the suburbs. These popular associations between drug use

and race are also significant in the American Indian community where this study took place, and in relation to American Indians as a whole. There is an abundance of evidence that drug and alcohol use have been historically racialized, and drug use among American Indian groups was one area of early anthropological study; American Indians have consistently been framed as susceptible to alcoholism (Prussing 2011: 72-75; Page & Singer 2010: 25-42). In comparison to the volume of literature on American Indians and drugs and alcohol in medical and psychological journals, the recent anthropological works on these issues is rather sparse. A disproportionate amount of attention is given to the Navajo as a group, and to the use of alcohol (as opposed to other drugs). It is not entirely clear why there is such focus on the Navajo Nation, but some possible reasons may be that they have the largest population of all US Tribes, a relatively well defined, contiguous and self-contained land base, and were one of the first (if not the first) Tribal Nations to develop a Tribal Institutional Review Board (IRB).

In the county where the major population center of the American Indian community in this study is located, the local newspaper has consistently reported on overdose deaths for the past several years. In 2014 there were three drug-related overdose deaths (race/ethnicity data unavailable), fourteen in 2015 including seven American Indians, eleven in 2016 including two American Indians, nine in 2017 including four American Indians, and five overdose deaths in the first quarter of 2018 (further details unavailable). Considering that the American Indian population is less than 5% of the county, the number of American Indian overdose deaths seems significant, but with such small populations overall it is hard to determine the actual disparity that may represent. Some of these newspaper reports actually included the sex, age, race and date of death in the article, making identification of the individuals very possible, given the size of the community.

It is also difficult for the Tribal government to consistently and accurately track overdoses of American Indians in the area, because of a number of factors. They are able to track most Tribal Member deaths because they are reported to the Tribal Enrollment office, but there is no mandatory reporting for descendants of the Tribe or Members of other Tribes, although they do receive health and behavioral health services from the Tribal health clinic. In addition, sometimes overdose is not immediately identified as the cause of death due to the process of toxicology testing, and in some cases, coroners have been known to attribute overdose deaths to other causes in consideration for the families. Tribal government employees have attempted to at least track Tribal Member deaths in the area for the past few years and have indicated overdose deaths may be even higher than documented in the newspaper. The number of overdoses is devastating to the Tribal community, with its relatively small population, and contributes to prejudice and stereotypes of American Indians in the area in ways that are consistent with historical prejudice and oppression.

Manifest Manners in Action: Othering & Racism

American Indians are the quintessential *others* of anthropology, and as a whole, continue to be othered, if not outright ignored by the popular media and general population of the United States. In the 19th and early 20th century, American Indians were portrayed as a "dying race," an idea based in racial/ethnic hierarchies legitimized by "scientists" who operated in the context of ongoing colonial projects and desired land expansion, concerns about the effects of modernity on humans, and Christian ideas about morality and work ethic (Lomawaima 1994: xiii-x, Kelm 2005: 371-372). Within this paradigm American Indians were characterized as "primitive," "savage," and "uncivilized," in direct opposition to Euro-Americans. Additionally, both

American Indian biology and cultures were blamed for illness and population decline (Keller 2002: 153-154, Kelm 2005: 373-375, Blackhawk 2006: 4-5).

This enactment of prejudiced and inaccurate ideas that portrayed American Indians as inferior in body and culture allowed for several iterations of manifest manners to coalesce—or perhaps—served several purposes. First, it allowed for Europeans to uphold their own ways as normal and "civilized," reinforcing manifest destiny, and justifying colonial conquest (Kehoe 1981: 504, 508, Jones 2006: 2124-2125). Secondly, because American Indians were considered to be at an earlier, "primitive" stage of evolution in which they were untouched by modernity and susceptible to disease, scientists and medical professionals saw opportunities to explore human origins with American Indians as objects of research (Kehoe 1981: 504, Kelm 2005: 373). Third, the dehumanization of American Indians as less-than Euro-Americans —physically, culturally, and intellectually—allowed for genocidal, paternalistic and assimilative government policies, such as the Boarding Schools in the US and Residential Schools in Canada (Littlefield 2004: 322, 325-327, Kelm 2005: 374-377).

By the 1930s, the medical community began to portray American Indian peoples and communities as hotbeds of contagion that were dangerous to non-Natives who came into contact with them, thus reinforcing racial divisions and promoting fear of American Indians not only as "savages," but also as sources of disease to be avoided (Kelm 2005: 381-382, 396). American Indian susceptibility to disease was blamed on their ignorant and unsanitary lifestyles, and women took the brunt of the blame for not upholding their proper gender roles in caring for children and maintaining a clean household (Kelm 2005: 388-390, Jones 2006: 2126).

While blatant scientific racism no longer reigns, the manifest manners of scientists and medical professionals has continued into the present, in ways that still place blame on American

Indian bodies and culture for illness and disease (addiction included), while obscuring socio-economic and political causes. A significant number of anthropologists have elaborated on the idea of risk as an instrument to both place blame on, and to assert and express control over particular populations (Nguyen & Peschard 2003: 457-459). For example, Poudrier argues that genes become a placeholder for the concept of race, and that identifying American Indian populations to be genetically "at risk", works to justify continued surveillance and control of their behavior, and portray them as "sick, disorganized, uncontrolled and dependent peoples" (Poudrier 2007: 241). Poudrier also asserts that reliance on genes and race as organizing categories is firmly embedded in historical narratives and research designs in ways that obscure other key factors in chronic disease such as class, marginalization, racism, and historical context (Poudrier 2007: 241-243). Nina Glick Schiller focuses on "risk" for addiction, and demonstrates that while the concept of "at risk" groups is used liberally throughout biomedical research and practice, it links "risky behavior" with culture, resulting in a re-inscription of "otherness" on groups deemed to be risky. According to Glick Schiller, this promotes assumptions about individuals and groups that interfere with effective health care, allows the U.S. elite to maintain their dominance, and obscures the social and economic structures that influence health and drug use (Glick Schiller 1992: 247-250).

"Risk" then has been used and deployed as a tool of coloniality, to "other" both 1) American Indians by acting as a stand in for race, and 2) drug users and other groups by acting as a stand in for culture (framed as unhealthy or "risky" behaviors). This obscures the real causes of inequality; coloniality. Part and parcel to early stereotypes and current framings of "risk" for addiction is the trope of the "drunk Indian," and the idea that American Indians are more prone to alcoholism and negative effects of drinking. Despite multiple studies and analyses refuting

this, these ideas persist (Prussing 2011: 72-75). Netherland & Hansen (2016) and Erica Prussing (2011) show more recent instances and impacts of the linkage of racial stereotypes and stigma surrounding drug use, and the accounts of Elders, community members, and employees in this American Indian community support and expand on these effects.

Development of Addiction & The Stigma of Drug Use

While human alcohol use was established at least 7,000 years ago, there is little evidence that its use (in general, or in excess) was problematized until the mid-1800s, and the concept of "addiction" did not even come into popular use as a stigmatized and medicalized condition until the late 1800s (Dietler 2006: 233, Singer & Page 2014: 53). Singer and Page (2014) argue that the process of "othering" drug and alcohol users, or defining them as abnormal/deviant, began with alcohol and opiate users in England and the United States in the 1800s. They link the temperance movement directly to: "The United States' expansive desire to 'reform the world,'" and promote moral purity based in Christian ideals, and to ideas surrounding appropriate work ethic and personal responsibility for the lower classes (Singer & Page 2014: 72-70); many of these impulses are inseparable from the manifest manners developed to justify and authenticate colonization and extermination of Indigenous peoples across the world. The negative connotations surrounding drugs and drug use result in stigmatization of groups and individuals.

Singer and Page also argue, that even positive representations of drug use in the media (such as its glamorization in literature and film) can contribute to the exoticization and othering of drug users, and misconceptions about the effects of drugs (Singer & Page 2014: 88-152). Additionally, many "drug scares," or shifts in the perceptions of the dangers of specific drugs, are directly related to who uses them. This is clear with the banning of marijuana in 1937, which was preceded by an increase in its recreational use, its association with Mexican immigrants at a

time when immigration was a hot button issue, and a short-lived "media frenzy" that exaggerated the effects and dangers of Marijuana use, especially on youth (Singer & Page 2014: 157-162).

Drug policy and understandings of drug and alcohol use continue to be dominated by Western biomedical ideals legitimized through the creation of scientific knowledge (like ideas of "risk"), but also through political rhetoric and popular media that continues to "other" drug users in different ways, and demonize drugs and alcohol. This is very clear in the war on drugs. Singer and Page argue that drug addicts are "useful" to the rich and powerful in multiple ways because they can be used as scapegoats for social disruptions, their stigmatization can obscure economic processes like the loss of jobs and adequate housing (e.g. it is their fault they are unemployed or homeless, because they are on drugs), and even their bodies are commonly used in scientific research after their deaths (Singer & Page 2014: 216-218).

Singer and Page, Gilliam, and Waterston (1993) all highlight the ways in which drug use is consistently linked to poor minority populations in the popular media (particularly blacks), a fact that obscures the reality; that whites use drugs at rates at least as high as minorities, and that poverty and marginalization are in fact a product of historical oppression, ongoing discrimination and social policies (Singer & Page 2014: 25-52, Gilliam 1992: 19-21). In this chapter I describe how hegemonic ideals and manifest manners directed at American Indians and drug users unite to present a complex and sometimes harsh politics of representation. This environment can be challenging and demoralizing for community members to navigate, especially drug using community members.

Prejudice and Judgement vs. Care and Connection

I walk into one of the multiple fast food restaurants where people often want to meet for interviews, searching for Jack. While it's a little busy, he is easy to spot. He is big and tall with

dark eyes and shortish brown hair, olive tan skin, and is in his mid-twenties. He is wearing saggy jean shorts and a loose t-shirt with spotless athletic shoes, sporting tattoos on his forearms and a gold chain across his chest. People leave space around him as he eyes the menu above the registers looking serious. I've seen him around the Tribal community, and we've talked before, so his smile is big and warm as I walk up. As we greet each other and order I see questioning looks on the faces of the white teenage cashiers. I think Jack and I look a bit mismatched. I am dressed all business casual because I spend a lot of time at Tribal programs lately, and have a couple of folders tucked under my arm with interview guides and consent forms (do I look like a social worker?). We fill up our drinks and find a booth to sit in toward the back of the restaurant while we wait for our food, but I notice that while Jack gets his Coca-Cola, a woman and her two kids approach. She looks at Jack, then eyes the line at the other pop machine and steers the kids toward it. He doesn't seem to notice.

Jack looks better than the last time I saw him, and as we talk, I find out he has been off of drugs (except for weed) for a few months. He is bright-eyed and smart, charismatic and happy. During the interview, he talks energetically in a deep voice, and tells me about how he started smoking pot and drinking with his older brothers and cousins when he was about 11, and how he transitioned to pills and then heroin later. He tells me he has a part-time job and him and his girlfriend just moved and are doing great. He has plans to go to college and maybe start his own business in a couple of years. When he tells me about his son his whole face lights up, revealing a dimple and straight white teeth, as his eyes crinkle at the corners and dance in the artificial light. His son is 3, and smart and big and funny like his dad, and Jack pulls out his phone to show me a picture of a healthily plump little boy with a mess of dark hair.

We talk and laugh for a while after the interview, with a backdrop of pop music, conversations of other customers, and fast-food prep buzzing around us, and then head out to smoke cigarettes in the big black-top parking lot outside before we say goodbye. I can feel the weight of attention from some of the people going to and from their cars and the restaurant. They eye us sideways. In disapproval? In fear? In curiosity? Is it the smoking? But Jack either doesn't notice, or doesn't let it phase him. We both leave smiling.

In this particular community, stereotypes against the American Indian community are pervasive and enduring, and in essence create a feedback loop with institutional policies, aka manifest manners. A 2011 study that interviewed 100 Tribal members on prejudice in the surrounding county confirms the association of American Indians with drug and alcohol abuse and argues that enduring racism results in multiple microaggressions and some instances of overt racism against them. This includes instances of doctors in the area assuming drug or alcohol use without eliciting any other information from the patient(s), and more everyday occurrences of racism such as being followed in stores, or people making racial/racist comments.

In interviews for this research study, all 26 community members answered yes when asked if they thought racism against American Indians was still a problem in the United States and in the area surrounding the community. Twenty-three of 24 community members (who answered the question) said they had personally experienced racism against them, while one woman said that while she had not experienced it personally, she was aware of others experiencing it. In addition, while they were not specifically asked about it, eight community members cited shame, stigma, or being judged by others as issues that worsened drug or alcohol use, worsened the life experiences of drug and alcohol users, and/or interfered with services provided to drug and alcohol users.

Tribal employees also widely recognized racism as an issue. When they were asked about racism in the area, fourteen out of fifteen employees answered that it is an issue, while one said they were unsure, and ten said that they had experienced it themselves. In addition, although they were not directly asked about it, two employees cited stigma and being judged as a barrier to drug and alcohol users being open/honest with their loved ones, receiving fair/adequate services, and/or to their recovery from addiction. When recounting stories of racism, a number of Elders, community members, and employees discussed the association of American Indians with drug and alcohol use, and ways in which this had detrimental effects on their lives. These responses are reflected in Table 2 below.

Table 2:Racism & Stigma

	Ongoing Racism Against American Indians in the area	Personally Experienced Racism	Shame/Stigma/Being Judged Make D&A use worse and/or worsen services
Community Members N=26	26	23	8
Employees N=17	14	10	2
*While N= the total # of interviews, not all participants answered each question.			

In opposition to stigma, prejudice, and being judged interfering with care, a number of community members, Elders and employees cited that understanding, patience, caring and compassion were key to addressing issues of addiction in the community (although they were not asked about any of these things specifically). When asked about how to improve services and/or best address addiction, five community members stated that having understanding, compassion, or care for those struggling with addiction was very important for clinicians/service providers, and four community members stated more generally that addicts needed the community or family members to demonstrate care/compassion or understanding.

One Elder argued that service providers in the community were not compassionate enough, while a second Elder expressed the importance of those struggling to have a safe space where they could talk and not be judged. Similarly, two employees said that clients knowing they cared was key to their work, and that other providers should also demonstrate caring. Additionally, one employee spoke more generally on people needing someone to show they cared. An additional employee argued that patience and understanding were necessary. The number of interviewees who highlighted these issues are shown in Table 3:

Table 3: Care & Understanding

	Service Provider Understanding, Compassion, Care	General Understanding, Compassion, Care
Community Members N=28	5	4
Elders N=15	1	1
Employees N=17	2	2
*While N= the total # of interviews, not all participants answered each question.		

This focus on care and support translated to other areas of the interviews as well. When asked about the greatest strengths of the Tribal community, six community members and three employees said that the community was supportive, caring, and/or loving, while two community members and eight employees said it was the closeness/close-knit nature of the community. Five community members and six employees said that it was all of the events and social activities, while seven community members and six employees cited good programs or that there are a lot of services available (three named specific programs). Four community members and one employee identified the community's commitment to addressing the drug and alcohol issues, and five community members and one employee indicated that the Tribe has already grown and accomplished a lot with their own resources (two community members added that the tribe

continues to work and strive to do better). Three community members and two employees recognized Cultural Revitalization and/or cultural activities as a main strength. The top answers to this question are represented in Table 4 below:

Table 4: Strengths

	supportive, caring, and/or loving	closeness /close-knit	events & social activities	good programs /services
Community Members N=28	6	2	5	7
Employees N=17	3	8	6	6
*While N= the total # of interviews, not all participants answered each question.				

One Elder told me that the association of American Indians with alcohol and related racism is a historical trend she remembers from her childhood:

> *"They used to come up here, throw eggs at our house, call us drunks, call us dirty squaws, throw tomatoes at our house, and they put rotten food in our mailboxes. We didn't have police. We didn't have Tribal court. We didn't have none of this. And then, the county sheriff would say, "Well, do you know what the car looked like? Do you know what that—? Did you get a license plate?" And by the time they got there you know; the kids knew that they could get away with it up here.*

There is evidence that this myth persists, and that the association between American Indians and alcoholism also extends to drug use. A number of community members and employees alluded to this connection, but one community first responder summarized it well:

> *The prejudice and racism is, you know, other people looking in think, "Oh, the natives are all just drug users," or, "All the natives are drunks"…I mean, they lump them all together regardless of if they are or they aren't, they're lumped together as drunks or drug users.*

In effect, the racism and maltreatment due to prejudice against American Indians is compounded by the stigma of alcoholism and drug use, regardless of whether or not any individual community member actually uses drugs or alcohol.

Additionally, many community members feel that the local non-Native run newspaper reinforces these stereotypes. A number of people I talked to both in interviews and more informally pointed this out. For example, when asked whether she thought drug issues are worse in the Tribal community versus the whole area, one community member said:

> *"No, it's bad all around. I think it's a smoke screen for people to say that, the Tribe is the cause of it. And I know people that were doing and still doing it, and the non-Native community even before the casino came along. So, and then…the stats they showed, um, the local newspaper actually, it's pretty much even, even though it seems like they really focus on when a Native overdoses, and they don't focus on the non-Natives. They just kind of like skim over that, whereas the Natives, the names, and – are all thrown out there which I think is wrong. But, so people assume that it's because of the Natives. It's not."*

While an in-depth analysis of all local newspaper coverage was not part of this study, I did find at least three articles that named specific Tribal Members that died of overdoses (at least two with pictures of the deceased), and came across several reports of overdoses that did not state a name or race at all. It is unclear how many overall were about American Indians, but it is clear that specific individuals were identified and written about in the paper. A number of community members expressed disgust, sadness, and/or anger about this, and felt American Indians were targeted in these types of articles.

These perceptions of drug and alcohol use being worse in the American Indian community reinforces and justifies racism in the broader area, but also shifts the blame to the American Indian community, and in effect also brands the reservation itself (often called "the Rez") as a place of danger. In opposition to this, Elders, community members and employees all described drug dealers targeting Tribal members beginning with the opening of the casino. It is now a common perception that Tribal members have excess money to spend, as one employee put it when asked about racism:

It’s become much more-much more subtle. Um, there is a sense of correctness. Um, but, um, you can see it in attitude. You can see it in, um, in the way that-that people smile. The-the reasons for the prejudice may have changed a little bit. You know? “Um, you just aren’t responsible with your money. That’s why you’re drunk. That’s why you’re under. That’s why you’re in debt. That’s why.” You know? Everybody lives in a big fancy house and, you know, lights five-dollar cigars with ten-dollar bills sort of a thing. It is, it’s much more subtle…but it is just as alive as it ever was.

Because of this idea that Tribal Members have excess funds, several people recounted how drug dealers will come in from bigger cities in the area, specifically to cater to Tribal Members, and sometimes even use threats, coercion or violence to get money. One Tribal Elder said:

…mostly it started when…uh, the casino took off, I think. That’s when it really got heavy. You know, I hear stories of, you know, drug dealers waiting for people. I heard they would charge up drugs. And then when, uh, payday came, they would be waiting at the bank for them, make sure that they got their money.

Another Elder added to this saying:

They know when you get paid, and so, when they're right here… But they will—nowadays, they even give it to you on credit. So, if you don't pay it, they'll threaten you, beat the crap out of you, and some of them will even take you right down … They take you to the bank, or go with you in the casino to cash it. And take you—they're right beside you. A couple of our members did that, and dealers took every penny of their loan. Every penny. They didn't have nothing.

This trend of targeting the reservation and Tribal members was confirmed by a local law enforcement drug task force in the area, who also stated that drug dealers sold drugs for much higher prices on the reservation than in other areas. In some ways then, stereotypes about higher drug and alcohol use by American Indians can be viewed as a self-fulfilling prophecy. Because of assumptions that Tribal members have money and Indians use drugs at higher rates, they are targeted, which may lead to increased drug use, and definitely creates easier access to drugs. They are further subjugated by drug dealers who charge them more, compounding issues of debt and fueling further stereotypes.

Also, because American Indians are racially profiled as drug and alcohol users, they are surveilled more closely than the general population in the area, and so get stopped more often by police, and stereotyped by local officials (including judges and police). One community member explained that she would not drive around with things identifying her as American Indian in her car because of potential police harassment/racial profiling, and that she advised others not to either. Others confirmed that they felt American Indians were profiled in general, especially in the linking of the Tribal community with high rates of drug and alcohol use, and that they did not receive the same treatment in the justice system:

> *I feel like Native Americans and blacks ... um, when it comes to like drugs, they-- you know, it's just throw 'em in jail, and that's it...the populations of natives in jail, the populations of blacks in jail or prison…is out of control.*

While this idea of racial injustice in the justice system is hardly novel, several community members and employees thought that stigma and judgement surrounding drug use, as well as related shame, actually interfered with service utilization and quality of services provided to Tribal members. One employee said:

> *I think the Tribe has a lot of great resources, but I just don't think everybody is always willing to use those because of the stigma, you know. Going to the behavioral health…They think they're going to be looked down on, maybe.*
>
> *You know, I had one person who told me that "Oh, the Judge just thinks I'm a, a drug addicted Indian." They don't feel like they're being seen as a person. They're seen as their addiction.*

Two young women I spoke with confirmed this issue: saying:

> *Like she said, they're judgey. They know that you're a user and like – they haven't been through it and they don't know what they're talking about.*
>
> *Yeah they just sit there and tell you that "Okay we get it. We've done research. It's bad." but have you ever –*
>
> *…if you haven't felt that then you can't talk about it and tell us to just get over it, because it's not like that.*

In addition, a few of the other community members highlighted the need for more services that took a non-judgmental approach. One woman told me:

> *Let them know what's there. Let them know they're not going to be judged if they reach out for help…And have it be confidential to where if they walk in the door they're not going to have to say "hi my name is . . . I need your help." You know it's just I don't think there's enough help like that available.*

A Tribal employee identified prejudice against drug users as a specific issue with service providers:

> *It's amazing how-how quickly some people's prejudice can come rising to the forefront including service providers. Yeah, yeah, we call it [addiction] a disease, but you really know that they're a bad person. And, um, we don't want to treat bad people. That's the toughest thing I see, and it's been… consistent.*

Additionally, a few of the interviewees argued that the stigma and shame related to drug use actually increased the likelihood of future drug use as a coping method. One interviewee said

> *…a lot of the people…have an addiction, and it seems like it's like a cycle. Like maybe they have mental health issues or depression or um, other issues. And then, it's like a coping mechanism and an addiction. (pause) And then they end up getting worse and shame and it's just, it's kinda like downward spiral.*

Similarly, a young woman told me:

> *I think if they like helped, you know, helped them get sober and push them in the right direction instead of "you did this, and you did that." Because it's too much shame, you know. You can't shame them because then they're going to go back to drugs and do it again.*

In a number of instances community members discuss caring, understanding and compassion as the implicit opposites of shame, stigma and "judging," and indicate that services that incorporated these things would be more effective. When asked how to best address drugs and alcohol in the community one community member said:

> *So, it's like, I definitely think awareness helps and like to have services and you know, um… I think just having those solutions. But um, maybe just having*

> *compassion for addicts and you know, their families, and just keep trying to encourage people. I think that would help.*

When asked how service providers could do better another community member said:

> *I think a lot of our clinicians are just here to get a paycheck, which I totally get, you know. They go to school all those years and there's really no heart.*

And another argued:

> [service providers need]… *more training on the overdoses and . . .being more how do I say it? Gentle …and loving instead of rough around the edges.*

A number of Tribal employees agreed with these sentiments wholeheartedly, and essentially argued the same thing. One man said that in order to work effectively, service providers needed to be:

> *…people that can demonstrate knowledge and understanding of addiction, and that doesn't mean that they need to be in recovery themselves. But they have to be able to genuinely care about-about individuals. They need to genuinely care about the community.*

And another argued that:

> *If we're in the position where we're working with someone who is trying to overcome their addiction, that um, they need help. You know, it's not, it's not easy to come in here and say like, you're going to do this and you're going to do it now. You need to be patient, you need to give them time. Um, their brain is going through... They say it takes six months for an addict's brain to heal. They're going through a lot of changes. They're not going to be perfect. They might run into roadblocks along the way. I think we just need to be patient and understanding when working with these people that face these demons of trying to overcome their addiction.*

These sentiments were echoed by others in all categories of interviews included here. Taken along with the critiques of judgement, prejudice, and stigma, they are an important indicator of how services could be improved. In addition, there have been some recent efforts to destigmatize addiction both at grassroots and programmatic levels. The Tribal court, medical clinic and behavioral health services have all turned toward the

medicalization of addiction and have had numerous events and speakers framing addiction as a disease as opposed to a criminal activity or moral failing (this is discussed in more detail in chapter three). In addition, a group of Tribal Members and employees were the driving force behind a newly minted Community Against Drugs Organization that is open to anyone in the area, including in the city and county. This group has focused significant effort on destigmatizing addiction and drug use, and on providing support and information to families and drug users in a non-judgmental way. However, all parties involved have expressed that there is still a significant amount of work to be done on this front.

Discussion: Survivance in the Face of Manifest Manners

A recurring question throughout this research study was: "Is it really worse in the Tribal community?" Existing statistics and counts are not very helpful here, because of a number of data collection and statistical challenges of documenting drug use in the area (and in many American Indian communities across the nation). It is clear that in some ways it is worse, and in some ways it is better. Like most questions surrounding addiction and treatment, there is no one answer, and no answer is simple.

It is worse because all American Indians in the community must deal with the manifest manners of racism and prejudice that are compounded by each newspaper article linking the Tribal community to drug use, and each person in the broader community spreading stereotypical views and blaming the Tribal community for drugs in the area. Singer and Page (2014), and Gilliam (1992) have demonstrated how apprehensions surrounding race and class are capitalized on by those with economic and political power to perpetuate and legitimize ongoing inequalities

and stereotypes, and the links between racism and stereotypes of American Indians and both individual and institutional oppression have clearly continued into the present in this community.

Continued bias of biomedical culture against American Indian peoples and cultures (as well as other Indigenous peoples), and their knowledge of health, healing, and illness is clear in medical and mental health literature and some anthropological work (Mehl-Mendrona et al. 2009: 90-98; Manson 1997: 250-256, Waldram 2013, 200-203; Tait 2008). Many approaches to American Indian health and mental health reinforce biomedical assessments of mental illness, minimize historical and socio-economic concerns, and affirm the biomedical focus on individual pathology (as opposed to community health and wellness), and in many ways extend coloniality on American Indian peoples and communities (Simpson 2008; Gone 2008; Howard 2014, 529-532; LeFrancois 2013, 109-119). It also runs counter to the ways in which many scholars, including Renya Ramirez (2004), Lisa Poupart (2002), and Wayne Warry (1998), articulate the importance of collective and community healing in American Indian communities.

These issues of understanding and bias within the medical community are enacted alongside surprisingly durable tropes of American Indians as “primitive,” “savage,” and “uncivilized.” While these are perhaps more nuanced than in the past, they are still widely used in the popular media and in primary and secondary education of US children, where many teachers know little about American Indians. This results in ongoing misperceptions in the general population (Jacobs 2017: 5-8; Harrington & Pavel 2013: 10-12; Lovern 2012: 867-872; Haukoos & Beauvais 1997: 77-81).

Elders, community members, and employees identified a number of ways in which this has direct impact on the community and individual people in their everyday lives. Microaggressions are one outcome of these prejudices, and are well documented by this and

previous studies. Community members must live with being suspected of drug use, or of being at increased "risk" for addiction just by virtue of being Indian.

These accounts support Poudrier and Glick Schiller's arguments about risk. Identifying American populations to be "at risk," works to justify continued surveillance and control of their behavior, whether it is framed in terms of genes, or culture (i.e. bad behavior), or both (Glick Schiller 1992: 247-250, Poudrier 2007: 241). They also align with studies that argue "risk" acts on individuals and groups to allow U.S. elite to maintain their dominance, obscure social and economic structures that influence health and drug use, and serve as an instrument to both place blame on, and assert and express control over particular populations (Nguyen & Peschard 2003: 457-459, Glick Schiller 1992: 247-250). Identifying American Indians in the area as particularly susceptible to addiction, allows the non-Native community to distinguish the American Indian community, or "the rez" as a center of addiction and danger, and further obscure the aspects of the opioid crisis (i.e. poverty, oppression, and other socio-economic and historical factors). In this case, both medical and police surveillance are justified by identifying the American Indian community as "at risk" for drug use.

Blaming of the Tribal community and individual drug users takes attention from real causes of the Opioid Crisis like pharmaceutical interests, long-term prescribing practices that are just beginning to be addressed, and social problems that are present everywhere but difficult to address (like historical and childhood trauma that will be discussed in chapter two). This is consistent with previous anthropological work that critiques the stigma of drug use and the "individual responsibility" paradigm that rules understandings of drug users in the United States. Like Page and Singer (2010) and Gilliam (1992) point out, these factors are not only symptoms

of disparate treatment of poor and historically oppressed groups, but also perpetuate and compound these inequalities.

This racial profiling and prejudice have other real and lasting effects on American Indians who are more likely to be caught up in the criminal justice system as a whole, and to be victims of crime (Poupart 2002: 144-146; Perry 2006:413-418, 430-438). Community members identified numerous instances of profiling. In some ways Tribal court employees may underestimate, or at least minimize, the long term and extremely detrimental impacts involvement in the criminal justice system generally has on individual's lives and their families (which will be further elaborated on in Chapter 3). Beyond this perpetuation of inaccurate and harmful perceptions, microaggressions, and racial profiling, community members and employees identified interference with services such as medical care and counseling because of these perceptions as an ongoing problem that perpetuates shame and stigma. Some studies have shown shame to be a factor in addiction, and that it may cause drug and alcohol users to use more as a coping mechanism (Dearing et al 2005, Wiechelt 2007: 403-406; Bilevicius et al 2019: 18-20). This only worsens the problem.

Essentially then, this judgement, shame and stigma is a function of the biomedical and mental-health establishments that both reinforce and feed off of broader stereotypes and tropes about American Indians. Culturally, historically and political situated institutions minimize historical and socio-economic concerns and seek to control and shape American Indian peoples and communities, essentially extending coloniality over them (Simpson 2008; Gone 2008 310-314; Howard 2014, 529-532; Howard 2018b, 1-4; LeFrancois 2013, 109-119).

The situation in the Tribal community is also better in many ways because of community survivance. There are extensive health, behavioral health and other services available to

community members for little to no cost, but as community members and employees identified, mostly because the Tribal community has exercised sovereignty and dynamism in maximizing and developing their resources to provide for community members. In addition, the Tribal community is very proactive in seeking to address drugs and alcohol and devotes a significant amount of attention and resources toward addressing addiction, which community members also identified as a strength. The recent efforts to reduce stigma are also promising, and the Tribal community has been generally more open about discussing drug and alcohol issues, especially in recent years. Thinking in terms of survivance, a more crucial consideration than whether things are better or worse in the Tribal community, is how to affect positive and meaningful change. How can systems laden with coloniality be remade for community members in new ways?

Although some community members cited the closeness of the Tribal community as a reason why drug overdoses were so devastating, when asked about what community strengths were, a significant number of community members and employees replied that the closeness and caring of the community was its greatest strength. According to both community members and service providers, existing resources and community commitment to this issue could be even more effective if change could be enacted across service provision to 1) further address/reduce shame, stigma and judgement, 2) address ongoing misconceptions, prejudice and racism that interfere with service provision, and 3) increase cultural and sensitivity information, training, and other resources to assist service providers in demonstrating understanding, caring and compassion to an even greater degree.

There are at least two issues that may be preventing the expression of love, compassion or caring in service provision. The first is that the terms, specific actions and expressions that read as love, compassion and caring to community members have not been specifically defined

or identified as priorities for service providers. This means that service providers may be unaware of community members' desire to have more compassionate and caring relationships with community service providers. The second and more daunting barrier is that the systems in which services are delivered, are designed to de-humanize, and sterilize. This does not make it impossible to move toward more loving, caring and compassionate services, it just means that these barriers need to be directly considered and addressed. In order to affect meaningful and needed changes, service delivery systems may need to be re-envisioned completely.

Because community closeness and caring are main strengths raised by interview participants, this may be the Tribal community's most significant asset in pushing ahead. A number of scholars have argued that community and collective healing is important and transformative in American Indian communities (Ramirez 2004: 110-113; Poupart 2002: 96-97; Tait 2008: 45-46). One community member enthusiastically expressed it like this:

> *What I love about it is the caring. Um, despite all the factions and things that happen, when something happens the whole community comes together. And during those moments you see all the – you don't see the negative side. You see the loving, caring, the ability to pull things together at the last minute to help support a family, to, you know, help support each other in times of tragedy and celebrations. I think even that's a positive. People reaching out, you know, I think is a strong part of being a Native community.*

By further recognizing, growing, and utilizing this existing survivance—the continued community closeness, caring and compassion in the face of coloniality—the American Indian community can affect addiction not only through programmatic service provision, but also through relationality expressed and experienced beyond the institutional boundaries that often harbor representations and paradigms that continue to work against American Indian peoples. These systems of relationality and community healing are lived survivance in the face of

biomedical and institutional manifest manners expressed through medical and scientific archetypes of respectability.

Conclusion

In the American Indian community at the center of this study, persistent and inaccurate ideas of race and the morality of drug and alcohol use rooted in colonialism and western ethnocentrism, have combined to perpetuate ongoing racism and oppression against community members. This has impacted them in multiple ways. Community members are framed as drug and alcohol users by virtue of being American Indian, blamed for drugs and alcohol in the broader community, and racially profiled and stereotyped by police, doctors, and other authority figures. This interferes with service provision to American Indians in the community, perpetuates shame felt by drug and alcohol users (possibly leading to more drug and alcohol use), and increases the cost and availability of drugs on “the rez” (due to targeting of the community by drug dealers).

Despite these extensions of coloniality, community members recognize that a main strength of the Tribal community is its closeness, care and love. In opposition to judgement and stigma directed at the Tribal community, community members, Elders, and employees argue that love, compassion, understanding, and caring are crucial to addressing drug and alcohol use in the community. These facets of existing survivance can be cultivated, emphasized, and directly employed in order to counter the narratives and mechanisms of coloniality, and reinforce Tribal relationality and self-determination in waging the war on drugs.

Chapter 2:
Trauma as Catalyst, Culture & Community as Healing

When I stopped thinking of myself I knew who I was and where I came from, and I believed in this dream the way I believe that the spirits of the ones who raised my father raised me up.

-Gordon Henry Jr.
Entries into the Autobiographical I
From The Failure of Certain Charms (2007: 35)

While addiction is complex, and it may be impossible to identify one or even several definitive root causes in any individual person's experience, this chapter explores how trauma is defined, described and employed in discourse and action in relation to addiction. I also examine how different explanations and iterations of trauma frame addiction and drug and alcohol users, as well as the Tribal community at the center of this study as a whole.

A recurring theme in interviews for this research is that trauma (both Historical Trauma and individual trauma) has a significant impact and may be a main cause or catalyst for drug and alcohol use. In addition, many of the stories shared about the links between trauma and addiction work to reveal and critique historical and ongoing inequalities experienced by the American Indian community as part and parcel to colonialism and contemporary institutional oppression. Despite this, many community members focus not on the wrongs and trauma itself, so much has ways to move past them. To this end, I outline some broad academic discussions of Indigenous conceptions of health and healing and convey specific ideas from my interviews on how to heal from historical and other types of trauma and addiction.

Contextualizing Trauma

Merriam-Webster provides the following definitions of trauma:

1 *a **:** an injury (such as a wound) to living tissue caused by an extrinsic agent*

*b **:** a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury*

c **:** *an emotional upset*

2 **:** *an agent, force, or mechanism that causes trauma* (Merriam Webster 2019)

While such definitions are presented as simple, Didier Fassin and Richard Rechtman's 2009 book *The Empire of Trauma: An Inquiry into the Condition of Victimhood* outlines the development of the idea of trauma as both a health and mental health concern, and as a moral, social and political concern. They argue trauma is a recent designation that has greatly risen in prominence over the past several decades, and represents a paradigm shift from mistrusting victims, to establishing victimhood as a revered, trustworthy category. The authors also show this has caused an equalization of traumatic events, in that "trauma" is a category consisting of a huge number of distinct and varying experiences (e.g. getting in a car accident is a trauma, and so is witnessing a murder). Furthermore, they note a shift in how collective traumas (e.g. the holocaust and American Indian experiences of colonization) allow for historical and political acts to be judged. Ultimately, they assert that trauma is not simple or straightforward; it is a historically, socially and politically constructed term that now allows for critique or redress for historical and recent "wrongdoing," and/or immoral acts(Fassin & Rechtman 2009).

More recently childhood trauma, or Adverse Childhood Experiences (ACEs), have risen to the forefront as a concern. The original ACEs study was conducted from 1995-1997 and identified a number of specific "ACEs" including experiences of abuse, neglect, and "household challenges" (such as having a member of the household with a serious illness, mental illness, substance abuse issue). Researchers then monitored participants' health and mental health outcomes in relation to their ACEs. As the CDC puts it, "The ACE Study has uncovered how ACEs are strongly related to development of risk factors for disease, and well-being throughout the life course" (CDC 2019). While the original study had some issues, such as including

predominantly white middle-class participants, more recent studies have linked ACEs to similar effects in other populations, and some have argued that community level adversity should also be added to ACEs measures (Cronholm et al. 2015; Turner et al. 2006; Umberson et al. 2014).

The rise of attention to trauma (including Post Traumatic Stress Disorder/ PTSD), ACEs, and Historical Trauma, has coincided with a rise in the medicalization of trauma and what is categorized as traumatic (Fassin & Rechtman 2009; Wilson, Pence & Conradi 2013). The concept of "Trauma-Informed Care" began in the late 1990s, and was quickly supported by government agencies and research institutions including SAMHSA (Substance Abuse and Mental Health Services Administration), Duke University, and UCLA. Since then, and in large part due to the success of early efforts by the aforementioned institutions and SAMHSA's creation of a National Center for Trauma- Informed Care (NCTIC) in 2005, Trauma-Informed Care has flourished into an ubiquitous, influential paradigm (Wilson, Pence & Conradi 2013: 5-6). Its main strongholds remain within the fields of mental health and social work, but its influence has permeated into many disciplines and contexts including schools.

Historical Trauma

Historical Trauma has been a key term in American Indian scholarship, communities and mental health practice for over 20 years (Brave Heart 1998; Brave Heart & DeBruyn 1998; Duran & Duran 1995; Prussing 2014). Yellow Horse Brave Heart and DeBruyn (1998) compellingly argued that: 1) American Indians face grief over historical losses which were and still are largely unacknowledged or recognized by dominant society, 2) trauma in families can and does affect subsequent generations, and 3) because American Indian communities still face the trauma of oppression and loss on a regular basis, these things are compounded to negatively

affect individuals and communities. This is reflected in high rates of illness, violence, drug and alcohol use, and other issues (Yellow Horse Brave Heart & DeBruyn 1998: 64-66).

A key component of Historical Trauma in American Indian communities has been the American Indian Boarding School system in the U.S. and Residential Schools in Canada. While there were some differences in policy and practices between schools (e.g. some were run by the church, and some by government), they all removed children from their families (often forcibly and coercively) and sought to assimilate and (re)educate them to be more like Euro-Americans. The banning of American Indian cultures, languages, religions, and lifeways within the schools were key to these efforts, and some children were rarely (if ever) allowed to visit or return home. These practices have been cited as a main source of Historical Trauma in American Indian communities alongside significant physical, mental, emotional and sexual abuse that occurred in many schools. There have been a number of studies and personal stories examining both the effects on Boarding School survivors, and their children and other descendants (Littlefield 2004; Bombay et al 2011; Lajimodiere 2012; Bombay et al 2014; Cromer et al 2018).

Despite the prevalence of Historical Trauma as an accepted framework in American Indian communities, some scholars have lingering questions, and see contradictions and problems with the concept. Erica Prussing (2014) argues that there are three research approaches—evidence-based , culturally relevant, and decolonizing—used to address Historical Trauma, and that these paradigms have different aims that are not always compatible or reconcilable.

Joseph Gone (2014) asserts that 1) "Historical Trauma is primarily a construct invoked in relation to *health status*—especially *mental* or *behavioral health status*," and so is subject to approaches and discourses of health related disciplines; 2) Historical Trauma "is an elaboration

and extension of an established psychiatric category, posttraumatic stress disorder (PTSD), as applied to AI [American Indian] circumstances and settings" but is focused on collective, cumulative and intergenerational as opposed to individual trauma;" 3) Historical Trauma "is most clearly distinguishable from PTSD by its alleged intergenerational character with a number of proposed means of transmission" in some cases independent of individual/direct exposure to trauma 4) "instances of oppression, colonization, and genocide by Europeans are properly designated as the principal causal factors for explaining contemporary American Indian community-based health and mental health disparities;" with a clear emphasis placed on European perpetrators and American Indian victims of oppression (Gone 2014, pp. 390-391).

Gone argues that this raises some significant questions about Historical Trauma and how it is used. For example, is it Historical Trauma if the perpetrators of trauma/violence are other American Indians and not European? How exactly is Historical Trauma transmitted generationally? How does Historical Trauma's biomedical framework limit the ways in which the processes of colonization and their effects are talked about and recognized?

Documenting Addiction & Indigenizing Healing in American Indian Communities

Historical Trauma has drawn attention to the continuing effects of colonization on contemporary American Indian mental health and addiction and has encouraged recognition and consideration of these effects beyond Indian Country, particularly among the biomedical and psychological communities (Myhra 2011, Gone & Calf Looking 2011). While addiction has been identified as a problem for Indian Country, it is important to recognize that American Indian communities and individuals are diverse, and have differing perspectives, approaches, and beliefs when it comes to drug and alcohol use, when it is a problem, and how to treat it. Distinct Tribal nations also have different legal and political status and concerns.

In general anthropologists studying these issues have pointed out that many American Indian communities represent and problematize drug and alcohol use as the intrusion of non-Indian ways into American Indian lives, and/or as the antithesis of traditional American Indian life. This is mentioned by Prussing (2011) and Calabrese (2013) in their ethnographies regarding treatment for alcoholism in the Northern Cheyenne and Navajo Nations respectively, and is a main focus of John Garrity's argument that Navajos have integrated multiple religious traditions into their lives in order to address issues of drugs and alcohol. (Garrity 2000: 535-537). Gilbert Quintero (2002) highlights this representation of drugs as an intrusion into Navajo life by tracing drinking narratives of individuals in the Navajo community, and their contrasting of those stories with a "nostalgic past." He contends that these juxtapositions are an accepted form of social critique that allows storytellers to comment on negative events of the present or past; colonization and its ongoing effects in particular (Quintero 2002: 15-17). The importance of storytelling in American Indian communities in general makes this argument particularly salient.

More general representations of American Indian illness, healing and wellness have been shaped by opposition between American Indian resistance, struggle, and resilience and the socio-political, economic, and cultural power dynamics involved in coloniality and oppression. While the diversity of American Indian and other groups Indigenous to the US and Canada, makes it difficult and sometimes misleading to generalize, many argue that Indigenous groups have a much more inclusive understanding of health than the dominant Western understanding. This is sometimes labelled as "wellness" or "wellbeing," and often distinguishes the following as key: holistic and concerned with balance, focused on community and connectedness, tied to the land, spirituality, language, tradition, knowledge, and education (Colomeda & Wenzel 2000: 245-252). For example, Naomi Adelson's (2000) discussion of the Cree word Miyupimaatisiium,

translated as “being alive well,” and Manitowabi and Shawande’s discussion of the Anishinabe conception of health as minaamodzawin, or a “good, holistic way of life” expand on broader conceptions of wellness (Manitowabi & Shawande 2013: 98-99).

While there has not been a significant amount of recent anthropological work published about American Indian addiction, or healing from addiction (aside from those mentioned here), there are some relevant pieces from other fields that seek to address both addiction and Historical Trauma. Gone and Calf Looking (2011) outline a “Culture as Treatment Hypothesis, “ which posits that American Indian culture should be effective in treatment for addiction because: 1. It is a reversal of many of the processes involved in Historical Trauma, 2. There has been a significant number of personal testimonies of American Indians who have recovered from addiction through immersion in their culture, and a few formal studies that document that participation in traditional activities increases the likelihood of recovery, 3. Plausible explanations for why this would work include spiritual revitalizations, social reorientations, and effects on identity, motivation, purpose, and/or an overall change in lifestyle, 4. May provide a way for recovery that promotes and builds American Indian nationhood, sovereignty and community (Gone & Calf Looking 2011: 291-296). Although the information is presented in a more clinical format, the authors highlight the ways in which American Indian culture and knowledge is valuable and the fact that communities have been proactive in addressing their own health issues.

Facets of Coloniality: Policy & Bureaucracy

Part of the problem of Historical Trauma is that American Indian knowledge systems, including knowledge of health, wellness, illness, and healing, have been targets of both US and Canadian policies since before their official inception as independent nation states. Virtually all

Indigenous groups experienced the broader processes of colonization, disease epidemics, forced relocation, boarding/residential schools, outlawing of American Indian ceremonies and religions, and ongoing oppression. These processes were not only causes of Historical Trauma, but have also impeded recognition of and healing from Historical Trauma (Yellow Horse Brave Heart & DeBruyn 1998: 57, Wexler 2009: 268, Kirmayer et al. 2008: 5-6). Coloniality in the form of policy and bureaucracy further interferes with healing.

While there are obviously differences in US and Canadian policy towards American Indians, overall both governments perpetrated colonial policies that privileged Euro-American and governmental agendas above American Indian life and welfare during their entire histories as nation states. For example, while the Indian Act in Canada and Blood Quantum requirements in the United States have significant impacts on individuals and communities, along with other programs, both aimed at reducing (and eventually eliminating) American Indian populations, as a way of walking back promises made to them under government agreements, including health care (Kirmayer et al 2008: 11-12, Vasiliki 2013: 73-81).

Along with an increased recognition of Historical Trauma, changes in popular, academic and medical discourse have been accompanied by policy changes toward American Indian self-determination in both the US and Canada. In the United States, Indian Health Services (IHS) has been chronically underfunded and ineffective in addressing the needs of American Indians since its inception in 1955, and notoriously bureaucratic (Warne & Frizzell 2014: s266). While the Indian Self-Determination and Education Assistance Act of 1975 paved the way for Tribes to take control over their own health programs, significant funding for Tribal health programs still comes from IHS. In the past these funds have been subject to political currents and congressional budget issues, and financial security is unevenly distributed across tribal communities (Warne &

Frizzell 2014: s266). While the Affordable Care Act (aka Obamacare) included permanent reauthorization of the Indian Health Care Improvement Act, securing funding for IHS, it is unclear if this decision will stand under the Trump Administration (IHS: 2019). These considerations deeply affect American Indian health programs, which are already subject to varying, but fairly stringent regulations related to their relationship with government agencies.

In the American Indian community at the center of this study, these regulations apply to health and behavioral health programs, which are modeled on US medical and behavioral health systems, meaning that prioritization of community and cultural considerations in service delivery are bound by biomedical frameworks to an extent, and funded at least in part through unwieldy government agencies. This means Tribal health, mental health, and drug court programs are subject to oversight and bureaucratic policies of IHS (Indian Health Service) and BIA (Bureau of Indian Affairs). While this will be discussed further in Chapter Three, it is important to note these relationships. IHS is also positioned squarely within the biomedical establishment, and as touched on in Chapter One, biomedicine has targeted Indigenous knowledge and cultures as barriers to health historically and into the present. Because biomedicine is its own cultural system, it has very distinct goals and assumptions about illness and healing that are not applicable to Indigenous knowledge systems (Waldram 2000: 619-620). For example, biomedicine focuses on individual bodies, and psychology primarily on individual minds/emotions. Neither meaningfully seek to address community trauma or community healing.

In thinking about addressing addiction and other mental health issues then, American Indian communities, and this community in particular, have framed their experiences of colonialism and oppression in terms appealing to biomedical and government agencies: Historical Trauma and ACEs. This not only ensures and justifies provision of resources needed

to address community issues, but also counters biomedical narratives that have placed American Indian individuals and communities as responsible for their health, mental health and social problems. In addition, it speaks to the everyday lives of community members.

Coloniality & Trauma, Family & Culture

I sit across from Cindy in one of the few coffee shops downtown. It has a bright, airy and modern feel with light wood floors, furniture straight out of Ikea and a slightly hipster feel. Cindy sips her tea from an oversized mug. She looks too young to have already lost a child to overdose. She doesn't mention it, but everyone knows, and I think about how many parents I now know who have lost a child, children who have lost parents, people who have lost brothers or sisters or cousins, aunts, uncles…I'm glad there is hardly anyone else in here. I carefully sip tea out of my giant white mug, and we start the interview.

Cindy is motherly, soft-spoken and has dimples when she flashes her sweet smile. Her round face is framed by wavy almost black hair that brushes her shoulders. Unlike some of the other people I have done interviews with, she doesn't attract stares or dirty looks. At least not here. But she is addicted to opioids. She's been in jail and treatment. There are a few programs she has been in the past year or so, but she says she is on some medicines that treatment programs won't let her take. Some are for pain, and like several other people I have talked to, her opioid use started with legitimate prescriptions from a doctor for an illness, or injury or accident.

Cindy is optimistic, and wants to get multiple college degrees and learn even more of her culture and language. She has other kids to love and take care of. She tells me that she prays for people who are struggling and for police officers a lot. Prays for their safety, and that they are

equipped to deal with what they face. The interview doesn't take long, because she gives short and to the point answers delivered in her gentle, kind manner.

A few weeks later Cindy comes up on my social media page as I am working late in the evening, and I want to see how she is doing. I am tired and have been doing multiple interviews a day several days a week for months. They all talk about loss. Her social media posts seem to me to be full of tributes to her dead child, and I can't stop scrolling through. I lose it, and tears start flowing slowly, until I am sobbing over my glowing laptop in my dark home office. I feel like an asshole for crying. I am not living with so much pain.

Time passes… I still haven't seen Cindy, but I heard she lost another family member since I spoke with her a couple of years ago. I check out her social media again and it is filled with life. She has been active recently so must not be in treatment or jail. She has shared sports and religious memes, community events, and pictures of her kids and family. I hope she's found healing, and imagine her sweet motherly smile.

In interviews for this study, Historical Trauma was identified as a significant issue by a large number of participants, particularly community members. Community members, employees and Elders were asked what they thought some of the main issues impacting drug use in the community are, and what they believe are the best ways to deal with those issues. Historical Trauma was frequently named as an issue. In addition, toward the end of the interviews, community members and employees were asked if they were familiar with Historical Trauma and/or if they thought that Historical Trauma had an impact on drug and alcohol use (Elder Oral Histories were less structured conversations, and Historical Trauma was not addressed directly in the interview guide).

Eighteen community members, seven employees and three Elders said Historical Trauma has an impact on drug and alcohol use and other issues in American Indian communities today. For example, one community member said:

> *My mother was-was part of trauma--Historical Trauma. She was in a boarding school at a young age... So that-that did a lot. No matter what anybody says--"Oh, you're responsible for your addictions," whatever, like that. It still boils down to each generation in some shape or way.*
>
> *So, we are responsible for ourselves as adults to a certain degree, but generational trauma has a lot still to do with it. It's your whole life basically, the way you grew up.*

Two community members said it does not have an impact, and one said they were not sure if it did. Of employees, one participant had never heard of Historical Trauma, one said they did not know enough to comment, two were not sure if it had an impact, one said it possibly had an impact and three said they did not believe it did. A small number of employees and community members who did not think Historical Trauma had an impact, thought that it was used as an excuse for bad behavior. For example, one employee stated:

> *No. No. I mean, Historical Trauma is more—would be more a crutch than anything. I mean, it didn't happen to you or me; it didn't happen to our grandparents. It happened to your grandparents' parents, maybe. So, I think that is a crutch to lean on when you have nothing else. I mean, everyone—we were born with the same opportunities in this day and age, and I don't think there's anything holding back because of your skin color, you know.*

Boarding school was frequently used as an example of Historical Trauma, and in contrast to the above quote, 17 community members said that they had a family member attend an American Indian Boarding School, while three said they did not know, and one said she wasn't sure but probably did. The vast majority of community members who said they did have a family member attend a Boarding School cited a grandparent as the attendee, and in a few cases even a parent. The following Table (5) summarizes participant responses:

Table 5: Historical Trauma

	Historical Trauma Still Impacts Drug & Alcohol Issues	Historical Trauma Does Not Impact Drug & Alcohol Issues	Not Sure	Don't Know Enough to Say/Never Heard of	Family Member Attended Boarding School
Community Members N=28	18	2	1	0	15
Employees N=17	7	3	2	3	N/A
*While N= the total # of interviews, not all participants answered each question.					

Even those who recognize Historical Trauma as an issue sometimes expressed mixed feelings about how it is used. One employee said:

> *Hmm. I think it's* [Historical Trauma] *used as an opportunity to say, "This is – this is why I'm the way I am…"But each one of us has a choice. We can either walk that path of hurt. Or we can walk that saying, "Hey, my, my ancestors were overcomers." They were able to overcome the atrocities of what took place during the boarding school…And now I can make a difference because of their resilience, and their steadfastness. I can make a difference of my generation forward. I think it's each – I think we each have a choice. It's up to the individual.*

In addition, although they were not specifically asked about it, 12 community members, six employees and six Elders identified parenting/upbringing/family norms as key impacts on drug and alcohol use. Boarding Schools were often linked to both addiction and to a lack of parenting skills. One woman told me:

> *I think the, probably the most recent thing that's impacted the generations since then is the boarding schools. Our grandparents, um, my grandparents, went to the boarding school. And my grandma in particular, she had to go to the boarding school. She went on to have, um, you know, lots of children. But from others, other families that I've seen their families be affected by like the grandparents not being…not showing the kind of love that they would have received if they had their parents to give them love. Um, so the parents, the grandparents that went to the boarding school didn't know how to show love, so I think that does affect the subsequent generations.*

When asked what he thought some of the main things that have affected the drug and alcohol use in the community were one man said:

I just believe through our Native communities in general there's been a lack of social skills passed down through generations because of an effect that happened from grandmas and grandpas being put in boarding schools and stuff, so they weren't able to teach their kids things they didn't do in order to be able to have productive and positive lifestyles. And so naturally they go to drugs and alcohol because it makes them feel better for things that are messing up in their life. That's what I believe at least.

An employee concurred saying:

…the disruption runs deep and has not really had an opportunity to heal or correct itself. So, I think that, for example, the boarding schools in Indian country and the disruption of family and family dynamic gets rippled out into, um, emotionally rigid people. People who cannot freely express emotions. That creates a greater vulnerability to drugs and alcohol.

One Elder explained how this affected her directly:

There is a period of time that kids aren't parented. I wasn't parented during that time and it was right around that time where they take the kids to the boarding schools, you know, about five, four or five, something like that, on because they – I remember nobody – I used to think nobody loved me because I would just wander outside. You know, I'd be playing down the creek, or nobody was checking on me or – I didn't think anybody was, but they were. But they just – there was like they didn't know how to parent. And if you think about it, they probably didn't because you learn how to parent. And if their ancestors, they were taught – they didn't have any kids to parent during that period of time because they were taken to boarding school. So, it was just a big mess.

Pain, Grief & Other Trauma

A number of interviewees in all categories identified individual issues and experiences that are considered traumatic in terms of prevailing definitions of trauma and ACEs as important concerns. These were not always named as "trauma" but were cited as negative experiences and/or factors in drug and alcohol use. In addition, 12 community members, 12 employees and 2 Elders raised concerns about trauma/dealing with pain in general.

Table 6 below shows how many interviewees in each category identified each issue as a key concern:

Table 6: Other Trauma

	death of a loved one	children split from parents	domestic violence /abuse	sexual abuse	child abuse	child neglect
Community Members N=28	4	6	5	4	4	1
Elders N=15	4	4	2	1	0	0
Employees N=17	8	2	2	1	0	1
*While N= the total # of interviews, not all participants answered each question.						

To highlight the issue of loss, one Elder said:

> *I think, when I look at families… I think…one of the issues is death. That people can't deal with it. I mean, my brother's family, after he died, they fell apart. And so, to me, one of my goals, to let my kids know, if I'm gone, you know, you keep doing what you need to do. Don't use it as a cop out, you know. And there isn't in this community…there's not a lot of teachings about death, or support groups or…I don't think…I don't know what there is. And people die…tragically, with overdose and with pills.*

A young man had similar sentiments when asked about the effects of addiction on him personally:

> *I've had friends, I've had close relatives um, die from addiction, like directly from addiction. I had a friend in an alcohol related accident. Stuff like that. I've had several people I knew that were related or like a close friend. Um, yeah. There's been a lotta people I knew that I was friends with at one time who ya know, lived that lifestyle. Who were caught up in their addiction then because I'm sober, um, I had to learn how to let go of a lot of friendships. Or even relationships even with family…I've just had to learn a lot with recovery and I still have a lot to learn. But it's just like there's alternative, you know. So… I think it affects a lotta people. I think it affects um, the families, the parents, the children, the friends. I mean, it affects a lotta people. It can be really devastating when a friend or a loved one, you know, is in their addiction. Or they die from it or even if they are just not available or they go to prison or whatever the case may be. Like it really affects a lotta people.*

In addition, during my time in the community, ACEs became a main concern within the education, social services, and behavioral health programs in particular. A number of initiatives were underway or in development to address this through service provision. In the American

Indian community, ACEs were consistently linked to, and discussed in the context of, Historical Trauma. While non-service providers did not use the term ACEs, they did discuss this linkage to Historical Trauma in terms of trauma generally, or more often in specific terms (e.g. physical abuse, sexual abuse, loss of a parent, emotional pain). For example, the concerns over ongoing trauma among youth was expressed by one woman I talked to:

> *I think a lot of stuff happened historically that causes those that struggle to go after it* [drugs and alcohol]*, because it -- it helps to check out. It helps you to just numb yourself and not have to deal with the trauma that goes on in life…a lot of children are being abused physically, sexually, emotionally. And so, as they get older and they're introduced to this stuff, it's like oh yeah. I'm going to try it. It makes them feel like; oh, I don't have to deal with nothing.*

Another community member stressed the importance of taking care of community youth:

> *…I love the kids. Half the population of the world is under the age of 16. So, we have our work cut out for us. The youth are really, we gotta take care of em. Because they're going to rise up and they're going to be leaders someday.*

Despite interviewees of all categories seeing a clear influence of historical and other traumas on drug and alcohol use, and the ways in which addiction is a cause of trauma, solutions to these issues, or ways to heal from them were not as well-defined. A key barrier to overcoming addiction identified by a number of community members and employees was the idea of "wanting" help, or "wanting" to get better. While this theme will be covered in more detail in Chapter Three, it is important to note that throughout the interviews there was a recurring tension discussed between Historical Trauma and individual choice/responsibility, and between a medicalized and criminalized view of addiction. For example, one community member said:

> *The most luck that I've ever had with any type of I guess overcoming addiction or changing thought patterns, so I don't have addictive thoughts has always been when I was forced to do it. So voluntary programs, unless you already want to change and just can't stop physically because you have an addiction because you experience withdrawals… I mean, people don't change until they want to. They really don't. I really didn't want to, and I just wouldn't…*

And another argued:

> *Communities, some people use their history as a crutch to enable themselves to do it. That's what I think. They, "oh my ancestors went through this and this and this, I have the right to say hit that crack pipe. That's my God-given right." No, your God-given right is to lay that down and learn about the history, not friggin use your history as a crutch to use drugs.*

In addition, individual perceptions of what is problematic drug and alcohol use is also cited as an issue by community members:

> *I wish we could do like prevention in families that are struggling because there are some of them refuse it. Even if you try to reach out, they're like; eh, I don't have a problem. You just think I have a problem.*

Culture, Spirituality, Language & Relationships

There were a wide variety of opinions among Tribal Members and employees as to the best way to address or heal drug and alcohol issues. But, culture, tradition, spirituality and in a few cases, language were seen as key factors in helping in this process. Thirteen community members, ten employees and five Elders discussed culture and tradition as important factors. This is reflected in Table 7 below:

Table 7: Culture & Family

	culture and tradition	parenting/family norms
Community Members N=28	13	12
Elders N=15	5	6
Employees N=17	10	6
*While N= the total # of interviews, not all participants answered each question.		

For example, one woman said:

> *I was raised-raised very strongly and religiously. We had--at the time didn't know why I was going--had to go to all these ceremonies and doings, but we were made as kids "You're going. You're going. Do this. Go over here. Get up and dance, you know. Do what your grandparents, mother, the whole family behind you watching you." And they praise you...Maybe they need more praise, give them some spirituality and say hey, you did a good job. Good beadwork, or you*

wrapped that feather real good, or you taped that drum down. Boy, that's nice. Maybe there needs to be more of that, you know.

Another community member agreed, and linked the loss of language and culture to increased drug and alcohol use, and argued that if culture and language increase drug and alcohol use would go down:

> *Um, like personally, and I don't know how many people agree with this, but I feel like a loss of culture, loss of language, stuff like that has definitely influenced an increase in numbers of usage because, the culture and language is not as prominent on the Rez as drugs and alcohol is. And I feel like if there was more of a balance of people's culture and language and, you know, stuff like that in our everyday lives--we have to do that--drug and alcohol use would go down.*

And a male community member said:

> *Well, cultural revitalization I think is really, really important to Native Americans. And, for the most part, from what I can see, there's been a lot of effort put into programs…things like that. I think it's going to be absolutely necessary to help with the substance abuse problems that are going on. Obviously, they're talking about how that goes together and whatnot. But, yeah, that's one thing that I think our community does really well is putting emphasis on the fact that we do need to be more spiritually active in order to be, you know, sober and productive.*

Some community members also said faith in general, Christianity or other types of spirituality are helpful in overcoming addiction. One community member said:

> *I think it has to include your faith in God and to be set free from that desire in your mind and in your heart and in your body. I think that that is the difference. That is why people are not being set free completely, who are just going to like AA meetings or maybe just behavioral health are not including the faith aspect to overcome.*

Another argued that the social norms surrounding religion would prevent drug and alcohol use:

> *I guess, like I said, let's just say if your religion requires you to, you know, not be under the influence of any drug or alcohol in order to, you know, be, like, true to that, then if you wanted to be true to that, or your family was really into it, then you probably wouldn't be under the influence of drugs or alcohol… Like if you're a Christian, you don't want to, you know, go into church drunk on Sunday or, you know, under the influence of something. And, I mean, I guess with any religion that...I guess you wouldn't want to be under the influence.*

Finally, another key theme that arose was that the closeness of the community, available programming, and social relationships are crucial to combatting the negative effects of drug and alcohol use. For example, one man said:

> *Their family, their friends. The social institutions. The clergy, the church, the temple, the motorcycle gang…just your social influences an individual chooses to…take upon themselves is a lot…for me, it's always been big.*

One employee explained this importance of relationships in more detail in terms of a support networks, and family ties:

> *One of the things that, um, friends, acquaintances – if you're on the Rez, there's groups that you grew up with. And you remain very, very close to that. And they almost become kind of a secondary family. So, I think that's part of the healing community. You know developing a healthy support network I think is critical.*

Another employee emphasized the community's ability to mobilize and support one another in times of need:

> *A lot of the things that this tribe does well is when the – there's a time of need... They come together. And you can see the support of, and differences put aside to help, uhm, either bring comfort, and to bring healing. Or just to stand in unity when something is comin' against the tribe as a whole. So, I think that's one of the, the strengths of this, this tribe.*

Discussion

While not all community members and employees thought that Historical Trauma has a significant impact on contemporary drug and alcohol use in the Tribal community, the majority of interview participants thought it was a primary factor that needs to be considered in addressing addiction. Childhood and other experiences of trauma were also seen as key concerns, although community members did not always use the term trauma in discussing these things. Within conversations between service providers (both native and non-native), the language of biomedicine and psychology were very prominent. These discussions of historical and childhood trauma/ACEs were virtually always linked, as part of the same system of catalysts for addiction

and other negative health and mental health effects. Drugs and alcohol are envisioned as external forces and essential parts of coloniality acting on American Indians, while at the same time addiction is seen as a product of colonial experiences and oppressions, one of many effects of Historical Trauma. This is clearly evidenced in a tag line used in the past by the Tribal behavioral health program, “Sobriety is Traditional,” and also fits with findings from other anthropological studies including Prussing (2011), Calabrese (2013), Quintero (2002), and Garrity’s (2000) work outlined earlier in this chapter.

The links identified between Historical Trauma and addiction are consistent with other studies in American Indian communities as well. For example, Myhra’s (2011) work on the effects of Historical Trauma on participants’ ability to maintain sobriety found that Historical Trauma was deeply related to drug and alcohol use in multiple ways, and family connections were important to participant recovery overall, as was a (re)connection with spiritual/religious practices (Myhra 2011: 30-33). In addition to Historical Trauma, participants also cited trauma from continued racism and micro-aggressions by dominant society as contributing to their drug and alcohol use (Myhra 2011: 30-32).

As Historical Trauma refers to and invokes colonialism as the perpetrator of many issues seen historically and as an ongoing process of coloniality that (re)traumatizes each generation through multiple channels, then ACEs are deeply connected to Historical Trauma, but can also be seen as separate. ACEs are both a product of Historical Trauma, and sometimes-separate phenomena that evoke ongoing oppression. Both of these terms then are used as critiques of colonial and post-colonial wrongs, but also serve as tools to secure resources, strengthen Tribal history & identity, and conceptualize healing. In using and seeking to heal and address these issues, community members are theorizing health, wellness, and survivance.

While Joseph Gone raised important questions about the concept of Historical Trauma as it has been theorized over the past 30 years, in this Tribal community, and most likely in many others, the idea of Historical Trauma is crucial. The use of the term in this context may address some of Gone's misgivings. First, Gone was concerned with the murkiness surrounding Historical Trauma generationally (Gone 2014, pp. 390-391). When linked to ACEs and in the context of the interruption of traditional parenting practices, the implication is that Historical Trauma is transmitted through social learning. As a number of interviewees in this study stated, people did not learn how to parent in boarding schools, and so did not have those skills to pass on to their own children. In addition, with new research into the epigenetic processes of trauma transmission, there may also be a biological component of intergenerational trauma transmission (Bombay et al. 2014; Hatala et al. 2016). Through informal discussions I heard a few community members and employees talk about how Native people have known about blood memory forever, and this epigenetic thing is just another case of science catching up with what American Indians already knew, and then acting like it is a new idea that scientists just discovered.

Gone's second concern was the way Historical Trauma has been theorized as primarily perpetrated by Euro-Americans (Gone 2014, pp. 390-391). In this community, the term is used to describe the effects of colonialism, and to educate people about the long-term oppression and coloniality faced by the community as an effect of colonialism and related policies. In some ways then, the term is productive in and of itself to argue for American Indian rights, institutions, and ways of thought. When discussed in the context of ACEs, it becomes clear that original traumas may or may not have been perpetrated by Euro-Americans. Trauma is a cycle that involves people of all backgrounds and walks of life. The real perpetrators of Historical Trauma and trauma in general are historical colonialism and ongoing coloniality, or the historical and

contemporary medical, social, political, economic and other institutions that perpetuate inequality and suffering in human lives. Current conditions are part of and products of these processes and institutions.

A third concern raised by Gone was the way in which Historical Trauma is primarily an elaboration of PTSD, but “is focused on collective, cumulative and intergenerational as opposed to individual trauma” (Gone 2014, pp. 390-391). When examined in the context of the community at the center of this study, rather than in the context of clinical psychology, this is less of a problem. If we conceptualize healing, as many Indigenous communities and scholars have, as more holistic and inclusive, then individual trauma is virtually inseparable from collective and generational trauma and must be healed collectively and inter-generationally. Part of Historical Trauma was damaging relationships and the vehicles to pass on culture, tradition and parenting skills through social learning. Insights into how this collective healing might happen were given by Tribal community members and employees, and Gone himself hinted at this potential in his 2011 article with Patrick Calf Looking on the “Culture as Treatment Hypothesis.” Essentially, collective healing incorporates spiritual revitalizations, social reorientations, and affects overall lifestyle, identity and purpose in life; processes that have potential to reinforce community connectedness, Tribal sovereignty, nationhood and self-determination (Gone & Calf Looking 2011: 291-296). Community member and employee interviews categorically support this theory.

Finally, Gone’s concern that “Historical Trauma is primarily a construct invoked in relation to *health status*—especially *mental* or *behavioral health status*,” and so is subject to approaches and discourses of health-related disciplines is also a concern in the context of this research (Gone 2014, pp. 390-391). As discussed in both this chapter and Chapter One,

biomedical bias against American Indians in general has been a significant problem both historically and in contemporary times, and genetic discourses have been particularly problematic (Tallbear 2013).

However, community members and service providers have been using Historical Trauma, trauma, and ACEs to exercise survivance in opposition to these biases, a process I will term as post-medicalization. Brian Brayboy (2005: 435) expands on Vizenor's survivance asserting: "Survivance, which combines survival and resistance, calls for adaptation and strategic accommodation in order to survive and develop the processes that contribute to community growth." By using Historical Trauma and ACEs, community members and service providers have argued against the idea of alcoholic Indians and other stereotypes, by contextualizing social problems within the framework of Historical Trauma. This is effective in large part because of the medicalization of Historical Trauma as a concept. Historical Trauma and ACEs are vehicles to highlight past wrongs and current oppression in terms made acceptable in no small part by their association with the biomedical establishment. Post-medicalization is an apt term to describe the ways in which community members are using these ideas. Community members are seizing terms popularized, defined, and legitimized by Western biomedicine in the process of medicalizing them, and are deploying them in their own ways. The resulting narratives are used to secure and expand resources and fight for healing on their own terms. This is a picture of survivance in action, and is best characterized by a return to the employee quote highlighted earlier:

> *A lot of the things that this Tribe does well is when the – there's a time of need... They come together. And you can see the support of, and differences put aside to help, uhm, either bring comfort, and to bring healing. Or just to stand in unity when something is comin' against the Tribe as a whole. So, I think that's one of the, the strengths of this, this tribe*

The community's post-medicalization of the terms Historical Trauma and ACEs align with Fassin and Rechtman's description of trauma as a historically, socially and politically situated term (Fassin & Rechtman 2009). What Fassin and Rechtman fail to address is that American Indian communities is where the term Historical Trauma became established (Gone 2014: 388, Prussing 2014: 436-437). This indicates its particular cultural, social, and political relevance to American Indian communities who have sought to counter and deconstruct false narratives—often based in biomedical, political, and popular bias and racism—against them. In the context of the Tribal community, biomedical and governmental institutions are concurrently sources of needed resources to address community needs, and loci of ongoing coloniality. With the further popularization of trauma, ACEs and Historical Trauma as valid and powerful monikers within these institutions, Tribal communities can make increasingly powerful arguments to obtain additional resources to address community healing in their own ways, but framed in terms that are meaningful to those institutions.

These opportunities are becoming even more accessible, with increasing research on American Indian (and Alaska Native) methods and best-practices for medical and biomedical service delivery, especially models that document the positive effects of American Indian culture, tradition, and spirituality on a number of health and mental health outcomes. Multiple studies have been conducted on resilience, positive youth identity, addiction recovery, and other issues in terms of culture & tradition, and from perspectives of both prevention and treatment (for example: Healey 2008, Kulis et al. 2012, Currie et al. 2013, Marsh et al. 2013, Kading et al. 2015, Reinschmidt et al. 2016, Barker et al 2017, Nelson & Wilson 2017). Many of these studies align with Gone and Calf Looking's (2011) Culture as Treatment Hypothesis and document the ways in which American Indian culture and spirituality are key to community healing. The

numerous assertions of community members, employees and Elders, that community culture, spirituality and language are key to addressing drugs and alcohol in the American Indian Community at the center of this study, are being heard by service providers, as virtually all Tribal departments include some aspects of these things.

My Community Advisory Committee, also worried about the increased programming of culture, language and spirituality, versus grassroots teaching and learning. They also thought that this expectation of programming might be a holdover from days when the Tribal community had to rely on government agencies (and namely the Bureau of Indian Affairs, or BIA) for needed resources and services. Taken in conjunction with interviewee concerns over parenting, family dynamics, and the importance of community connectedness, this is a significant concern. The community (and many other Tribal communities), are no longer forced into the same degree of dependence on government agencies, and expressions of Tribal sovereignty and self-determination have grown through hard-fought political, economic, and social initiatives demanded by Tribal Nations themselves. However, there are still existing, necessary, and complex relationships with these agencies. This is true particularly in health, behavioral health, education and public safety service provision.

With the abundant research on culture and tradition as prevention and intervention in American Indian communities, promoting and funding them is easier, especially in the context of the community's post-medicalized formulations of Historical Trauma and ACEs as barriers to health and mental health. However, the greatest cultivation of these crucial community foundations seems to happen in the community, and in families, not within programs facilitated by Tribal departments. Again, the caring and connectedness of the community will be crucial in these efforts. Service provision may be an access/and or entry point for some into increased

involvement in culture, tradition, language, and spirituality, and programs with biomedical and mental health frameworks may be the best candidates to secure outside funding. The best way to address these issues may be to expand focus to informal channels of care, connection, and relationality. Gone and Calf Looking's Culture as Treatment Hypothesis, and the expanding work on community healing mentioned in this chapter support the viability of these options as an alternative to bureaucratized and over-programmed system of care.

Conclusion

Community member and Elder expressions of worry and anger over Historical Trauma and childhood trauma/ACEs are in essence critiques of colonialism and ongoing coloniality. This is similar to arguments made by Waldram (2004) in his discussion of both individual and Historical Trauma in the context of how American Indian mental health has been conceptualized (Waldram 2004:221-236). Interviews and participant observation for this study clearly established a connection between colonial practices—boarding schools in particular—and ongoing social issues in the community documented by people in all categories of interviews conducted. A key form in which Historical Trauma was and is transmitted in this community is through the disruption of community knowledge and practices surrounding parenting, and intentional assaults on American Indian culture, spirituality and inter-generational learning.

The ways in which people employ the terms Historical Trauma and trauma in the community are an example of what I have termed post-medicalization. Because the terms themselves have been medicalized, they have increased power and weight. Community members demonstrate thoughtful and purposeful navigation of these existing narratives and ideas surrounding trauma and Historical Trauma to critique ongoing injustices, and harness additional resources for the good of community. This is survivance at its essence.

Furthermore, the use of these terms in this context may answer some of the lingering questions about Historical Trauma raised by Joseph Gone and other scholars, especially questions surrounding its perpetration and transmission in relation to more limited "treatment" frameworks. Community members and Elders especially argue that culture, tradition and spirituality are key to addressing both trauma and drugs and alcohol in the community, which is consistent with Joseph Gone & Patrick Calf Looking's (2011) Culture as Treatment Hypothesis. While this alone may not completely ameliorate addiction and trauma in the community, it is a strong start, and exemplifies survivance as Vizenor put it:

> *Survivance is an active sense of presence the continuance of native stories, not a mere reaction, or a survivable name. Native survivance stories are renunciations of dominance, tragedy and victimry (Vizenor: 1999).*

While some argue that discussions on Historical Trauma and ACEs may focus too much on the past, in this community the main concerns are how to disrupt and reverse the trajectories of trauma to foster and grow community healing and wellness. In order to do this, the past must be acknowledged and understood, but much of the attention is on the children and youth of the community and breaking the cycle of trauma. The focus is on the future.

Chapter 3:
On the Front Lines in the War on Drugs

"the only reason she's probably alive today is because we put her in jail."

"they're dropping like flies"

"It's good to see you, I'm glad you're safe"

"we're trying to keep you alive"

"He doesn't have a monkey on his back, it's a dragon"

"It's like a battlefield, we can only take out the life-threatening shrapnel…we're on the frontlines"

This chapter begins with quotes from a number of Tribal drug court team members that I collected during participant observation at drug court team meetings (where service providers discussed drug court participants) and court sessions with participants in attendance. While some community members and employees mentioned that they thought the Tribal Council's declared War on Drugs had fizzled out, there has been a significant expansion of programs and services since the War was declared. In essence, the War on Drugs in the Tribal community is now being fought "on the frontlines." First responders, behavioral health professionals, Tribal court staff, and other service providers are continually searching for new and better ways to deal with issues surrounding drug and alcohol use and must confront the effects of these things on a daily basis. Federal policy and bureaucracy, and the norms of the criminal justice, medical, and mental health professions pose significant barriers to this.

Throughout the several months I spent observing team meetings, court sessions, participant check-ins with drug court staff, and more informal moments (such as cigarette breaks

and pre- and post-court discussions), humor, urgency, frustration, hope, despair, compassion, anger, and determination were exhibited by staff and participants at various times, sometimes in quick succession or even simultaneously. Media stories and statistics on drug addiction and the Opioid Crisis are bleak and devoid of much hope. The day to day lives of drug court participants and drug court team members (service providers) in the American Indian community in this study present a much more complex picture. Both participants and team members emphatically expressed hope and confidence in participants' ability for success yet were also continually haunted by the spectres of relapse, overdose and death.

This chapter discusses my participant observation and interviews with 16 drug court participants and team members, to highlight some main issues in addressing the Opioid epidemic. These include:

1) Anxiety over the best course of action; there is no one size fits all model for success.
2) Tension between individual participants' choices, free will and freedom versus what will "save their lives."
3) Contradictions in treating a medicalized conception of addiction framed as a disease through the criminal justice system meant to deal with criminals and developed in conjunction with a U.S. Federal Government model.
4) Community desires for more compassionate, effective, and culturally rich programming are constrained by federal requirements and bureaucratic strings tied to program funding.

In the face of these challenges, both drug court team members and participants expressed anger and sadness in day to day interactions. In the context of a Tribal Nation, these issues can be seen

as an expression of ongoing *coloniality.* The long-term optimism of drug court staff and participants remain a foundation of possibility and promise for the future; an expression of community survivance.

Government to Government Relationships

The development of contemporary criminalization, or conceptions of who and what is considered criminal, overlaps in many ways with the history of ideas about both American Indians and addiction/addicts discussed in Chapter One. This is true in that there were similar processes at work, similar conclusions and representations as a result of these processes and overlap between categories. Drug users have almost always been criminalized, and the criminalization of American Indians may be less evident now than during the bulk of US history but is still significant. Chapter One demonstrated that community members and employees in this study felt that Tribal members were stereotyped and targeted for increased surveillance by police. This phenomenon has been well documented across American Indian communities in the United States, and is in large part tied up with enduring stereotypes (Poupart 2002: 144-146; Perry 2006). The over-policing of American Indian communities and increased surveillance adds fuel to the fire because it produces higher statistics about crime and arrest data, that are then used to justify over policing and surveillance (Poupart 2002). In many ways this is an extension of colonial domination of the U.S. Government seeking to control and manage American Indian peoples and nations (Poupart 2002; Perry 2006).

Valerie Lambert (2016) points out that in many cases, contemporary relationships between Tribal Nations and the Federal Government are actually much more complex than they have been framed in scholarship, and in anthropology in particular. The federal government has treaty and trust obligations to Tribal peoples that include funds and operational contracts to

provide things like education, health care, and public safety support (Chaudhuri 2004: 22-32; Nesper 2004: 313-318; Pickering 2004: 127-128; Warne & Frizzell 2014: s266). Perhaps because of the insufficiency of funding streams in fulfilling US obligations, a large number of federal grant opportunities are available to Tribes, some of which were/are created to address specific issues in Indian Country.

Lambert focuses on the complicated relationship between the BIA (Bureau of Indian Affairs) and American Indian Tribes, and the ambivalence she describes toward federal government agencies is evident in some of the discussions I observed in the community. For example, the Tribal drug court is grant funded, and one team member commented that they were very fortunate to have grant funds, but that if the program was not re-funded, they could operate more creatively, and not have to follow the same level of regulations. This ambivalence runs counter to the majority of scholarship which frames Tribal-Federal relations in an overtly negative light (Lambert 2016). In addition, the Tribal clinic and behavioral health programming is IHS (Indian Health Service) affiliated, meaning that those programs are also answerable to government standards framed in Western biomedical and psychological norms.

This relationship between Tribal governments and the federal government is important to (but not the only factor to consider in) the ways in which Tribal Nations deal with health and social issues such as addiction. Biomedical and criminal justice institutions are essentially inseparable from government in a number of capacities. Rules, regulations, and accepted understandings of addiction permeate the relationships between Tribal institutions and the federal government. These rules, regulations, and understandings are predicated on the medical, legal and social "best practices" endorsed by federal agencies. However, Tribal governments have some leeway in how they enact and follow these standards. This is especially true in the

past few decades when researchers and federal agencies like the BIA and IHS have increasingly accepted (or at least payed lip-service to the idea) that Tribal Governments have the most relevant knowledge and experience to make decisions about and provide services to their communities (NCAI 2019, 12-32). Despite this recognition, IHS, BIA and other governmental bureaucracies still have specific and often stringent requirements tied to funding streams and accreditation processes.

Coloniality & Drug Courts in American Indian and Alaska Native Communities

To address the strong links between substance abuse, crime, and incarceration in the United States, drug courts have been on the rise since the 1980s. In 1997 The Drug Courts Program Office (within the U.S. Department of Justice) and the National Association of Drug Court Professionals created an advisory committee to adapt the drug court model for use in American Indian communities, which is the primary model used today, although it is always undergoing evaluation and change as new research and best practices emerge. Unique aspects of this model are that American Indian culture and traditions are often included as part of the program, and there is a focus on life balance and wellness in addition to staying "clean" or sober (TLPI 2019). In addition, a team approach is used in which court staff, medical and mental health professionals, attorneys, social service representatives, police, and other service providers all discuss client issues and progress and use all of the resources they have/can harness to assist the participants. They also give input and insight to the Judge, who holds final decision-making power (TLPI 2019).

This team approach essentially extends the oversight of the court. For example, in the Tribal community of this study, court staff now includes program coordinators and case managers whose primary responsibility is to manage and coordinate participants, and medical

and mental health issues are discussed and considered for each participant of drug court. Effectively, the logics and epistemologies of the medical and mental health fields are being infused into the philosophies and knowledge of the courts in ways that allow for considerations beyond criminal activity. This also allows for increased surveillance and governmentality; products of having a whole team of people to discuss each participant's progress through sharing of their health and mental health concerns. Since this is in the context of their "compliance" with the goals of drug court (which is essentially a term/requirement of probation), it allows for increased governmentality over participants in a number of areas of their lives.

With the special status and sovereign nature of American Indian Tribes, Brian Noble's (2015) extended definition of *coloniality* may be even more useful to theorize these relationships. Noble highlights two domains or processes of coloniality he has encountered in his work as an anthropologist working with Indigenous Canadian communities, which he describes in two parts:

1) Coloniality as oppositional encounter of self & other is:

> "the tendency of a ''self ''in an encounter to impose boundary coordinates—such as those of territory, knowledges, categories, normative practices—on the domains of land, knowledge, ways of life of an other ... Importantly, coloniality as encounter makes an additional move to rationalize the dominant presence of this self within those coordinates and to make the presence of the other subordinate to it—often as a tactic for dispossession" (Noble 2015: 429).

2) Coloniality as Apparatus and Milieu

> Coloniality "…operates as an apparatus of modernity, a workaday containment field for defining, constraining and incorporating persons, as well as delimited populations and polities. In this sense, coloniality can be thought of as a corollary of Foucaultian governmentality (the conduct of conduct), imposing an effective ontology of territory, ownership, knowledge, rule and much more. Crucial here, is the way that coloniality as apparatus is the embracing milieu for coloniality as encounter, where it appears to sustain the other and maintain a dialogue between the self and the other, while always ensuring, by whatever flexible means, that the other remains other, partially welcomed into the arrangement but necessarily in a subordinate position, subjugated, inscribed as other by self, thereby securing the power position of self" (Noble 2015: 429-430).

I argue that even though it was developed with Tribal communities in mind (with the assistance of a special advisory committee), the Tribal drug court model is in large part an expression and extension of coloniality by the federal government, which limits the choices and options available to drug court team members and participants.

Theorizing Addiction & Recovery: Free-will, Medicalization, and Surveillance

Coloniality is habitually at odds with self-determination in both a collective and individual sense, which is in many ways an extension of free-will and choice. The anthropological literature on addiction and treatment is varied, but a significant subset of studies focus on free will or choice, and the implications of the increased medicalization of addiction; or in other words its social construction as a disease. Essentially, increased medicalization of addiction shifts it even further from a primarily criminal and moral issue to a medical one and provides an even greater avenue for knowledge and practices from biomedicine and mental health institutions into the justice system. The Tribal drug court is a kind of coordination of participant treatment, in that it exercises oversight and imperatives in a number of ways to convince participants to get sober and complete the program. There were a few times when Tribal drug court discussions surrounding practices of surveillance and control were heated, a reflection of unease and disagreement between members from different professional fields.

A number of anthropological studies explore the ideas of choice, control and by extension governmentality in addiction treatment and service provision. A. Jamie Saris (2013) explores "What's at Stake for Anthropology in Addiction," by examining the assumptions and theoretical concerns surrounding the use of the terms *addiction* and *addict*, and highlighting areas of ambiguity in the ways that these terms have been understood. Saris explains how research surrounding addiction focuses in large part on biology, neuroscience, and seeking

pharmacological treatments and vaccines to help control choice or "will" (Saris 2013: 268-279). He effectively illustrates multiple ways in which addiction is tied up in theoretical conundrums and what he calls a "commitment" to will or choice (Saris 2013: 277-283). Saris also cautions that anthropology still relies too heavily on scientific, biological and neurological paradigms of addiction (Saris 2013: 278-283). In the community described in this study, and in the drug court in particular, addiction is framed as a matter of choice by many, or in other words a question of having will, or will power.

Nancy D. Campbell (2013) also explores the nuances of addiction and choice, through examination of addiction narratives given by drug users, neuroscientists, and addiction specialists on television shows. Campbell analyzes the use and discussions of neuroimaging to show how the technology is increasingly used to explain addiction and undesirable behavior in terms of chemical reactions that happen outside the realm of conscious decision-making, and to assuage the personal responsibility of addicts (Campbell 2013: 256-257). While she contends that there is too much emphasis on finding pharmaceutical "magic pills," Campbell also stresses that neuroimaging offers a way to counteract some of the moralizing discourses that focus on individual responsibility and abstinence (Campbell 2013: 255-257). This is tied to the ways in which medicalization has been framed as destigmatizing in the Tribal community, and how Medication Assisted Treatment (MAT) gained support.

Specialized medical (or pseudo-medical) treatment for addiction continues to exist and develop, and a number of anthropologists have also examined drug treatment or "rehab" alongside and through the experiences of addicts themselves, and through the employees and structures of treatment programs. Geoffrey Skoll (1992) demonstrates how individuals attending addiction treatment come to accept/portray themselves as addicts. Through analysis of the

operation of an addiction treatment facility, Skoll exposes the gaps between the supposed intent of the facility and the day to day practices of repression and imposed narratives surrounding resident identity (Skoll 1992: 178-184). Skoll shows that residents had to learn to represent themselves in ways that adhered to the treatment program's ideologies and prescribed ways of talking about their lives in order to successfully complete treatment, and avoid punishment (Skoll 1992: 119-147). Summerson Carr's work on an outpatient addiction treatment program for homeless women reveals strikingly similar processes to those described by Skoll (Carr 2011). Her detailed descriptions and analyses of interactions between clients and professionals associated with the program (e.g. case managers, counselors) illustrate how client language is key in determinations of their progress and eligibility for certain services and privileges (Carr 2011: 224-226). In effect, professionals constantly monitor and seek to reshape clients' presentations of themselves, and clients learn how to talk and represent themselves as "the recovering addict," in order to gain access to needed resources (Carr 2011: 224-226). Carr also examines the ways in which both clients and professionals are constrained and influenced to act and speak in certain ways by larger socio-economic forces (Carr 2011: 224-228).

In addition to these broader institutional and structural conditions surrounding addiction treatment, Angela Garcia (2010) adds an historical dimension to her examination of a "pastoral clinic" and delves further into the subjective experiences of treatment attendees and their lives outside of the clinic (Garcia 2010: 29-36). Through a focus on the history of the landscape, or the pastoral (as theorized by both Raymond Williams and Michel Foucault), and the history and experiences of individual drugs users, Garcia artfully links personal stories of addiction to historical dispossession, economic downturn, and repeated loss (Garcia 2010: 33-36, 203). In describing drug addiction as a chronic condition, and depicting intergenerational heroin use in

detailed context, Garcia shows how sharing and care are key to the relationships of the women whose lives she describes. She also implies that perhaps drug treatment attentive to a broader array of issues, and centered on the care shown by these relationships, could offer a more effective and responsible treatment model (Garcia 2010: 111-149, 183-203).

Finally, Jarett Zigon takes up religion and ethics in his discussion of a Russian Orthodox Church drug rehabilitation program, in which participants described addiction as "A Disease of Frozen Feelings" (Zigon 2010). Zigon narrates how the program focused intently on teaching attendees to control and express their emotions appropriately for social interaction, and on remaking participants into new ethical and moral people (Zigon 2010: 340-341). Zigon argues that the program is reflective of a trend of services (like drug rehabilitation programs) being relegated to the private sphere, and of the cultivation of the neoliberal ideals of self-regulation and personal responsibility (Zigon 2010: 340-341). While I do not fully explore neoliberalism, many of these ideas overlap and coincide with issues I identified in the Tribal drug court.

The Tribal Drug Court

The Tribal drug court in this study has four progressive stages that participants move through week to week by complying with program requirements. Compliance includes showing up to court & check ins with drug court coordinators, "clean" drug tests, attending AAs, behavioral health and medical appointments, keeping a journal and calendar, and at later stages either finding employment or attending school. In addition, participants are required to complete 200 hours of community service before graduation from drug court. These activities are essentially an exercise of governmentality over participants in that, they are pressured to be compliant, or "successful." This does not mean participants do not have agency. They do choose to be in the Tribal drug court (although the "choice" is also complicated), and choose whether to

comply or not. In fact, in many ways the program gives participants a wide range of choices about how they comply with rules and program goals. During my time observing the drug court, participant numbers grew from roughly five or six participants at one time to ten to fifteen participants.

An interdisciplinary team including a judge, the Tribal magistrate, one to two drug court coordinators, a case manager, Tribal behavioral health staff, social service professionals, the Tribal prosecutor and police chief, a workforce development manager, a traditional healer, and a representative of the Elder's board, as well as other Tribal and non-tribal professionals at various times considers each participants progress. In addition, there is an added emphasis on overall health and wellness, mostly through requiring participants to attend behavioral health, medical and dental appointments, cultural teachings and activities throughout the community, and specially organized life-skills classes organized by drug court staff about once per month. The participants also have the opportunity to gain up to three hours of community service per week by working out at the fitness center which is open to all Tribal members and employees.

During this project I attended drug court team meetings every Monday morning for 1.5 to 2 hours, where the coordinators and service providers report on individual participant progress and the team discusses each person, and whether they should move ahead for the week, and/or receive an incentive or sanction. In addition, I observed the drug court itself where participants go before the judge in front of the other participants, discuss their progress and challenges, and receive approval or denial of their "moving forward," as well as any incentives or sanctions.

Each stage of the program has an allotted number of weeks that participants must "move forward" to be moved to the next stage. So, for instance, Stage One is 16 weeks. If a participant moves forward their first week, they move to Stage One: Week Two. If they do not comply with

program requirements the team may decide to "hold them back" and they remain at Stage One: Week One. They must successfully be moved forward 16 weeks in Stage One to move to Stage Two. Participants are also required to read a letter to the court before they move into a higher stage of the program, to lay out their progress so far, and plans and goals for the future. Finally, I attended several check-in days between the participants and drug court coordinators (one to three days per week depending on the participants' stage) where they discuss their progress, hand in community service hours, AA attendance sheets, confirmation of other appointments, and do their required drug tests.

Care, the Road to Success & the Spectre of Overdose

Tribal drug court starts at eleven on Monday mornings. I almost always have a knot of anxiety roiling in my stomach when walking into the courtroom, not only for participants, but also because even after months of coming here the setting and authority figures like police and judges still make me edgy. The courtroom is similar to other court rooms I have been in, but the furniture is all a light, dull honey colored wood and there are beautiful paintings by community artists hung across the walls. Even so, the furniture seems like it's from the 1990s, and the rows of seating kind of remind me of pews in a church. The benches are hard and uncomfortable. There is a tension in the air as we wait, as usual. Some days people whisper, or even giggle, but it is pretty quiet today. I sit on the right side of the aisle on a hard, blond wooden bench toward the back and wait.

At 10:56 a young woman named Lola rushes in and exclaims "that was a close one!" The doors lock at 11:00 am, and if participants don't make it into the courtroom on time, it counts as an absence from court and could result in sanctions or a warrant being issued for their arrest. Lola has shiny dark hair, is in her mid-twenties to early-thirties, and is dressed casually like a

number of the women in drug court. T-shirts and sweatpants or jeans and t-shirts are the norm, although occasionally there are participants who comes to court dressed in suits or other more formal attire. Several other participants and the drug court coordinator follow right on her heels.

Participants continue to quickly filter in, until there are 13, including one woman brought over from the jail who sits in a separate raised area to the left of the room, and rests her handcuffed hands in her lap. Her name is Julie. She was sentenced to jail at drug court last week for missing appointments and other small but chronic infractions. The other participants sit across the front of the courtroom in the defense and prosecution boxes, and in the first couple rows of benches on each side of the aisle. The jury box looms empty on the right side of the general seating area, even though it has actual chairs that look pretty comfortable instead of the hard benches. One participant is graduating from the program this week, and so there is a potluck after court, so while we wait, the coordinator reminds everyone that if they brought a dish to pass they will be entered into a drawing to win two movie tickets.

We all stand as the judge comes in at 11:04, and sits several feet above the rest of us on his tall judge's bench. Things proceed pretty much as usual. Participants are called in front of the judge to check in one by one, and are organized by gender. The women are up first this week. Laura, the young woman who is graduating, steps up to a podium equipped with a microphone between the defense and prosecution boxes. She is also dark-haired and probably in her mid-twenties, and reads a letter to the court. Letters are required when entering the program, moving from phase to phase, and graduating the program. She tells us in a quiet and monotone voice that she has over 500 days sober (everyone claps and smiles), and how the program has helped her build her life again. She thanks the court staff for their care and guidance, and says she will

always try to do better in life. Everyone claps again, and the judge smiles and congratulates her as she goes back to sit down. I reflect on its similarity to other letters I have heard in this room, and wonder what exactly that means.

The next woman up is Julie. The bailiff holds the swinging door on the little seating area she is in as she steps out, because she is still handcuffed. They exchange polite greetings, but the judge is not smiling now, and you can hear it in his voice. He quickly gets down to business and informs her, "I am gonna have you released to go to residential treatment immediately if not sooner upon release." She doesn't look all that happy to be getting out of jail. There is silence that lasts a few beats too long to feel comfortable. Julie tells the judge that her brother will take her from jail to treatment and asks a bit curtly if she can at least go home to pack some things. The judge denies her, and instructs her (also a bit curtly) to have a family member do that for her. There is silence as she walks back to her box, and the bailiff holds the little door again.

A couple of women have excused absences today, so the Judge acknowledges this, and then Lola is up. She moves ahead a week for good behavior and exclaims "finally!" The rest of the women and the men go before the judge without much incident, and the judge asks some of them about books or sports or cars or their kids, and they have short and pleasant conversations. It looks like no one is going to jail today. Except for Julie. A police officer leads her out of a side-door in the courtroom, where she will be taken back to jail until the paperwork clears to have her officially released to go to treatment.

One of the most striking observations in my time at the Tribal drug court was that the drug court team as a whole and individually, were extremely dedicated and passionate about their work, and expressed deep care, concern and worry for participants. This was conveyed in a

number of ways, across the entire time I spent with them. For example, in Court sessions, this was voiced directly to participants in the following (and countless other) ways:

"we are really worried about you"
"we want you to get help"
"we are here for you if you need us"
"we want you to succeed"
"we need to get you healthy"
"we are concerned for your safety right now"

In addition, team members expressed serious concern and caring for participants in team meetings and individual interviews with me, and participants in the drug court also commented that they thought the team was concerned for them. One woman shared: "Like, sometimes he [the judge] can be hard on you. But I think it's just for your safety. He just wants to make sure to keep you safe." When asked how she thought the drug court team was helpful to her another participant said, "They ask about the problem, and they ask why, who, what, where, what avenue, why do you feel this way. It's like they really get into…they want to know what happened. And they want you to know that they care for you, and this is why this is in place." As another example, one team member said that when participants got frustrated, he told them, "We're not just gonna push you through [the drug court], we care about you, and want you to make it through." Most often however, this concern was framed in terms of saving lives, and avoiding overdose and death. At the vast majority (if not all) of the team meetings and court sessions I attended this was brought up, and it was also mentioned as a key concern by half of the Team Members in individual interviews. One Team Member said:

> *Because of the epidemic, of drug use. And we've lost several people in our community. I mean, more than just several. We were losing people like once every three months. And, you know, before this program, people were…it was on people's minds…even my own. Who's going to be next. And you could almost guess who was going to be next. But we have saved several heroin users, who have overdosed three or four times. One is two years sober, working a very good*

> *job. So, we've made a change; I know we've made a change in the community. We need this program.*

This anxiety and worry over the death of community members was not limited to the drug court team. Twenty of the community members, 10 Elders, and all 15 Tribal employees interviewed for this study also discussed overdoses as a key concern in the community. While they were not directly asked about it, 2 drug court Participants also brought up the issue. One participant said:

> *At first, I was kind of resenting it, resented getting caught, but after I started and when I started finally clearing out, it was really easy to see that this program, this court, had actually saved my life. Because I had just been getting worse and worse. Eventually, addiction will take your life. In multiple ways; it can either be a car accident, overdose, get shot…*

In practice, this process of saving/changing lives is complicated, fraught and hard to pin down. Most drug court team members I interviewed basically boiled success in the drug court program itself down to a small number of factors; but some also said that each participant is different, and there is no one size fits all model. The 4 key elements Team Members cited for success were 1) wanting to change/wanting to succeed 2) compliance/putting in the work 3) having a good support system 4) having/learning structure. These were often still framed in terms of saving lives. For example, the following quotes are representative of what team members told me they thought most successful participants had in common:

> Team Member 1: *Yeah, they have the willingness to engage and take it seriously. I think that's a big thing. Just take it seriously and I guess, open up…to the extent that they can. And acknowledge that there is a problem. And boy, because we'll bend over backwards to keep them alive. We really will. And…Compliance with the rules, and this…attitude. And you can see it, generally. And you can see it in their face once they get healthier, you can just see it.*

> Team Member 2: *Desire. Unwillingness to change their lifestyle in order to…be successful. Because we provide them with the skills, the structure and opportunities to change, but sometimes their support system is not allowing them to, or they don't want to leave their support system, which is dysfunctional.*

Team Member 3: *Everyone's different, and you have to want to be sober. So, that's a really hard question… hard one to answer. It depends on the person. It depends on their support group. If they don't have a support group, and they've burned all those bridges, it's going to be hard for them to be successful. So it's…there's a lot of things that would make them not successful.*

Team Member 4: *I think it's just like anything else…and maybe we're not so different as a Native community, because it still depends on the individual and how willing they are to embrace recovery.*

While most of the Drug Court Team Members said that they thought all of the participants were capable for success, half of the participants I talked to thought the expectations of them were reasonable, while half did not. For example, when asked if they thought that the expectations of them were realistic, participants had the following to say:

Participant 1: *Not in the time they usually gave you. I mean, it might have changed since I've been in there, but…counseling, meetings, all this other stuff…unrealistic. Especially when I didn't have my license; you needed to depend on others. And they'd always say, "well, you had a…you would always find a way to get your drugs, why can't you find a way…?" You know, things like that. And, how can you even compare that? You can't.*

Participant 2: *I mean…I don't think it's really realistic. I mean, it's just more of what they're hoping for. You know, they really want to see someone accomplish and graduate…you know, see a different change in their lives. But I don't think it's like, realistic to me.*

Participant 3: *I mean, I'm pretty sure it's doable in their minds, you know, the way that they see it, but if they were out here living the lives of us, I'm pretty sure that they'd be like, "okay, you know… sorry."*

Participant 4: *Actually, a lot of people…because I was in jail with a lot of people who opted out of drug court and ended up doing their whole year, because they said that it was just a set-up. Like, that they weren't getting nowhere. They told me, to them it seemed like no matter how hard they tried to work on their stuff, they'd never get anywhere. And they were in drug court for about as long as I've been in it.*

Additionally, while team members largely said that wanting to change/succeed and having the right attitude were key to success, every single participant I talked to said that they wanted to stay sober (although a couple said they did not when they first started) and get a job or

go to school. In addition, all participants but one said that they wanted to go to medical and behavioral health appointments, and all except for one said that they wanted to attend AA meetings. Furthermore, every single participant I talked to said that the program helped them stay sober while they were in it, and that they did (if they were already out of the program) or believed they would (if they were still in the program) stay sober after they were released from the program. This indicates that a positive attitude or wanting to stay sober, may not be a key difference in participants who do or do not successfully complete the program.

Some team members and participants questioned the ways in which success and compliance was measured. One team member said:

> *One of the things that I kind of noticed that they have in common is that, someone that's successful, everyone likes them. They kind of like, go to bat for that person, you know…so, while those that have been unsuccessful, there's a lot of almost, at the meetings, kind of a blaming, you know, non-supportive discussion about them.*

And one participant said:

> *Because there's a bunch of people running it. I don't know what each individual is going to say about me. Like, I'm trying as hard as I can, and one person's opinion could just knock my whole week out.*

Lack of consistency was seen as a significant issue and the related issues of not knowing what to expect were key concerns for the majority of participants and team members I interviewed. For instance, one participant told me they were now always nervous when attending court days because they did not know what to expect:

> *Okay, one week I go in there, you know, and I'm like, expecting to go to jail, and I'm just literally just like, "you know what, to hell with it, I'm going to go to jail anyway." So, I just went into court and they didn't put me in jail. And then the next…you know, that whole week I'm sitting there and doing everything that I'm supposed to do…you know, making my times and everything, and then like, I just go to jail.*

Another said:

> *Sometimes I'd get told one thing by a worker, or the judge even, and the following week or week after, they would have different specifics about our conversation. You know, like different terms, I guess. They didn't honor them. That was once in a while. That happened to me twice.*

And another participant shared:

> *In my first couple months in it, yeah, it helped me a lot. And it does still help me, but at the same time, it's like, are they ever going to be satisfied with what I'm doing?*

Just over a third of drug court team members, and half of participants questioned the fairness of inconsistent sanctions in a number of different ways. For instance, one participant argued:

> *Well, I just think it's not fair when some people drop dirty* [test positive for drugs in their system] *or don't do their AAs, or stuff like that. I think they should be given the same sentence as the other person, instead of, "well, you have to go over to the clinic," or, "you have to go to jail for 10 days." I think it should be the same for every person, not "well, you have to do this, and you have to do this." I think it should be the same punishment for everyone.*

A drug court team member had similar concerns, and said:

> *I think if you look at, you know, the…the way the program and the different levels are applied towards participants, I don't think they're consistent, and…there's an inequality about it. And it's not…I can't put my finger on it yet. It could be you know…someone might drop dirty and he has to do 20 hours of volunteer work, and another person can come through and drop dirty and they would get 3 days in jail. You know, so it's hard to have people complete a program when things are just inconsistent.*

This was countered by a small number of team members who said that each participant is different, and you cannot use a one size fits all model. For example, one team member said:

> *…each one of those 20 people are different, and the moment we treat them all the same it becomes cookie-cutter. It becomes like the state court, where you have sentencing guidelines…and you can't do that. They're all individuals.*

Medicalization, Surveillance, Confidentiality & Choice

Confidentiality was another concern brought up in Team Meetings, and in both participant and team member interviews. Essentially, participants of the program sign away their

rights to confidentiality to a certain degree. As part of admittance to the program, they sign a number of release forms to allow information about them to be shared with the drug court team (including from the medical clinic and behavioral health center). Despite this, a few participants addressed confidentiality and surveillance as a concern of theirs:

> Participant 1: *I was kind of like, "man, I've got to speak up there?" I've got to talk in front of all these people I don't even know? But, it's not like that anymore. You get used to it.*
>
> Participant 2: *I think they could change it up a little bit, on going into the courtroom. I think sometimes when they put all your business up there, it's not for everyone to hear. Maybe they can just say, "hey, I need to see you after."*
>
> Participant 3: *…They were too nosy. You know, they wanted to know too much personal stuff, instead of just about what you're doing for the program…You know, and some of the people knew my family, so they'd always ask questions about my family and stuff. I just don't feel that's appropriate, you know?*

This was also a concern of some of the team. Here's how one team member framed it:

> *Well, if there's one challenge to it, it's where the other participants can see the success or failure that's happening to their fellow clients. That's one of those things, of confidentiality, that they've lost because of being part of the program.*

While they do sign the releases, not a single participant I talked to said that they understood the decision-making process, and one participant was a little taken aback when I explained it in the interview. Here is an excerpt of our conversation:

> Kehli: *Do you know who decides, and how they decide, if you move from week to week?*
>
> Participant: *[shakes head no]*
>
> Kehli: *Okay. It's basically a team from all over different departments and they get together and talk about each participant, and then they kind of give the judge a recommendation.*
>
> Participant: *I don't see how they can do that. They don't know any of us. They don't know none of us.*

Kehli: *Well, the team is people who work with the different departments, probably.*

Participant: Yeah, but I know there's a bunch of people in there that I probably don't know.

Kehli: Yeah, there's at least some, probably.

Participant: Yeah, and they don't know me either. So, you know, if they knew me, that would probably change what they thought. Instead of just thinking, "yeah, everybody in there's a criminal, and they're all trying to get out of something somewhere." And that's not the case, most of the time. You know, sometimes things happen, that people just cannot help it.

These concerns about confidentiality and the opaqueness of the drug court decision making process in the eyes of the participants raise some important questions about choice. In addition, the information shared in drug court team meetings goes far beyond what is shared in court, and it is unclear how much participants understand the extent to which they are monitored and discussed before they even arrive for their court sessions. Drug court team members discuss any challenges, "violations" (such as testing positive for drugs aka. dropping dirty, overdosing, additional run-ins with police), matters of non-compliance (like missing medical or behavioral health appointments, or AA meetings), in addition to details about their health and behavioral health diagnoses, romantic relationships, the status of their children, if they have had a loss in their family, if there are others in their social circles who are drug and alcohol users, and anything else that team members may deem relevant in assessing their progress or lack of progress for the week, in "holding participants accountable," and providing them with assistance/services, and "structure."

The increasing level of medicalization of addiction during my time undertaking participant observation in many ways increased the level of surveillance. Early in my participant

observation drug court staff had made connections with a number of experts in addiction science, and addiction was talked about as a disease to a greater extent. This was tied to the efforts to destigmatize addiction, but was primarily an effort to find additional solutions to assist community members who were not overcoming addiction through existing services. This led to an increase in discussions and trainings around the neurochemistry of the addicted brain, and on MAT. For example, when asked if every participant was capable of completing the drug court program, one team member said:

> *Some just aren't…some might not have the cognitive ability, and you don't know that until you get in. Of course, there could be brain damage as a result…as a result of the abuse. But at the same time, we learn from Dr. Douglass, that the brain will rewire, however there are some people who are, prior to the drug abuse, who are just not cognitively able. But, at the same time, I've had people that are succeeding, who at the beginning I didn't think they could write their own name, but once they start to get sober, they're fine. But then, the big worry is, what happens next?*

These increasingly medicalized conceptions of addiction among Tribal service providers and community members did have a number of impacts, including exploration of avenues to assist and/or deliver MAT to community members (first Vivitrol and then Suboxone). For instance, when asked about the best way to address addiction in the community, one team member said:

> *Help is…put it back on the medical field again. I mean, I hate to say it, but they started it, they need to finish it by putting them on Suboxone, and then weening them off the Suboxone. It's the…medically assisted treatment for addicts, that's very very important. At first, I didn't believe in that…it's like trading one for another…*

Despite some original doubts, over time Tribal court staff especially encouraged drug court Participants to use MAT, and Vivitrol in particular because it was provided by the Tribal medical clinic, and is approved for use to treat both alcohol and opioid addiction. However, there was some lasting contention and discussion over MAT for a number of reasons.

In addition, communication and cross-surveillance of participants across Tribal Programs was streamlined. This was in part because some drug court participants were involved in multiple programs that all drug tested them, and the expense and time commitment of this was prohibitive for both Tribal Departments and participants. In addition, efforts to better share and coordinate Tribal information—in addressing addiction especially—were underway due to a number of reasons, including the development of a strategic action plan to address drugs and alcohol in the Tribal community. These factors only increased the amount of information that was shared about participants across departments, but between the Tribal court and the medical clinic especially. Participants were often strongly encouraged to attend residential drug treatment programs, and were required to fulfill all program requirements including attendance at medical and counseling appointments as recommended in their intake assessments as conditions of probation.

While drug court team members frame participation in the program as a choice, and many participants did say they chose to participate in the program, a significant number of participants said they did not really think it was much of a choice at all, or that it was an easy decision because of the consequences they would face if they did not enter the program. Two benefits that were commonly cited by participants were to avoid jail time and have their charges reduced or dropped if they completed the program. A little less than half of participants did say they chose to join the drug court because of personal choice. For instance, one said:

> *My main reason, really, was to change the person who I was, because the person I was…I was broken. I didn't spend time with my kids, I was always broke. I woke up struggling, every morning, trying to find my next high. I would do everything I could to get my needs first, before my kids. It was just a lot of hurt, a lot of hurt trying to deal with everything addicts do, just to get high. I was tired of it.*

A slight majority of participants said that dropping of charges or avoiding jail was a factor in their decision and/or that they did not feel like it was much of a choice when faced with their other options. For example, some participants described their main reason for joining:

> Participant 1: *Yeah, well so, there wasn't a lot of choice, for me. The other way was, probably, the result would be death or something. Like that or in prison.*
>
> Participant 2: *Because it looked challenging and they said if I completed it, my charges would be wiped clean.*
>
> Participant 3: *It was an easy decision, because it kept me out of jail, pretty much.*
>
> Participant 4: *They gave me a choice; it was either jail or drug court, so I had to pick drug court.*

Jail as Safety: A Symptom of Systemic Challenges

While drug court participants do have some choices about how to fulfill program requirements (such as where to get counseling or medical care, whether to go to school or get a job, what activities they do to fulfill community service), the actual program requirements are pretty stringent, and many of the weeks I observed drug court, someone went to jail or a warrant was issued for an arrest. In team meetings this was frequently discussed as a last resort, but it was used often, and most often when the team expressed concern for someone's life and/or safety. For example, one participant was told in court: "you were discussed at length today and we are concerned for your safety," and was then ordered to "see your counselor at behavioral health today at one, or we will issue an order for your arrest." After some explanation from the participant that he had a hard week but was not reverting to his old ways he was also told, "the last place we want you is in jail but we gotta get you sober and strong."

A fairly heated debate over the use of jail arose when one drug court participant who was also enrolled in residential drug treatment was possibly going to be discharged from treatment

for a violation of rules. The debate was over if jail was an appropriate method to keep the participant safe if they were discharged from treatment, since there were no other options available at the time. There were multiple perspectives shared on the best course of action. One argument is best characterized by a team member ardently declaring that "burying another one of our children is not an option." On the flip side, a team member argued, "residential treatment is a voluntary program, anyone can walk out whenever they want." While trying to resolve the argument, the lack of serious alternatives was a huge issue, and one team member stated, "we have other sanctions [aside from jail], but do we really have other sanctions?" In the end, one team member remarked, "We all get frustrated because there are no easy solutions." In the court session directly after the heated meeting, participants were told:

> *"we're trying to keep you healthy here kids and you're slip sliding around…we're gonna keep you safe and healthy over Christmas one way or another…either in jail or in treatment."*

One barrier frequently encountered in discussions was finding appropriate treatment facilities quickly. Sometimes locating a program and completing all of the necessary paperwork and bureaucratic steps took several days or over a week. This caused great anxiety among team members, and in several cases, jail was the preferred alternative to a participant not being in treatment or directly in the care of a responsible service provider. Over the time I observed meetings, the process of transferring someone directly from jail to treatment with no gap was also streamlined. Team members often talked about how they could get more participants into the program earlier. Or in other words, identify ways to get participants into the criminal justice system earlier, so they could protect and "save" them. While this was talked about in terms of helping them, discussions I observed did not cover or consider the ways in which entry into the criminal justice system has multiple negative effects on participant lives well into the future.

Optimism, Success Stories & Plans for the Future

Despite the frustration, sadness and anger expressed by both staff and participants, overall everyone I interviewed was much more positive and optimistic about both the drug court itself, and the participants' futures than I had anticipated before this study and when I first began participant observation. As stated earlier, most of the drug court team members said that they thought all of the participants were capable for success, and a few beamed when talking about success stories. One team member said:

> *I think it's a change of spirit, where they actually have a cognitive change, where the light switches on, after a period of sobriety, and a lot of times it happens after the second phase, where it's like, "okay, I didn't really want structure in my life, where people were telling me what to do, but because I have structure in my life, I'm starting to get my life back. I'm doing better medically, I'm doing better scholastically, my family life is getting better, my work life is getting better." All part of the components….For those people that have been able to successfully complete the program…have been able to see how their lives have changed, how their families' lives have changed, how their work has changed, how their marriage has changed. There's a multiplier effect to it, so that's the encouraging part.*

Small successes were also celebrated in court, where team members and participants clapped, laughed and smiled when participants hit a milestone. These included things like moving to the next phase of the program, sharing their number of days sober, reading a letter to the court, getting their driver's license back, graduating from a treatment program, or achieving another success. Still, a majority of team members interviewed thought there should be even more recognition or "incentives" to participants to celebrate successes.

All the participants I talked to had clearly defined (large and small) goals for the future and were hopeful about achieving them. 25% said they wanted to finish a high school or GED program, 50% said get a college degree, and 25% said go to some sort of technical school. There were also dreams of just living better, being a better parent, starting a business, and learning

more traditional language and culture. In addition, even the participants I talked to who were ultimately not successful in the program thought that things they learned in the program would help them in the future. Here is what one participant had to say about the program's impact:

> *I'm more open to things. I'm more being a whole new person, being sober. I'm accepting who I am. Although I'm struggling a bit, I'm still getting through it. The halfway mark, at least. And…it's interesting, learning all them things, and what we're capable of [inaudible] and when I think about it, I can be pretty capable of a lot of stuff. Good and positive.*

While the participant who gave the perspective above focused on learning, and recognizing what she is capable of, another participant focused more on accountability, and having options aside from jail:

> *Well, what's helping me the most is the…[long pause]…being accountable. You know, they help me be accountable for my actions and everything that I have to do. And it's given me a lot to look at. Like, I wouldn't…if I hadn't got in that program, I would probably be in jail right now. You know, just sitting there; just a waste of time. Being sober and able to do everything I always wanted to do…without drugs, and it's amazing. So, the program helped a lot. It's still helping. I'm actually learning to love it. [laughter] I am.*

Discussion

While there have been a number of benefits to the community in the establishment of the Tribal drug court, in some ways it is also an expression and extension of coloniality which limits the choices and options available to drug court team members and participants. In large part because a rise in frequency of overdose deaths in the community over the last decade—but also because of the rise in opioid addiction in the U.S. as a whole and related desires to destigmatize it, and increases in national level efforts of federal/health agencies—addiction was increasingly medicalized during my time in the community. This did work to destigmatize addiction to a point, but also worked, like medicalization often does, to refocus attention on individual treatment of participants and their personal responsibility to *want* to get better. This is somewhat

mitigated by the connectedness of the Tribal community and multiple community events and services available. Participants in drug court did community service hours in the Tribal community by being involved in community events and programs (and were not allowed to serve those hours elsewhere).

Despite this community involvement, medicalization has allowed for the deepening of control and coloniality over drug court participants by increasing surveillance on them in two significant ways. First, lines of information sharing between the Tribal court, clinic, and behavioral health services were strengthened. Second, encouragement of MAT among participants was often discussed in court, and individual meetings with program coordinators, and the court and medical clinic shared information about administration of MAT. Participants were also asked about their health, or "how they feel" in court sessions in front of other participants. This extension of surveillance increased coloniality over participants in ever-expanding areas of life. This included governmentality over and discussion of their economic, physical, mental, emotional, social, spiritual and cultural realms. This aligns with and goes beyond the ways in which Carr (2011), Zigon (2010) and Skoll (1992) discuss the reframing of individual identities and narratives in terms of securing services and adhering to addiction treatment.

The treatment and recovery narratives discussed by both Skoll and Carr are similar to the ways in which Tribal drug court participants are asked to behave, and similarities are obvious when considering instances when participants were asked to reflect on their progress and goals in the program through reading letters they wrote during court sessions when graduating to a new phase of the program. While the Tribal drug court staff are extending coloniality over participants through the (mostly) necessary use of federal law and policy, they also continually

express care and worry over participant health and wellbeing, that cannot be reduced to simple justification of coloniality. Because many of the drug court team members are community members and/or have worked in the Tribal community for years, they absolutely, and emphatically care about the community and participants (who are sometimes family members). However, this context also shows the ways in which care is limited by the programs policies and the way it is organized. While I do not extensively address neoliberalism here, Zigon's work relates to the Tribal drug court, in that both participants and team members talk about the transformation, or "life changes," that participants go through if successful in the program, and forefront self-regulation and personal responsibility in ways that shift attention from historical and structural conditions.

Alongside my experiences, observations, and discussions surrounding the Tribal drug court, these authors reveal a tension between a shifting of moral responsibility for drug use from the individual to the "disease" of addiction in its medicalized sense, and the reframing of individual choice and will as key to recovery, despite constraints imposed by the coloniality. Or in other words, despite institutional, socio-economic, and political forces—imposed by biomedicine and western governmental, social, legal and behavioral norms. In essence, while addiction is now often (but not always) framed as a disease instead of a moral failing, through and because of the coloniality of the systems in place, it is still the personal responsibility of the addict to recover, preserve their own life, and to foster their health and wellness. Drug court participants must adhere to drug court ideas and requirements of acceptable speech, behavior, and personal responsibility in virtually all realms of their life in order to be successful in the program. Those who do not are sanctioned and often sent to jail in the short-term, and those who consistently do not conform to requirements are discharged from the program entirely (and

return to jail or regular probation). In other cases participants quit, either by informing the court or just ceasing to attend (at which point a warrant is issued for their arrest).

Because it is part of the larger U.S. Justice system, and grant funded by a government agency, there are a number of constraints and limits to what the drug court can and cannot do. One limit is the lack of alternatives to incarceration for participants in terms of "holding them accountable," and ensuring their safety. This was exhibited by the ways in which jail was framed as a "last resort" in many interviews and conversations I observed, but used so frequently. This was also due to the process involved in getting participants into addiction treatment, which was often not fast enough for the team to feel confident in participants' safety. In the court sessions and (sometimes heated) discussions I observed between team members, putting participants in jail was used as a punishment, but also as a way to express care and caring for participants, as well as to express anxiety about losing another community member to drug overdose, and to hopefully prevent overdoses and "save lives." The possibility of death was always a concern, and was discussed virtually every time I attended team meetings. It is also a very understandable concern considering the fact that a number of drug court participants overdosed since the program began (including some of the participants I talked to). While some lived to share their stories of overdose, others did not. This conundrum reveals a serious contradiction in trying to treat something framed as a disease, or medical condition, in a system designed to deal with criminal activity and behavior.

Part of the issue is that the drug court is situated firmly within the US justice system despite—and in some ways in support of—Tribal sovereignty, and in effect, drug court team members are acting within professional norms, boundaries and epistemologies that work to constrain the options available. Like Lambert highlighted in her discussion on the BIA, Tribal

nations often have complicated relationships with the federal government, and this is true of the Tribal drug court which relies on government agencies because of grant funding, and must adhere to national laws and policies, but seeks to work toward community specific solutions (Lambert 2016: 334-337). In addition to criminal justice norms, behavioral health and medical norms and boundaries were also barriers to finding solutions at times, and in a few cases Team members from different professional fields blamed each other, and each other's policies, practices, and priorities for perceived failures. The gaps between these norms and goals acted to conceal the larger problems. Instead of focusing on the ways in which each system was flawed in some ways, and in how they could be improved, these differences in training and understanding allowed for obfuscation of systemic failures and possible alternative solutions.

Part of the anxiety over solutions is also owed to the fact that addiction treatment is often unsuccessful, and recidivism rates related to drug use are high, although when compared with mainstream courts/probation, drug courts across the country do have lower rates of drug use and recidivism among participants (U.S. Department of Justice, Office of Justice Programs 2018). Similarly, while drug court team members and some participants argued that overcoming addiction is a choice—about will, about wanting—this may not be the case. All the participants I spoke with wanted to stay sober and fulfill (at least most of) program requirements. But, in many ways it is the very systems trying to help them that fail them and continue to limit their free will. The increased surveillance, airing of their personal information and life circumstances in front of other participants, and putting them in jail for their own safety aim to help them, but also perpetuate stigma, blame and shame.

There are no easy answers to drug and alcohol issues, but one solution is to focus on the goals and priorities of the Tribal community itself, and how they can best be enacted in service

provision. The community has hope, and desire and plans for the future, and so do the drug court participants and team members. In reflecting on Chapters One and Two, there are some clear answers about what the community (including community members, Elders, and employees) consider solutions:

1) Culture, tradition, and language.

2) Community acknowledgement of past and pain, and coming together as healing.

3) Understanding, non-judgement and caring.

While many programs include these ideas, creative solutions to prioritize these things within and outside of Tribal programs are needed. Tribal drug court team members have increasingly included culture, tradition, and language as components of the drug court program, particularly in options for participants to complete their community service. However, how effective is delivery of these things through programs/programming versus in more grassroots/personal interactions? In addition, drug court team members have expressed caring and understanding, but judgement is a key component of the US justice system, and so a key component of Tribal drug court. This is a challenge in many ways, as judgement is often situated in opposition to care and understanding in community member discussions about addressing addiction. In addition, in the drug court itself, it seems that participants would like to see more transparency about how decisions are made about their progress through the program, and about who is actually making those decisions, and have more say and choices in fulfilling the program requirements. These things are connected to care and understanding, so could be perhaps be incorporated alongside those as guiding principles.

Like Angela Garcia's work on multi-generational heroin use in New Mexico, this study raises questions about care and addiction (Garcia 2010: 111-149, 183-203). Garcia focuses on

how care is enacted in Mother-Daughter relationships, and how care is expressed in ways that may seem harmful by broader social norms; for example, a daughter caring for her mother by getting her heroin. However, through this and other examples she shows that care is enacted to show love and ease pain (Garcia 2010: 111-149, 183-203). In the case of the Tribal community's drug court, team members enact their caring for participants through surveillance, judgement and punishment, but to save participants from addiction and death. This often takes the form of jail time. This raises important questions about the expression of care and the often incommensurable balance between free will, choice, and "saving lives."

Conclusion

Coloniality has constrained the options available to Tribal drug court team members and participants through overarching government policies of the federal government and criminal justice system, and increasing medicalization of addiction. The limitations imposed by the coloniality of the system are demonstrated (at least in part) through several closely related themes. First, drug court team members seek to shape participant behavior in a multitude of ways. They consistently express care and concern for the participants, in team meetings, court sessions, interviews, check-ins. This constant and recurring expression of care tends to run counter to how people working within the justice system are portrayed and written about. This care is often expressed through words, but words often accompanied by punishment (or at least threat of punishment). While team members express and enact tremendous care and caring for participants and seek to "save lives" in the face of disproportionate overdoses in the Tribal community, the ways in which they can convey this care and concern is most often through putting them in jail.

Second, while success or failure in the program is often attributed to will or choice, participant choices are limited, and all participants I spoke with wanted to adhere to main program requirements. Third, while the medicalization of addiction is frequently framed as destigmatizing, it allows for the deepening control and surveillance over participants in the program by focusing attention on participants as the locus of change—expressed through assertions that participants must want to change in order to be successful in the program—in addition to expanding oversight of participant lives into more and more areas. These include their medical and behavioral health issues and diagnoses, medications, personal relationships, feelings, spirituality and cultural and community connectedness. In order to be successful in the program participants must reframe their lives and representations of their progress in terms of drug court priorities and guidelines, and concerns about consistency and confidentiality in the drug court make this challenging.

Fourth, systemic barriers related to government bureaucracy reduce options for participants and team members. Drug court team members' anxiety and uncertainty about the best ways to help and "save" participant lives, are compounded by professional norms and frameworks that limit choices and possible actions, especially in the context of limited options for participants to enter into addiction treatment programs in a timely manner. Resources and services available are also limited and shaped by overall US policy and politics. These structural issues are symptoms of coloniality, which encompasses jurisdictional issues surrounding Tribal nations, as well as the complex relationships between Tribal governments and federal agencies.

Despite the challenges, inconsistencies and complications of the drug court problem, participants and team members generally have positive things to say about it, and are very

optimistic about the future. If these issues could be addressed and the systems shifted to better fit community needs and strengths, how much more impactful could Tribal drug court be?

Conclusion: The End. And The Beginning.

The Problems of Research

Vizenor might say that American Indian nations and peoples (and really any groups in general) can't truly be documented or represented, especially in writing, and in the decontextualized way I have presented this research to protect the community. However, in his own work, he does work to call out and deconstruct manifest manners. I build on this and the work of many other scholars and tricksters by identifying and critiquing a few symptoms and layers of coloniality, and demonstrating how they affect one American Indian community. I tried to undertake this research in a good way, to be guided by and accountable to the community as much as possible, and to offer back as much as I can. Despite all of this, I am still fearful that this work could somehow be used in ways I cannot foresee.

Telling stories is a responsibility, and being a good storyteller is hard. Too often, this responsibility has not been properly taken up by anthropologists and other academics. Vizenor, Deloria, Simpson, and countless other Indigenous scholars have identified some of the ways in which these responsibilities have not been honored in the past. Since I entered the world of graduate school, I have seen a few of these transgressions still happening directly and through written or oral accounts from other American Indian scholars and community members. They generally fall into three categories. First, some researchers have come and gone into American Indian and other Indigenous communities to document and theorize without offering reciprocity, without identifying solutions, without doing any good. Second, I have learned that many researchers feel it is their right to access, gather and share knowledge because it is "fact," or "no one owns history." Third, some researchers have minimal understanding of American Indian (or other Indigenous) communities in general, and so do not understand the possible effects that

spreading some knowledge could have. As I hope this dissertation demonstrates, stories are powerful, and research is a form of storytelling. We must be careful with stories, and honor those who share their stories with us.

I believe the stories of the community I hold responsibility and obligations to, and the survivance and solutions they express in the face of coloniality can do good. To affect change, they need to be expressed and heard and taken as an impetus to examine our systems of service delivery, of care, of justice, and of thought. Many Tribal Nations are using innovative, creative, and culturally grounded methods to do just that in the face of significant challenges. Survivance is an ongoing shared process.

Identifying Problems of Coloniality

In part, this is a story about the mechanisms and effects of coloniality, a few of which have been outlined here primarily in terms of service provision. First, *Coloniality as oppositional encounter of self & other* acts as a force to define people, norms and territories (Noble 2015: 429-430). In the case of this community, both American Indians and drug users are coded as "others." This doubly stigmatizes American Indian drug users, and frames the reservation as "dangerous." Stereotypes and stigmatization of both American Indian peoples and drug users are historical products of political and colonial agendas that have echoed into the present. These stereotypes and stigma are reinforced through local and national media, and the absence of American Indians in public education curriculum. These constructions of categories and perceptions are then acted upon by police, doctors, and other service-providers and authority figures in carrying out their responsibilities and duties. Community members, Elders and employees argue that stereotypes and the related judgement and stigma, then interfere with American Indian life in general (in the form of things like racial profiling), and with recovery of

community members from addiction. If we think of *Coloniality as Apparatus and Milieu*, in terms of the normalizing forces and structures acting on all of us as individuals and collectives, it is clear these two processes of coloniality are virtually inseparable (Noble 2015: 429-430).

Second, interview participants in this study identified a relationship between addiction and both historical and childhood trauma. While some scholars have taken issue with lingering questions around Historical Trauma, how it is defined, when it applies, and how it is transmitted, in this case at least one mode of transmission is clear. Since American Indian Boarding Schools separated children from their parents and in many cases inflicted multiple forms of abuse on students in efforts to assimilate them, many of those children not only never learned how to parent, but also suffered from childhood trauma. While not all boarding school attendees used drugs and alcohol as a coping method, some community members and Elders argued that some use these things because of their boarding school experiences. Thus, *Coloniality as oppositional encounter of self and other* and *Coloniality as Apparatus and Milieu* worked together to shape boarding school students and their descendants (Noble 2015: 429-430). In fact, the disruption of intergenerational learning in American Indian communities, was exactly what boarding school creators had in mind. While a small number of participants were skeptical about the effects of Historical Trauma, most interviewees argued that its effects are real and ongoing. Culture, language, spirituality, and relationships/connection are seen as solutions to addressing trauma and other issues related to drug and alcohol use.

Third, coloniality is clearly expressed in the structural and conceptual limitations experienced by both staff and participants in the Tribal drug court. Participant and staff actions were limited by their own perspectives on addiction that were shaped by wider norms and values, the way the drug court is set up, and by the lack of options available for drug users involved in

the criminal justice system. Although drug court team members expressed great care and concern for participants, they frequently resorted to placing participants in jail to "keep them safe," or "save their lives." While medicalization of addiction has been shifting the treatment of addiction within the drug court over the past several years, and has worked to destigmatize addiction to a degree, it has also imposed different limits and additional surveillance on participants. For example, participant medical and mental health diagnoses were often discussed, they were required to attend doctor's appointments in addition to counseling and AA/NA (Alcoholics Anonymous/Narcotics Anonymous) meetings, and participants were greatly encouraged to use MAT to address their addiction.

The limited choices available and the medicalization and increased surveillance are part of coloniality. In this case several interrelated processes and conditions combine. Ongoing government surveillance (aka. funding, aka. technical assistance) of Tribal Nations, misunderstandings between different professional fields, the primacy of Western conceptions of health and healing, and prejudice/racism combine to act on programs and systems which are then limited in how they provide services and interface with those individuals and families who need services. In fact, these processes even influence how they define who needs services.

While documentation of coloniality and ongoing racism is certainly not unique within Anthropology or American Indian Studies, this dissertation has furthered detailed the ways in which they affect individuals and communities, and highlighted important ways in which service provision can be diminished, disordered, and unsettled by them. The ways in which certain concepts—like Historical Trauma—may be questioned and dissected within academic spaces, need to be examined in relationship to the ways those same concepts are accepted and seen as useful in particular historically oppressed communities and spaces more often.

Expressing Solutions of Survivance

Tribal survivance, sovereignty and self-determination are the bedrock of Tribal nations, and the framework for building creative and community specific solutions that give priority to culture, language and tradition. Solutions and strengths to existing problems identified by Tribal community members, Elders, and employees should be prioritized and could work to decrease the power of coloniality. These solutions and strengths include: community closeness, collective acknowledgement of the past and ongoing pain and trauma, culture and language, spirituality, and understanding, compassion and caring. Meaningful and impactful implementation of these would mean not only their incorporation at the level of individual employees (for instance training a social worker to show increased compassion and understanding of Historical Trauma), but also changing the ways programs and service provision are set up. Instead of biomedical or psychological frameworks limiting and circumscribing the way services are delivered, how could programs be reimagined to maximize the desires of community members actually experiencing services and programs?

For example, one of my Community Advisory Committee members said something along the lines of, "we always talk about how resilient we are as a people, but what if our kids didn't *need* to be resilient?" This exemplifies a way of thinking about change outside of biomedical and psychological norms. Instead of focusing on building resilience in each of our kids individually, how can we transform systems and communities so that it doesn't matter if our kids are resilient or not? They can thrive. Why are we putting the responsibility of resilience on our children? How can we diminish and demolish coloniality, instead of continually struggling against it? Exploring the answers to these questions seems difficult, crucial, and part of survivance.

One way to envision other possible shifts is to return to the American Indian and Indigenous studies literature in which this study was originally conceived and framed. Indigenous methodologies were developed by and for Indigenous peoples, to serve as ideals and best practices for working with Indigenous communities, and can be employed in areas beyond just research. The 6 tenets of Indigenous research identified in Chapter One seem especially relevant (if simple) when we think about reimagining Tribal programs and service provision:

1. *Highlight, change or revolutionize the traditional ~~research process~~ service provision model itself*
2. *Privilege Indigenous ways of knowing; Include Indigenous Worldviews and /or Traditions*
3. *Address history and/or continued oppression*
4. *Practice reciprocity and develop/foster/grow relationships with community and individuals*
5. *Be relevant and practical for American Indian communities*
6. *Be community specific*

While I was unable to directly and explicitly address all of these tenets in writing this dissertation, they were all considered and adhered to as much as possible in the entire research process. These ideas came from Indigenous communities, and so are already enacted by many Indigenous communities/Tribal Nations. However, biomedical and psychological norms, and other laws, regulations and institutions have perhaps had too much of a foundation in coloniality to be easily subverted to better serve communities. This is due to government to government relationships, historical power relations and economics, and other complex dynamics. Academic practices, methodologies, and theories are being transformed slowly, yet incompletely, over time

by some of these very ideas. This means other systems can be too, regardless of current federal regulations, and biomedical and psychological norms.

This is important to consider not only for American Indian scholars, communities and nations, but also for others. Anthropologists in particular are skilled in challenging, deconstructing and critiquing norms, terminology, and systems/structures, but are not as apt to offer salient system wide ideas or solutions. As a discipline we are great at tearing down, and at highlighting strengths and triumphs of individual research participants or communities, but are not known as great builders of anything aside from theory. Medical and applied anthropologists are great at offering context specific solutions, and troubleshooting specific issues, but systems wide change or policy is something few seem to attempt, let alone commit to. Indigenous methodologies are in many ways focused primarily on change, and on systems change in academia in particular. In addition, using survivance as an analytical framework could help anthropologists emphasize community strengths in a variety of contexts. This could counter historical trends that primarily focus on deficits of Indigenous communities, and offer excellent starting points to identify solutions to the problems of coloniality.

Considering the origins and history of anthropology in relationship to Indigenous peoples and colonial systems, it seems almost absurd that these things aren't more widely discussed and used as guidelines within anthropology. In particular, anthropologists might benefit from further consideration of relationality. Practicing reciprocity and developing/fostering/growing relationships with community and individuals (tenet #4) is essentially relationality, and is another way to envision the understanding, compassion and caring that community members so frequently reference in the American Indian community at the center of this study. As I put it in the Introduction, relationality is about connections to our families, ancestors, and the world

around us. It is about mutual responsibility, respect, and reciprocity (McGregor, Restoule & Johnston 2018: 11-19; Howard 2018a: 271-272). If we are operating in terms of relationality, recognizing our connections and ancestors, and respecting those around us, there will be less space left for judgement and stigma, racism and prejudice. Relationality is about connections and relationships; by forefronting relationality, we increase our understanding of our relationships and obligations. While prioritizing relationality in the systems of coloniality (where objectivity and professional distance are highly valued) may not be easy, it is an expression of survivance.

And so I come full circle. I will end with relationality, survivance, and the power of stories expressed in the beautiful words of my father. But as is the case with circles, there is no real end; in each end there is change, and there is also a beginning.

Like a seemingly dislocated band moving beyond borders, driven from home and family, stories and songs continue with other bands and families, to live on, in ever-extending sites of struggle where the spirit of affiliation develops anew, to energize and empower people in an on-going development of faculties, for understanding themselves, ourselves and others.

-Gordon Henry Jr.,
The Eagleheart Narratives
From Stories Through Theories, Theories Through Stories (2009: 304)

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