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## Ethnic-specific Support Systems as a Method for Sustaining Long-term Addiction Recovery

Although addiction recovery mutual aid support groups have grown dramatically and now span secular, spiritual, and religious frameworks of recovery, most of what is known from the standpoint of science about these groups is based on the early participation of treated populations in Alcoholics Anonymous. Many questions remain about the effects of participation in other mutual aid groups and different pathways and styles of recovery within and across diverse ethnic groups. This paper reviews existing data on ethnic group participation in recovery mutual aid groups, summarizes the history of culturally indigenous recovery movements within Native American and African American communities in the United States, and describes strategies aimed at increasing recovery prevalence and the quality of life in recovery for persons of color in Philadelphia, Pennsylvania, USA.

**KEYWORDS:** Addiction recovery, mutual aid, race, ethnicity, racial disparities, recovery support, recovery mutual aid

### Introduction

The prevalence of alcohol and other drug (AOD) use and related problems and access to and participation in treatment and recovery support resources are not equally distributed across racial/ethnic groups in the United States (Caetano, Baruah, & Chartier, 2011; Chartier & Caetano, 2011; Mulia, Ye, Greenfield, & Zemore, 2009; Wallace, 1999). Although non-Whites experience remission from substance use disorders at rates comparable to Whites (Arndt, Vélez, Segre, & Clayton, 2010), AOD problems within communities of color have been historically portrayed in the mainstream media through a lens of pathology rather than through the perspectives of resilience, resistance, and recovery (White & Sanders, 2008). Pejorative racial stereotypes long imbedded within anti-drug campaigns in the United States have misrepresented the source, scope, and solutions to AOD-related problems within communities of color (Helmer, 1975; Leland, 1976; Musto, 1973; Neuspiel, 1996). If there is a yet untold addictions-related story at public and professional levels, it is the rich tradition through which communities of color have actively resisted the infusion of alcohol and drugs into their cultures,

adapted mainstream recovery support resources for cultural fit, and mounted indigenous responses to the rise of AOD-related problems (Coyhis & White, 2006; James & Johnson, 1996; White & Sanders, 2002; White, Sanders, & Sanders, 2006).

This article: 1) reviews the diffusion and adaptation of recovery mutual aid resources within communities of color, 2) outlines the history of abstinence-based religious and cultural revitalization movements as frameworks of addiction recovery within Native American and African American communities, and 3) describes culturally indigenous recovery support resources that are being utilized as adjuncts and alternatives to mainstream recovery mutual aid and addiction treatment organizations in the City of Philadelphia. An introductory caution is in order. U.S. *communities of color*—as a collective concept and in reference to particular ethnic groups—are characterized by substantial intra- and inter-group differences. The resulting limitations in drawing broad conclusions will require readers to test the viability of suggested principles and strategies within their respective local communities.

## **Ethnic Participation in Contemporary Addiction Recovery Mutual Aid Organizations**

Addiction recovery mutual aid organizations are assemblies of individuals who have joined together for the sole purpose of rendering each other peer-based, non-professional support for the resolution of alcohol and other drug problems. Such groups have risen around the world within highly diverse cultural contexts, including the Swedish Links, Vie Libre (Free Life Movement), the Polish Abstainers Club, the Danshukai movement in Japan, and the Pui Hong Self-Help Association in China, to name just a few (White, 2004a). Alcoholics Anonymous and other 12-step groups have dominated addiction recovery mutual aid in the United States even as the spectrum of secular and explicitly religious alternatives to 12-step programs has grown in recent decades. This dominance elicited early criticisms that the 12-step program was based on the experience of white men and therefore inappropriate for historically disenfranchised minorities (For review, see White, 1998).

This particular criticism has not withstood historical and scientific analysis. First, AA and other 12-step programs exist and continue to grow throughout much of the world, including Latin America, the Middle East, Africa, and Asia, and representation of people of color in 12-step programs has progressively increased in the U.S. since their founding (White, 1998, 2004a). Second, scientific studies of ethnicity and AA have concluded that:

- 1) AA's view of alcoholism and its solution are widely accepted within communities of color (Caetano, 1993; Goebert & Nishimura, 2011).
- 2) Non-Whites affiliate with AA at similar or higher rates than Whites following professional treatment (Humphreys, Mavis, & Stoffelmayr, 1991, 1994).
- 3) African Americans have lower dropout rates in AA than do Whites (Kelly & Moos, 2003).
- 4) 12-step program emphasis on mutual support with a community of shared experience and its elevation of the role of spirituality in healing personal wounds are themes quite congruent with the cultures of many communities of color (Humphreys et al., 1994; White & Sanders, 2008).

Such conclusions may challenge the experience of many clinicians who have witnessed low engagement rates of clients of color within predominately White communities and mutual aid groups. It is the authors' experience that the engagement of people of color in predominately White mutual aid groups remains difficult until a certain critical mass of participation is reached, after which ethnic representation can grow quite dramatically.

There has been very little research on ethnic group participation across the spectrum of addiction recovery mutual aid organizations, but a glimmer of such participation can be gleaned from survey data published by key recovery mutual aid organizations. Table 1 summarizes the latest available survey data reported by White (2009a) for AA, Narcotics Anonymous, Cocaine

Anonymous, Secular Organization for Sobriety, Women for Sobriety, LifeRing Secular Recovery, and Moderation Management.

**Table 1: Demographic Characteristics of Recovery Mutual-Aid Societies**

<b>Membership Ethnicity</b>	<b>AA (2007)</b>	<b>NA (2007)</b>	<b>CA</b>	<b>SOS (1992)</b>	<b>WFS (1992a.b)</b>	<b>LSR (2005)</b>	<b>MM (2004)</b>
Caucasian	85.1%	70%	68%	99.4%	98%	77%	98%
African American	5.7%	11%	19%	*	1%	5%	*
Hispanic	4.8%	11%	6%	*	0%	4%	*
Asian American	2.8%		1%	*	0%	1%	*
Native American	1.6%		5%	*	0%	1%	*
Other (or no answer)		8%	1%	.6%	0%	12%	2%

Table 1 suggests substantial participation of non-Whites in 12-step programs but low rates of such participation in most secular mutual aid groups, although comparison of these groups is difficult because of varying survey methodologies and different years in which available data was collected. Membership profile data are not available for faith-based addiction recovery support groups such as Celebrate Recovery.

Most of the critical research questions raised by Caetano in 1993 about ethnic group participation in AA and other recovery mutual aid groups remain unanswered nearly 20 years later, but some conclusions can be drawn. First, there is clear evidence of efforts by 12-step groups to reach out to people of color (e.g., specialized literature; Alcoholics Anonymous, 2001). Second, AA and NA now have an established presence within most urban ethnic communities in the U.S. Third, while these groups were birthed within a particular historical and cultural context, they have been nuanced for cultural fit as they spread across ethnic boundaries (Caetano, 1993; Hoffman, 1994; Womak, 1996).

### **Abstinence-Based Religious and Cultural Revitalization Movements within Communities of Color**

Culturally indigenous recovery support resources (CIRSR) are recovery mutual aid efforts organized by and on behalf of members of particular ethnic cultures. CIRSR mobilize distinctive cultural features (e.g., history, language, values, symbols, rituals, art, music, humor) to buttress successful recovery from addiction. To illustrate the role of indigenous recovery-focused cultural and religious revitalization movements as a framework of long-term addiction recovery, we will briefly describe the evolution of such movements within Native American and African American communities.

Organized mutual support for addiction recovery first occurred within Native American tribes experiencing a rise in alcohol problems in tandem with efforts to revive their cultural traditions in the face of physical and cultural assaults on their communities. These blended religious/cultural revitalization and personal healing movements date to the Delaware Prophets of the 1730s and extend historically through the Handsome Lake Movement, the Shawnee Prophet Movement, the Kickapoo Prophet Movement, Indian Christian evangelism, Indian temperance societies, the Indian Shaker Church, Peyote Societies, the American Indian Church, the ghost dance movements and the more recent “Indianization of AA,” the Red Road, and the contemporary Wellbriety Movement (Coyhis & White, 2002; Womak, 1996). These movements

were birthed by charismatic “wounded healers” who escaped addiction through a transformational change experience that was sudden, unplanned, positive, and permanent—similar to that of AA co-founder Bill Wilson in late 1934 (White, 2004b).

Early milestones in the rise of indigenous addiction recovery movements among African Americans include the use of early mainstream temperance societies as a framework for recovery initiation (Signorney & Smith, 1833) and Frederick Douglass’ 1845 personal commitment to sobriety and his call for sobriety as a preparatory step toward full citizenship (White et al., 2006). Douglass played a key leadership role in the “colored temperance movement” and the growth of local African American temperance societies (e.g., the Black Templars; Cheagle, 1969; Herd, 1985).

This tradition extended into the mid-20<sup>th</sup> century through creation of AA groups specifically for African Americans (beginning in Washington, DC in 1945), the subsequent racial integration of AA and NA, the growing use of the Black Church as a place of healing and recovery, Malcolm X’s conversion to the Nation of Islam (NOI), and NOI outreach efforts to addicted African Americans (C., Glen, 2005; White, 1998; White et al., 2006). Addiction ministries of the 1950s and 1960s rose in response to rising heroin addiction among African Americans—with drugs framed as tools of genocide by the Black Panthers and other Black Nationalist organizations (Tabor, 1970). The past two decades have witnessed the rise of indigenous faith-based recovery movements within predominately African American communities and the birth of recovery advocacy and peer support organizations serving predominately African American communities (Whiters, Santibanez, Dennison, & Clark, 2010; Williams & Laird, 1992). Collectively, these religious and cultural revitalization movements have provided diverse Africentric pathways of addiction recovery initiation and maintenance. Clergy now constitute a major recovery support resource within African American communities (Bohnert et al., 2010; Sexton, Carlson, Siegal, Leukefeld, & Booth, 2006). Faith-based organizations may be particularly well-suited to provide non-clinical addiction recovery support services (DeKrall, Bulling, Shank, & Tomkins, 2011).

CIRSR exist alongside the growth of AA and NA within Native American and African American communities, with individuals picking which resources best met their needs, participating in both simultaneously, or using one program to initiate recovery (e.g., AA/NA) only to then migrate to another to maintain that recovery (the Black Church/Celebrate Recovery)—the latter reported among a population of African American women in recovery in the urban centers of Illinois (White, Woll, & Webber, 2003). Whether individuals within communities of color respond best to mainstream groups, culturally specific recovery mutual aid resources, or combinations of such resources may be linked to different degrees of cultural affiliation (Bell, 2002).

## **Distinctive Features of Culturally Indigenous Recovery Support Resources**

Culturally indigenous addiction recovery support resources (CIRSR) share many features with the mainstream spiritual, religious, and secular recovery support groups described elsewhere in this special issue of *Journal of Groups in Addiction and Recovery*. Nearly all are founded and led by people in recovery. Most share an abstinence-based approach to problem resolution. All involve a reconstruction of personal identity, daily lifestyle, and interpersonal relationships, although to different degrees of intensity. All but Moderation Management contain the elements of problem admission, commitment to abstinence, service to others, and sober fellowship. That said, there are distinctive differences between mainstream recovery mutual aid groups and CIRSR.

*Etiology of Addiction.* CIRSR share a broader understanding of the etiological roots of addiction. Addiction is often viewed within communities of color as an outgrowth of historical/intergenerational trauma, the targeted promotion of drugs to communities of color (a tool of economic and political exploitation), and as a personal response to present social, economic, and political marginalization (Brave Heart, 2003). Sharing of cultural pain within

CIRSR as a dimension of personal recovery may include discussions of slavery, the loss of land, extermination campaigns, epidemic diseases, the purposeful break-up of families and tribes, the loss of families and culture via immigration or deportation, forced internment as prisoners of war, other forms of physical sequestration, immigration distress, acculturation pressure, racism, and discrimination. Within CIRSR, the sharing of such experiences is viewed as a valuable step in consciousness raising, identity reconstruction, and embracing recovery as an act of personal/cultural healing rather than as strategies of denial, diversion, or rationalization as they are sometimes cast in mainstream mutual aid and addiction treatment contexts (Green, 1995; White & Sanders, 2008).

*Ecology of Recovery.* Within CIRSR, personal recovery is nested in broader concerns for the survival and healing of families, neighborhoods, and communities—recovery as *a people*. Recovery is often framed as a political as well as a personal act—a means of cultural survival and revitalization. Recovery of the person, family, and community are viewed as inseparable, suggesting that one part of the recovery ecosystem cannot be treated or healed without treating and healing the whole. This is reflected in the Wellbriety Movement’s concept of the *Healing Forest* (Coyhis, 1999) and the concept of *community recovery* that is gaining salience in predominately African American communities (White, Evans, & Lamb, 2010). This simultaneous focus on person, family, and community can be evidenced in Rev. Cecil Williams’ personal recovery/community revitalization work in the Tenderloin district of San Francisco (Williams & Laird, 1992) and in the historic recovery and renewal of the Alkali Lake community following decades of pervasive alcoholism (Chelsea & Chelsea, 1985; Taylor, 1987).

*Culture as an Agent of Healing.* One of the underlying premises of many CIRSR is that AOD problems rose in tandem with the loss of cultural traditions and that the renewal of those traditions and their adaptation to contemporary needs can provide a framework for recovery of the person, family, and community (Bowser & Bilal, 2001; Sanders, 2002; for studies of the association of recovery with increased cultural identification, see Flores, 1985 and Westermeyer & Neider, 1984).

*Continuity of Support.* Within CIRSR, what is traditionally called “relapse” is not viewed as a moral failure deeming someone unworthy of further support. The individual who has resumed AOD after seeking recovery is viewed as a fallen warrior in the struggle for personal/cultural survival. The corollary to that belief is that no warrior should be left on the battlefield—that the community has a responsibility to care for its wounded warriors—a concept exemplified in White Bison’s Warrior Down relapse prevention and intervention initiative for Native Americans (White Bison, 2012).

*Multiplicity versus Singularity of Purpose.* Where 12-step and many secular recovery mutual aid groups adhere to a singularity of purpose and avoid getting involved in what are perceived as “outside issues,” CIRSR tend to see AOD problems nested in multiple contexts that deserve attention. Organizations promoting CIRSR have much more boundary fluidity—e.g., involvement in mutual aid, professional treatment, and policy advocacy as well as simultaneous involvement in such issues as addiction, mental illness, domestic violence, child neglect and abuse, homelessness, HIV/AIDS, health care disparities, cultural revitalization, and economic development.

*Mutual Support and Political Advocacy.* The greater link between recovery support and personal and political advocacy seen in CIRSR may stem from awareness that recovery of persons within communities of color involves finding ways to survive and thrive in the face of multiple sources of stigma and discrimination—first described by Bell and Evans (1981) as *double consciousness*.

*Respect for Transformational Change Experiences.* CIRSR share a deep respect for life-transforming conversions, epiphanies, defining moments, peak experiences, and the personal “calling” to service that often emanates from such experiences. Service to others in this context is less a task to be completed to support one’s own recovery and more a manifestation of the newly reborn person. The affirmation of the transformational power of spiritual experience that

permeates CIRSR draws on deep traditions within communities of color and unapologetic respect for the multiple therapeutic functions served by culturally indigenous religious institutions (Thompson & McRae, 2001; Whitley, 2012; Wright, 2003).

*Hope versus Pain.* CIRSR rise from communities whose members have lived a literal and metaphorical “bottom.” In this context, hope is a greater motivator for addiction recovery than new increments of physical or psychological pain. CIRSR serve communities, families, and individuals with unfathomable capacities for prolonged physical and psychological pain. Pain in this context is not viewed as a motivator for recovery in the absence of hope. Hope is viewed as the key catalytic ingredient in recovery initiation.

*Catalytic Metaphors.* Hope is conveyed within CIRSR through *catalytic metaphors* that are culturally vibrant (“hot”). Such metaphors encompass words, ideas, and stories that, by creating dramatic breakthroughs in perception of self and the world, spark and anchor processes of personal transformation. These catalytic metaphors are linked to recovery and integrated as prominent themes in an overarching culture of recovery. In a very real sense, culture and its stories and metaphors become the “treatment” (Spicer, 2001).

*Witnessing.* Within the CIRSR context, one is expected to give as well as receive hope. That is achieved by becoming a recovery carrier—one who makes recovery contagious through the act of personal witnessing in the community. Such assertive and public recovery evangelism, in contrast to the anonymity practiced by most mainstream recovery support groups, is a way of offering hope (living proof) of the transformative power of recovery and the fruits it can bear through community service and cultural awakening.

*Indigenous Healers and Institutions.* CIRSR within communities of color emanate from or subsequently engage culturally indigenous healers and institutions. Such healing roles include the medicine man/woman, cacique (Indian healer), curandero (Mexican folk healer), Espiritista (Puerto Rican spirit healer), minister, priest, shaman, monk, and herbalist (Abbott, 1998; Brave Heart & DeBruyn 1998; Jilek, 1974, 1978; Singer & Borrero, 1984; White & Sanders, 2008).

*Community Credentialing.* Credibility of recovery carriers inside communities of color is based on *experiential knowledge* (lived knowledge of the problem and its solution) and *experiential expertise* (the ability to translate personal knowledge into skills in helping others within the community—living proof of one’s power as a healer; Borkman 1976). This vetting is guided by community elders and conveyed through community storytelling. It constitutes a credential that no university, professional association, or governmental body can bestow (White & Sanders, 2008).

## **The Philadelphia Story**

Community recovery capital is the quantity and quality of extra-personal/familial assets available to individuals to initiate and maintain addiction recovery and enhance the quality of personal/family life in long-term recovery (White & Cloud, 2008). There have been recent calls to develop and mobilize community recovery resources beyond professionally directed addiction treatment and recovery mutual aid organizations (White, 2009b; White, Kelly, & Roth, this issue)—particularly within communities of color (Coyhis, 1999; White & Sanders, 2008). The goals of these efforts include increasing the ethnic diversity and level of representation within mainstream recovery mutual aid groups, increasing the presence and capacity of CIRSR within ethnic communities, and building bridges of collaboration between these natural resources and mainstream addiction treatment and allied health and human service organizations.

The authors have been involved for seven years in efforts to achieve these goals within a larger recovery-focused transformation of the City of Philadelphia’s behavioral health care system facilitated by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBH/IDS; See Achara-Abrahams, Evans, & King, 2011; Evans, 2007). The importance of achieving these goals is indicated in part by Philadelphia’s growing racial diversity:

43.4% Black; 41% White; 0.5% American Indian or Alaskan Native; 12.3% persons of Hispanic or Latino origin; 6.3% Asian persons; and 2.8% persons reporting two or more races (U.S. Census Bureau, 2010). Table 2 outlines those strategies consistently reported through service recipient and provider focus groups and town meetings as well as through internal DBH/IDS evaluations that have been identified as most important in increasing recovery capital within communities of color in the City of Philadelphia. The strategies are organized within six core functions: 1) mapping recovery resources, 2) celebrating recovery at a community level, 3) mobilizing culturally diverse peers, 4) assuring representation, 5) assertive community outreach, education, and collaboration, and 6) targeted funding.

**Table 2: Strategies to Increase Community Recovery Capital for Diverse Ethnic Groups**

Strategy	Reported Effects
<b>Core Function: Mapping Recovery Resource</b>	
<i>Health disparities and recovery resource mapping:</i> analysis of service utilization across ethnic communities; identification of all treatment providers, recovery support meetings, recovery homes, recovery ministries, etc. by zip code.	<ol style="list-style-type: none"> <li>1) Increased ability to assure recovery resources as close as possible to areas with the highest density of AOD problems.</li> <li>2) Increased choices and improved matching of individuals to treatment and recovery support resources.</li> <li>3) Increase in targeted RFPs for recovery support in underserved areas.</li> <li>4) Creation of “learning community” to generate lessons for whole service system.</li> </ol>
<i>Bi-annual recovery prevalence survey</i> included within a larger public health survey.	Increased capacity to measure: 1) recovery prevalence by ethnic groups, 2) health status of people in recovery across ethnic groups, 3) perceptions of quality of addiction treatment by areas of the community and by ethnic groups, and 4) changes in recovery prevalence over time in areas of focused recovery support initiatives.
<i>Focus groups and town meetings</i> exploring issues related to accessing services and supports in communities of color.	<ol style="list-style-type: none"> <li>1) Increased understanding of the barriers related to service access and retention.</li> <li>2) Increased dialogue and collaboration between people in recovery, CIRSR, and treatment providers.</li> </ol>
<b>Core Function: Celebrating Recovery at a Community Level</b>	
Support for public <i>recovery celebration events</i> and visible <i>celebration of multiple pathways of recovery</i> across diverse ethnic communities.	<p>People from diverse and previously closed recovery groups beginning to see themselves as part of a larger entity: <i>People in Recovery</i>.</p> <p>Persons from diverse backgrounds seeking recovery see “people like me.”</p>
<b>Core Function: Mobilizing Culturally Diverse Peers</b>	

<b>Strategy</b>	<b>Reported Effects</b>
Work with treatment providers to develop <i>consumer councils/alumni associations</i> and <u><i>assertive linkage procedures to mutual aid and other recovery support entities.</i></u>	<ol style="list-style-type: none"> <li>1) Transition from treatment culture to a recovery culture within provider agencies.</li> <li>2) Recovery leadership development within all geographical areas of the City of Philadelphia.</li> </ol>
<i>Youth Leadership Initiative:</i> Developed Philadelphia Youth Move (Motivating Others Through Voices of Experience). Focused on increasing peer supports for children and adolescents, promoting advocacy for and by youth of color, addressing stigma through education and sharing of personal recovery stories, and providing youth of color with leadership training.	<ol style="list-style-type: none"> <li>1) Inclusion of child/adolescent/family recovery support needs within all strategic planning efforts.</li> <li>2) Increase in adolescent peer recovery support groups.</li> </ol>
<i>Assertive outreach</i> to recovering people of color to promote their participation in Storytelling Trainings.	<ol style="list-style-type: none"> <li>1) Increased sharing of hope-based recovery stories by people of color.</li> <li>2) Increased representation of recovering people of color during community events.</li> <li>3) Development of informal peer-based recovery network in communities of color.</li> </ol>
<i>Peer-based community outreach</i> through the Taking it to the Streets Initiative: Focus on peer outreach to underserved populations in the community at venues such as homeless shelters and safe havens.	<ol style="list-style-type: none"> <li>1) Increased awareness of recovery support services among people of color.</li> <li>2) Assertive linkages of persons in treatment to CIRSR.</li> </ol>
<b>Core Function: Assuring Representation</b>	
<i>Assuring ethnic diversity and recovery representation</i> in DBH/IDS staff and all DBH/IDS policy and advisory councils.	Improved constituency representation in DBH/IDS leadership initiatives across ethnic communities and diverse pathways of recovery.
<i>Expectation of cultural competence</i> within practice guidelines governing treatment and recovery support services.	Increased recruitment, retention, and long-term recovery support for underserved populations. Concept of cultural competence now extended to encompass diverse communities of recovery.
<b>Core Function: Assertive Community Outreach, Education, and Collaboration</b>	
<i>Cross-systems collaborations</i> to bring increased recovery orientation to systems with high representation of persons of color, e.g., drug, mental health, and juvenile courts, recovery homes for prison	Increased access of historically underserved populations to addiction treatment and recovery support services.

Strategy	Reported Effects
re-entry, assertive linkage to communities of recovery within child welfare projects.	
<i>Faith &amp; Spiritual Affairs Initiative</i> aimed at mobilizing recovery support within faith communities, including a special initiative aimed at enhancing service access and recovery support within the African American Muslim community.	<ol style="list-style-type: none"> <li>1) Increased acceptance of and support for people of recovery within Philadelphia’s religious institutions.</li> <li>2) Religious leaders embracing role of their organizations as CIRSR.</li> <li>3) Growth of 12-step support group adaptations for the Muslim community.</li> </ol>
<i>Use of Community Coalitions Initiative and Mini-grants</i> to imbed recovery support services within non-traditional service providers and forge education, outreach, and recovery support coalitions of treatment providers, community service providers, recovery community organizations, and faith organizations.	<ol style="list-style-type: none"> <li>1) Increased recovery orientation of treatment providers.</li> <li>2) Enhanced community capacity for delivery of peer-based recovery support services.</li> <li>3) Increased utilization of treatment and recovery support services via their integration into non-stigmatized service sites.</li> </ol>
<i>Creation of Culture-Specific Community Task Forces</i> to identify and respond to education and recovery support needs within various communities of color.	<ol style="list-style-type: none"> <li>1) Recovery-focused education and support embedded within indigenous culture-specific service organizations.</li> <li>2) Mobilization of indigenous community leaders to serve as recovery advocates and promote the sustained development of community recovery capital.</li> <li>3) Ensured that strategies and solutions were community-driven.</li> </ol>
Committee-led efforts to <u>address stigma of medication-assisted recovery</u> and increasing the recovery orientation of medication-assisted treatment.	Increased advocacy related to stigma attached to medication-assisted treatment and recovery within ethnic communities.
Published and posted articles, interviews, and video clips that increase <i>visibility of CIRSR</i> .	Heightening the visibility resistance, resilience, and recovery within ethnic communities.
<b>Core Function: Targeted Funding</b>	
Financial and volunteer support for <i>recovery mural arts projects</i> .	Increased public visibility and celebration of recovery within ethnic neighborhoods.
Funding support for PRO-ACT (recovery advocacy organization) to operate <i>recovery community centers</i> accessible to people of color.	<ol style="list-style-type: none"> <li>1) Heightened visibility of PRO-ACT as a recovery advocacy organization.</li> <li>2) Recovery community centers serve as a central meeting place for diverse recovery support organizations and a peer-based service hub.</li> </ol>

DBH/IDS used a mix of funding mechanisms to support the strategies outlined above. These included reinvesting savings from Community Behavioral Health, Philadelphia’s own non-profit, managed behavioral health organization for Medicaid recipients, as well as assertive efforts to increase federal support for behavioral health services. In addition, consistent with the

larger recovery-focused transformation that is underway in Philadelphia, many DBH/IDS staff roles and responsibilities have been realigned to support the transformation effort. As a result, many of the strategies employed to expand CIRSR were cost neutral. For example, existing staff conducted focus groups to explore people's experiences with accessing services, led storytelling trainings, and identified and mobilized people in recovery who volunteered their time to conduct street outreach and provide community education. This realignment of staff roles has been critical to the sustainability of these efforts, as many of these efforts are now embedded in the culture of the organization.

The specific strategies outlined in Table 2 were developed in response to Philadelphia's local culture, needs, and resources. Most importantly, they were developed in partnership with diverse stakeholders in the community, including people receiving services, treatment providers, recovery advocacy organizations, and faith-based organizations. We have found that CIRSR can be strategically increased within a community through efforts by federal, state, and local planning and funding authorities. Although the specific strategies might change across communities, many of the outlined core functions of CIRSR can serve as a framework for developing and organizing efforts to promote more community recovery capital for diverse ethnic groups.

A warning caveat is pertinent for systems seeking to facilitate the development of CIRSR. There is a long tradition of harm in the name of help in the relationship between culturally dominant institutions and poor communities of color. For generations, politicians, philanthropists, researchers, educators, and armies of professional helpers and social control agents have tried to rally local ethnic communities with promises of outside help. All too often, these efforts were ill-informed, ill-timed, inadequately resourced, too narrowly focused, and too short in their vision and execution. In retrospect, most such projects drew more resources out of the community than they put into it.

What poor communities of color do not need is another outside organization or charismatic rescuer conveying the message, "You have the problem, I/we have the solution" (Humphreys & Hamilton, 1995). A long history of colonization in the name of empowerment (and the inevitable aftermath of the experience of betrayal and mistrust) dictate efforts to build recovery support structures that assure sustained continuity of commitment and contact and a sustained partnership with indigenous community leaders—both community elders and vetted recovery carriers within ethnic communities (White & Sanders, 2008). Strategies to promote CIRSR must be designed to ensure that solutions come from within and remain in the control of these communities and their CIRSR (Humphreys & Hamilton, 1995).

## Summary

There has been a progressive increase in the participation of persons of color within 12-step mutual aid groups in the United States, and research to date suggests that affiliation, retention, and recovery rates of ethnic minority members within these groups is comparable to such rates for Whites. Rates of participation of persons of color within most secular recovery mutual aid societies remain quite low, while such rates of affiliation are currently unknown for explicitly religious recovery mutual aid societies. Significant progress is being made in understanding diverse secular, spiritual, and religious frameworks of recovery. The next frontier will be the greater understanding of how pathways and styles of addiction recovery differ across cultural contexts. There is some evidence that as minority representation increases within recovery mutual aid societies, culturally nuanced adaptations of core ideas and meeting rituals occur that enhance affiliation rates and benefits of participation.

There is an equally rich history of culturally indigenous recovery support resources (CIRSR) within communities of color, particularly within Native American and African American communities. CIRSR share many characteristics with culturally dominant recovery mutual aid organizations, but they differ in such areas as their conceptualization of the etiology of addiction,

a whole personal/family/community recovery perspective, an openness to transformational change as a primary medium of recovery initiation, and the inclusion of culturally salient catalytic metaphors and healing practices. Co-participation in CIRSR, mainstream recovery mutual aid groups, and professionally directed addiction treatment is common and warrants study to determine what particular service combinations and sequences create recovery outcomes for persons of color greater than experienced with any of these elements in isolation. CIRSR have historically risen spontaneously within communities of color, but CIRSR may also be increased strategically through carefully crafted social policies and programs. Such resources have increased within the City of Philadelphia as part of the city's recovery-focused transformation of its behavioral healthcare system. Several strategies were suggested for possible replication in other communities, but a caution was added on the critical importance of nesting these strategies within a long-term commitment to and partnership with local communities of color. Supporting the development and mobilization of culturally indigenous recovery support resources that are non-hierarchical, reciprocal, non-commercialized, and neighborhood- and family-based may be particularly important within communities whose historical experiences have engendered distrust of offers of help from culturally dominant social institutions.

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