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Brief Field Report

Addiction Recovery Communities as Indigenous Cultures: Implications for Professional and Scientific Collaborations

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This commentary conceptualizes recovery mutual aid organizations and other grassroots, non-professional recovery support institutions as indigenous cultures, identifies ethical issues that can arise in professional and scientific collaboration with such cultures, and provides a checklist that can guide professional and scientific collaborations with grassroots recovery support organizations.

KEYWORDS Experiential knowledge, indigenous intelligence, recovery communities, recovery mutual aid

Introduction

Addiction treatment as a specialized system of care has grown significantly in the United States over the past half-century. One of the more important contextual changes now influencing that system of care involves the expansion and diversification of non-clinical recovery supports available as an adjunct or alternative to addiction treatment (Valentine, 2011; White, 2009, 2010). Secular, spiritual, and religious recovery mutual aid groups have grown in size, have become more geographically accessible, and now extend to Internet-based recovery communities (White & Kurtz, 2006). New grassroots recovery community organizations have formed and linked themselves into an increasingly vibrant new recovery advocacy movement—new in terms of its constituencies, core ideas, and strategies (White, 2007). New recovery support institutions have emerged through this process that fall outside the traditional categories of professional treatment and recovery mutual aid groups. These new recovery institutions include recovery community centers, recovery homes, recovery schools, recovery industries, recovery ministries, recovery cafes, recovery-focused sporting activities, and recovery-themed activities in literature, art, music, film, and theatre (White, Kelly, & Roth, 2012).

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Interest is growing in the effects these recovery support alternatives can exert on long-term recovery outcomes (White, Humphreys, et al., 2012). As a result, addiction treatment and addiction research organizations are increasingly reaching out to collaborate with these new recovery support organizations (Achara-Abrahams, Evans, & King, 2011), and such collaborations are likely to increase under the growing influence of the Affordable Care Act (Buck, 2011). In our work with such groups in Philadelphia, Pennsylvania and throughout the country, we have become acutely aware of some of the difficult ethical and professional practice issues that are arising within the context of these collaborations (White et al., 2007).

Based on this experience, we contend that: 1) local communities of recovery are best viewed as indigenous cultures (indigenous understood here to mean rooted within and naturally arising from the community; natural support as opposed to professionalized support within a formal health care institution), 2) many forms of inadvertent harm in the name of help can flow from these professional-indigenous collaborations, 3) the ethical issues and ethical guidelines noted in the professional literature on the relationships between addiction professionals/researchers and historically disempowered ethnic communities can be applied to relationships with communities of recovery, and 4) professionals can use a process of self-inventory to help heighten their effectiveness, ethical sensitivities and ethical decision-making abilities within these collaborative relationships. The primary purpose of this article is to share the inventory checklist we have developed to guide our own collaborations in this area.

Inventory for Professional Collaborations with Indigenous Communities of Recovery

Table 1 illustrates the kinds of questions that can guide professional collaborations with indigenous communities of recovery. These are the kinds of questions that have arisen through our collaborations and through our consultations with other collaborative ventures—both in the service and research contexts. The table may be used as a self-assessment instrument, or questions can be used as a survey to be filled out by key persons representing particular collaborations.

Table 1: Inventory for Professional Collaborations with Indigenous Communities of Recovery

Rating Scale: 1=very weak; 2=weak; 3=adequate; 4=strong; 5=very strong; Circle the appropriate rating in response to each question.

Area of Collaboration	**Key Questions**	**Rating**
Conscientious Preparation	Did we adequately educate ourselves about indigenous recovery cultures in preparation for the collaborative project?	1 2 3 4 5
Mental & Emotional Stretching	Have we explored how the specific community with whom we are collaborating views the etiology of AOD problems within their community?	1 2 3 4 5
	Did we prepare ourselves for alternative ways to view the etiology of alcohol and other drug (AOD) problems and their solutions (e.g., historical trauma, colonization, cultural disintegration, economic marginalization; as an example, see	1 2 3 4 5

	Brave Heart, 2003; Brave Heart, Chase, Elkins, & Altschul, 2011; Brave Heart & DeBruyn, 1998; Coyhis & White, 2006)?	
Credibility	Have we established our value to indigenous recovery communities through vetting of our authenticity within these communities as well as through our professional credentials or organizational authority?	1 2 3 4 5
	Have we articulated both our personal and professional commitment to the issues?	1 2 3 4 5
	Have we focused on establishing credibility through building rapport, personal relationships, and trust (Achara-Abrahams et al., 2012)?	1 2 3 4 5
	Have we consistently demonstrated respect for indigenous elders for their wisdom and leadership?	1 2 3 4 5
First Do No Harm	Have we discussed ways in which past collaborations between professionals/scientists and indigenous cultures have caused harm and injury and how the risk of such injuries can be minimized (See White, 2009)?	1 2 3 4 5
	Have we asked the community about their concerns related to the current partnership and fully addressed these concerns?	1 2 3 4 5
Representation & Inclusion	Have members/leaders of indigenous communities of recovery been fully involved in the design, implementation, and evaluation of the collaborative effort—to include formulation of findings and recommendations?	1 2 3 4 5
	Has attention been given to overcoming barriers to participation, particularly among those community members who may have been under-represented in past projects/research (Green et al., 2007)?	1 2 3 4 5
Focus	Is the project/based on mutual benefits and the perceived need for change across all partners?	1 2 3 4 5
	Have we explored whether the project or research issue is supported by or of concern to members of the recovery community?	1 2 3 4 5
	Did the impetus for the project/research come from the recovery community? If not, has the community had an opportunity to refine the focus to reflect their interests and needs (Green et al., 2007)?	1 2 3 4 5
Authenticity of Representation	Were recovery community members involved in the selection of who would represent them within the collaboration? (Were we able to avoid problems of "double agentry"—persons representing hidden personal or institutional interests?)	1 2 3 4 5
	Does the representation of people from the recovery community reflect the diversity of views and lived experiences that are inherent in the community?	1 2 3 4 5
Humility & Respect	Have we consistently acknowledged in word and deed respect for experiential knowledge (concepts of indigenous science, indigenous intelligence, and indigenous healing rituals) of	1 2 3 4 5

	communities of recovery as a starting point rather than an adjunct to professional/scientific knowledge (See Borkman, 1976; Echo-Hawk, 2011; Lucero, 2011; Wharerätä Group, 2010)?	
Self-respect	Have we consistently refused to participate in any indigenous cultural practices that we felt posed harm to others or violated our own personal/professional beliefs?	1 2 3 4 5
Theory-building	Did we incorporate experiential knowledge of diverse recovery communities into our theory-building process? Are recovery community members actively involved with interpreting research data and verifying conclusions or lessons learned? Is there a mechanism in place to resolve in a transparent way any differences between the conclusions of the recovery community and those of the professionals? (Marshall & Batten, 2003).	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
Partnership	Has the authority and power of decision-making been equally shared within the collaborative relationship, e.g., a supportive versus directive relational style (see Echo-Hawk, 2011; Lamb, Evans, & White, 2009)? Are positions of leadership and authority shared with recovery community members?	1 2 3 4 5 1 2 3 4 5
Empowerment	Were opportunities for mentorship and leadership development included reciprocally within the collaborative process (See Achara-Abrahams et al., 2012)?	1 2 3 4 5
Understanding	Have we exhibited through word and deed our belief in the legitimacy of multiple pathways and styles of long-term recovery (See Sanders & Powell, 2012; White & Kurtz, 2006)?	1 2 3 4 5
Recovery Focus	Have we designed this project/study in a way that will help answer important questions that individuals, families, and communities have about recovery from addiction and related problems?	1 2 3 4 5
Stewardship	Did we establish an explicit agreement across the collaborative partnership that fairly allocated financial resources and other assets (professional and public recognition, co-authorship, etc.)? Is the indigenous community stronger today because of this collaboration?	1 2 3 4 5 1 2 3 4 5
Honesty & Fidelity	Have we been truthful in our collaborative communications (and did we avoid making promises or raising expectations that could not be met)?	1 2 3 4 5
Flexibility	Does the implementation process include a mechanism for collaboratively monitoring progress? Did we demonstrate flexibility in changing the methods and focus, as deemed necessary by the recovery community (Green et al., 2007)?	1 2 3 4 5 1 2 3 4 5
Amends	When mistakes of omission or commission have occurred within the collaboration, have we admitted such mistakes and made	1 2 3 4 5

	amends where possible?	
Loyalty	Have we maintained continuity of contact over time with those with whom we have collaborated (and avoided replicating patterns of exploitation and abandonment)?	1 2 3 4 5
Discretion	Have we respected the confidentiality and privacy of those with whom we are collaborating?	1 2 3 4 5
Consent	Have we engaged in ongoing communication and continued to ask for consent at every step of the project/research process to ensure that the community is still fully informed and engaged (Marshall & Batten, 2003)?	1 2 3 4 5
Hope	Have we conveyed information about this project/study in ways that will convey hope to individuals, families, and communities, e.g., emphasis on strengths, resiliencies, and solutions rather than focus on the intractability of problems (See White & Sanders, 2008)?	1 2 3 4 5
Advocacy	Have we taken what we have learned in this collaboration about recovery support needs and supported recovery community mobilization, promoted pro-recovery policies, and garnered resources to address these unmet needs?	1 2 3 4 5
Service via Transfer of Knowledge	Have we—both professional and indigenous partners—disseminated findings and lessons from this project in ways that will reach members of diverse communities of recovery and the larger pool of individuals concerned about the effects of alcohol and drugs on individuals, families, and communities?	1 2 3 4 5
Gratitude	Have we consistently expressed our gratitude for the collaborative relationship?	1 2 3 4 5
Self-interest	Have we protected ourselves and our organization from any harm that could result from this collaboration?	1 2 3 4 5
Measurement	Have we integrated culturally nuanced measures of change with professional/scientific approaches to evaluation? Have we measured changes in the family, neighborhood, and community environment as well as changes in individuals? Were data for this project collected in a culturally nuanced manner?	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5

Summary

Collaborations between the professional/scientific community and new recovery community institutions mark new territory laden with complex ethical and professional practice issues. This article presents an instrument that can be used for purposes of self-evaluation by organizations involved in such collaborations. Once such an inventory has been completed by the key participants in the collaboration, discussions can begin on how to sustain or improve performance in these key areas.

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