

White, W. and Sanders, M. (2004). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. Posted at www.bhrm.org

Recovery Management and People of Color: Redesigning Addiction Treatment for Historically Disempowered Communities

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Abstract

Communities of color have been ill-served by acute care models of treating severe alcohol and other drug (AOD) problems that define the source of these problems in idiopathic (biopsychological) terms and promote their resolution via crisis-elicited episodes of brief, individual interventions. This article explores how approaches that shift the model of intervention from acute care (AC) of individuals to sustained a sustained recovery management (RM) partnership with individuals, families and communities may be particularly viable for historically disempowered peoples. The advantages of the RM model for communities of color include: a broadened perspective on the etiological roots of AOD problems (including historical/cultural trauma); a focus on building vibrant cultures of recovery within which individual recoveries can be anchored and nourished; a proactive, hope-based approach to recovery engagement; the inclusion of indigenous healers and institutions with the RM team; an expanded menu of recovery support services; culturally-grounded catalytic metaphors and rituals; and a culturally-nuanced approach to research and evaluation.

Introduction

Addiction has been characterized as a “chronic, progressive disease” for more than 200 years (White, 2000a), but interventions into severe alcohol and other drug (AOD) problems continue to be based on serial episodes of self-encapsulated, acute intervention (O’Brien and McLellan, 1996; Kaplan, 1997). Recent research has confirmed the chronic nature of severe AOD problems (Simpson, Joe, & Lehman, 1986; Hser, Anglin, Grella, Longshore, & Pendergast, 1997) and compared such problems to other chronic health disorders (e.g., type 2 diabetes mellitus, hypertension and asthma) in terms of their etiological complexity, variability of course, and recovery and relapse rates (McLellan, Lewis, O’Brien, & Kleber, 2000). Calls for shifting addiction treatment from an acute care (AC) model to a model of sustained recovery management (RM) are increasing (White, Boyle, & Loveland, 2002, 2003; Compton, Glantz, & Delaney, 2003; Edwards, Davis, and Savva, 2003; Moore & Budney, 2003), and components of such models are currently being evaluated with adolescents (Godley, Godley,

Dennis, Funk, & Passetti, 2002) and adults (Dennis, Scott & Funk, 2003). The emerging model of recovery management has been defined as:

...the stewardship of personal, family and community resources to achieve the highest level of global health and functioning of individuals and families impacted by severe behavioral health disorders. It is a time-sustained, recovery-focused collaboration between service consumers and traditional and non-traditional service providers toward the goal of stabilizing, and then actively managing the ebb and flow of severe behavioral health disorders until full remission has been achieved or until recovery maintenance can be self-managed by the individual and his or her family (White, Boyle, Loveland and Corrigan, 2003).

This article contrasts the application of AC and RM models of intervention into severe AOD problems within communities of color.¹ We will focus specifically on those American Indian/Alaskan Native², African American, Hispanic/Latino and Asian and Pacific Islander communities whose members present unique obstacles and resources as they enter publicly funded treatment for severe AOD problems. Our contrast of AC and RM models is drawn from the pioneering work of McLellan, Lewis, O'Brien and Kleber (2000) and from the descriptions of the RM model set forth by White, Boyle and Loveland (2002, 2003). We argue that historically disempowered persons, and, in particular, communities of color, have been ill-served by acute, biomedical models of intervention into AOD problems, and that models of recovery management hold great promise in providing more effective solutions to AOD problems within communities of color. We will explore elements of RM that tap deep historical traditions within communities of color and that are highly congruent with contemporary, abstinence-based religious and cultural revitalization movements within communities of color.

Great care must be taken that discussions of the needs of ethnic communities do not inadvertently contribute to stereotypes about communities of color. To determine whether RM models of intervention hold greater promise than AC models within communities of color, we will need to explore those characteristics of communities of color that have relevance to the viability of these models. Given the enormous differences within and between ethnic communities and the changes in communities over time, we would ask readers to keep all observations, ideas and strategies set forth in this article on probation pending their validation within particular communities and with particular individuals and families. "People of color" and "communities of color" do not constitute a monolithic group to which any single explanatory or intervention model can be indiscriminately applied. We also recognize that the concepts set forth here may not be limited to communities of color and may also apply to particular white communities. Testing components of the RM model will need to be conducted in all ethnic communities and across multiple subpopulations within those

¹ While we have limited our discussion to communities of color, many reviewers (including Hennessey and Simonelli) of early drafts of this paper were struck by how applicable the ideas and strategies set forth in this paper are to women of all ethnic backgrounds.

² All future references to American Indians or Native Peoples are intended to include Alaskan Natives.

communities. To achieve this will require redesigning addiction treatment in light of new recovery management models and doing this within the larger framework of cultural competence.³ We hope this introductory paper will stand as an invitation for such sustained exploration. Our vision is the development of culturally competent models of recovery management within all communities and the dynamic evolution of RM principles and practices based on experience within and dialogue between communities.

We will begin by contrasting how AC and RM models conceptualize the sources and solutions to AOD problems and then explore the RM model's emphasis on proactive engagement, the use of indigenous healers and institutions, catalytic rituals and metaphors, new technologies of monitoring and recovery support, a sustained recovery management partnership, and the need for culturally-nuanced approaches to recovery research and evaluation.

AC and RM Models: The Source of AOD Problems

American Indians experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This phenomenon,...contributes to the current social pathology of high rates of suicide, homicide, domestic violence, child abuse, alcoholism and other social problems among American Indians. --Brave Heart and DeBruyn, 1998

When people are taught to hate themselves, they will do bad things to themselves. -- Sanders, 1993.

Acute care (AC) models of intervention have assumed that the sources and solutions to AOD problems reside within the individual, and that brief interventions to alter an individual's physical, cognitive and emotional vulnerabilities can produce a permanent resolution of these problems. When the AC model fails to resolve AOD problems, the root of that failure is viewed as residing inside the individual. The professional response, in practice if not in theory, is to prescribe additional repetitions of the failed intervention. Of people admitted to publicly funded addiction treatment in the U.S., 60% have been in treatment before (including 23% 1 time, 13% 2 times, 7% 3 times, 4% 4 times, and 13% 5 or more times) (OAS, 2000). An aggressive system of managed behavioral health care has lowered the intensity and duration of these treatment episodes, further lessening the viability of addiction treatment for persons within communities of color who present with high problem severity and chronicity. Awareness of this inadequacy has triggered the rise of indigenous recovery movements, including the Wellbriety Movement in Indian Country (see www.whitebison.org) and

³ Cultural competence has been defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations." Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Afrocentric frameworks of recovery, e.g., faith-based recovery ministries (Glide Memorial Church, One Church—One Addict, Free N’ One, African American Survivors Organization, Turning Point) (Sanders, 2002). Recovery within these movements is seen not as a singular goal but a therapeutic byproduct of participation in larger cultural and religious revitalization processes.

The premises of the RM model contrast sharply with those of the AC model. RM models posit that AOD problems spring from multiple, interacting etiologies; unfold (suddenly or progressively) in highly variable patterns; ebb (remission) and flow (relapse) in intensity over time; and are resolved at different levels (from full to partial) via multiple long-term pathways of recovery. This opening proposition has particular relevance to communities of color. It suggests that people of color may be at risk for AOD problems but that these risk factors differ between and within ethnic groups (Matsuyoshi, 2001). It suggests that historical, political, economic, and socio-cultural circumstances can also serve as etiological agents in the rise of AOD problems. Client discussions about cultural pain (e.g., slavery, the loss of land, attempted extermination, epidemic diseases, the purposeful break-up of tribes and families, the loss of families and culture via immigration or forced deportation, forced internment as prisoners of war, other forms of physical sequestration, immigration distress, acculturation pressure, racism and discrimination) are viewed, not as defocusing or acting out, but as a medium of a consciousness raising and catharsis that can open doorways to personal and community healing and transformation (Green, 1995). This approach is much more congruent with beliefs within communities of color that their AOD problems result as much from historical trauma⁴, economic and political disempowerment, and cultural demoralization as from biological vulnerability (Manson, 1996; Brave Heart & DeBruyn, 1998; Brave Heart, 2003). This view recognizes that historical trauma and cultural oppression elevate risk factors for substance use problems and erode resiliency factors that operate as a protective shield against AOD problems and speed their natural resolution (Brave Heart, 2003). Culturally-nuanced models of RM reflect an understanding of the effects of intergenerational trauma (grief, rage, self-hatred, self-medication) upon whole communities. Positing multiple pathways of long-term recovery also opens up the potential for culturally prescribed frameworks of AOD problem resolution (abstinence-based religious and cultural revitalization movements, e.g., Nation of Islam) as well as cultural adaptations of existing recovery support structures (e.g., the “Indianization” of Alcoholics Anonymous and the adaptation of A.A. within Hispanic/Latino communities) (Womak, 1996; Hoffman, 1994).

RM models assume that severe AOD problems constitute complex, chronic disorders that require sustained individual, family, community and cultural interventions for their long-term resolution. In this view, treating severe and persistent AOD problems via AC models of intervention is as ineffective as treating a bacterial infection with half the effective dose of antibiotics. While providing temporary symptom suppression, such treatment results in the subsequent return of the problem, often in a more virulent and treatment-resistant form. In the RM model, the treatment of severe and persistent AOD problems is best done within a

⁴ Maria Yellow Horse Brave Heart (2003) has defined historical trauma as “cumulative emotional and psychological wounding over the lifespan and generations, emanating from massive group trauma experiences.”

sustained recovery management partnership that provides on-going recovery support and consultation and anchors the recovery process in indigenous supports within the client's natural environment.

Chronic disorders such as diabetes and heart disease take an undue toll on communities of color, but substantial efforts are underway within communities of color for the prevention, early intervention, and sustained management of such chronic health problems. People of color are learning that the successful management of these disorders requires an understanding of:

- personal/family vulnerability
- the influence of environmental conditions on the ebb and flow of these disorders
- the propensity for these disorders to generate collateral health and family problems, and
- the role of daily lifestyle decisions (eating, sleeping, exercise, etc), and the need for sustained self-vigilance, in the management of these disorders.

As communities of color learn more about the nature and treatment of chronic primary health disorders, that knowledge base can be extended to severe AOD problems. There is already some recognition of addiction as a chronic disorder via people of color sustaining hope for a family member or friend's recovery, long after the rest of the world has lost such hope. That capacity for patience, compassion and forgiveness is not a sign of pathology (codependency), but an unheralded resource of hope and support within communities of color that the RM model seeks to build upon.

The acute model rests on the assumption that AOD problems are self-contained and that individuals have the internal and external resources to sustain recovery and assume full social functioning following detoxification and brief treatment. It assumes a foundation of pre-morbid skills and social functioning. This rehabilitation model promises the client that he or she will regain prior levels of functioning and status lost via the accelerating severity of AOD problems. This model is poorly suited for individuals who have not achieved such prior levels of successful functioning and who have no significant support for recovery within their family and social networks. The model is particularly unsuited for those poor communities of color whose members present with high AOD problem severity, numerous co-occurring problems, and low "recovery capital" (internal and external resources that help to initiate and maintain recovery) (Granfield and Cloud, 1999).

In contrast, the RM model assumes that clients have widely varying degrees of problem severity and recovery capital and that the degree and duration of need for recovery support services requires differential allocation of services across these levels of functioning. Where levels of care within traditional treatment are dictated primarily by problem severity, RM models set service intensities and duration based on the unique interaction of problem severity and recovery capital. For example, the African American business executive with high AOD problem severity but high recovery capital would be viewed as needing less intensive and sustained recovery support than an African American adolescent with low AOD problem severity but with many co-occurring problems and low recovery capital. For those with little

recovery capital, RM provides a framework for sustained habilitation.⁵ The RM shift in emphasis is from recovery initiation to recovery maintenance (the movement toward global physical and emotional health, a reconstruction of personal identity and interpersonal relationships, and the development of a recovery-based, pro-social lifestyle). This habilitation emphasis is one of the driving forces behind the expanded menu of recovery support services (described below). This same habilitation emphasis is also extended to the families and communities within which AOD problems are enmeshed.

The RM Solution: Personal, Family and Community Renewal

Ultimately, it is the community that cures....To cure the wounded, one need only return them to their community or construct a new one.
--Philip Rieff, 1987

Community healing along with individual and family healing are necessary to thoroughly address historical unresolved grief and its present manifestations. --Brave Heart and DeBruyn, 1998

The unit of service within the AC model is the individual with an AOD problem. Professional interventions are designed to lower the biological vulnerability and alter the beliefs and behaviors thought to sustain addiction. Within the RM model, individuals with AOD problems are viewed as being nested within a complex web of family, social and cultural relationships. Each level of this social ecosystem can contribute to the development of, help resolve, or sabotage the solution of these problems. As a result, it is the whole ecosystem rather than the individual that is the target of the RM intervention. RM moves beyond the clinical skills of assessment, diagnosis and treatment of individuals to encompass the skills of family reconstruction, community resources development, and nation-building (see the work of White Bison for examples of the latter).⁶ RM in communities of color is premised on the belief that the community—experienced through group solidarity with a historical and geographical community--is an essential dimension of personal healing (Murphy, Personal Communication).

In the AC model, the family is a stimulus for help-seeking, a source of emotional and financial support for treatment retention, and a target for brief education and referral to peer-support (e.g., Al-Anon). The assumption is that whatever wounds the family suffered through the addiction experience will naturally and quickly reverse themselves following the addicted family member's recovery initiation. In contrast, the RM model assumes that:

⁵ Rehabilitation assumes the existence of and need for replenishment of recovery capital; habilitation assumes the lack of pre-existing recovery capital and the need to dramatically reconstruct personal identity, interpersonal relationships and a sobriety-based lifestyle.

⁶ Nation-building as used here refers to the process of linking disempowered community into a larger consciousness and identity and a process of healing that seeks to heal historically disempowered communities AND the dominant culture of which they are such integral parts. One of our reviewers (Simonelli) called this "the next frontier of healing."

- Addiction is but one wound families of color have suffered via the intergenerational transmission of historical trauma (e.g., the forced breakup of family units in slavery, the Indian boarding schools and their prolonged aftermath, traumatic separation via immigration) and that the family unit itself needs a sustained process of recovery from these wounds (Brave Heart and DeBruyn, 1998).
- The addiction-related transformation of family roles, relationships, rules and rituals are deeply imbedded within family members, and habitual patterns of family interaction and will not spontaneously remit with recovery initiation.
- There are developmental stages of family recovery that entail personal healing, a realignment of family subsystems (adult intimate relationship, parent-child relationships, and sibling relationships), and the families relationship with the outside environment—tasks that consume the first 3-5 years of stable recovery (See Brown, 1994; Brown and Lewis, 2002).
- Families who do not have sufficient supports to make these difficult transitions are at high risk for disintegration—in spite of their having remained intact through years of addiction (Brown and Lewis, 2002).
- Sustained recovery monitoring and support for family members is as crucial as it is for the individual recovering from severe AOD problems.
- RM services for families need to be refined based on the unique family and kinship patterns that exist within particular ethnic communities.

A major focus of RM is to create the physical, psychological and social space within local communities in which recovery can flourish. The ultimate goal is not to create larger treatment organizations, but to expand each community's natural recovery support resources. The RM focus on the community and the relationship between the individual and the community are illustrated by such activities as:

- initiating or expanding local community recovery resources, e.g., working with AA/NA Intergroup and service structures (Hospital and Institution Committees) to expand meetings and other service activities; African American churches “adopting” recovering inmates returning from prison and creating community outreach teams
- educating contemporary recovery support communities about the history of such structures within their own cultures, e.g., Native American recovery “Circles,” the Danshukai in Japan
- introducing individuals and families to local communities of recovery
- resolving environmental obstacles to recovery
- conducting recovery-focused family and community education
- advocating pro-recovery social policies local, state and national levels
- seeding local communities with visible recovery role models

- recognizing and utilizing cultural frameworks of recovery, e.g., the Southeast Asian community in Chicago training and utilizing monks to provide post-treatment recovery support services, and
- advocating for recovery community representation within AOD-related policy and planning venues.

The importance of community in understanding AOD problems within communities of color is perhaps most evident within the rising Wellbriety movement in Indian Country. A central idea within this movement is the “Healing Forest” metaphor developed by Don Coyhis (1999). In Coyhis’ work, the AC model of treatment is analogous to removing a sick tree from diseased soil, nursing it back to health in well-fertilized and well-watered soil and then returning it to the diseased soil from which it came. Coyhis suggests that we would need fewer tree hospitals if we treated the trees AND the soil in which the trees suffer or thrive. He calls for the creation of a “healing forest” to nurture sobriety and wellness. This broader vision of creating healthy communities that resist AOD problems and within which recovery can thrive is pervasive in communities of color but is markedly absent within the professional field of addiction treatment.

In communities of color, the individual, the family and the community are inseparable. To wound one is to wound the other; to heal one is to heal all (Red Road to Wellbriety, 2002). When interviewed about how the Shuswap tribe in Alkali Lake, British Columbia successfully reduced its alcoholism rate from nearly 100% to less than 5%, Chief Andy Chelsea declared simply, “the community is the treatment center” (quoted in Abbot, 1998; See also Chelsea and Chelsea, 1985 and Taylor, 1987). Frameworks of recovery within communities of color have always been, and continue to be, framed in terms of an inextricable link between hope for the individual and hope for a community and a people. The most effective and enduring solutions to AOD problems among people of color are ones that emerge from within the very heart of communities of color. The RM model seeks to tap this vein of resistance and resilience by recognizing and enhancing the recovery support capacities of families, kinship networks, indigenous institutions (e.g., mutual aid groups, churches, clans) and whole communities and tribes. The focus of RM interventions is not restricted to the individual, the family or the community but is focused on all levels of this recovery ecosystem and their inter-relationships.

Proactive Engagement

My clients don’t hit bottom; they live on the bottom. If we wait for them to hit bottom, they will die. The obstacle to their engagement in treatment is not an absence of pain; it is an absence of hope. —Outreach Worker (Quoted in White, Woll, & Webber, 2003)

The AC model of intervention is essentially crisis-oriented. It relies on internal pain or external coercion to bring individuals to treatment, and places the responsibility for motivation for change squarely and solely on the individual. It assumes that people move from addiction to recovery when the pain of the former state reaches a point of critical mass. The AC model is

also characterized by a high threshold of engagement (extensive admission criteria and procedures), high rates of client disengagement (terminating services against staff advice) and high rates of client extrusion (“administrative discharge” for non-compliance). In contrast, the RM model is characterized by assertive models of community outreach, pre-treatment recovery support services, and the resolution of personal and environmental obstacles to recovery. Motivation for recovery is not assumed to be static—a dichotomous (you have it or you don’t) entity, but one that emerges out of and is sustained by an empowering service relationship. It is assumed that such motivation waxes and wanes and that active recovery coaching can help the client transcend periods of heightened ambivalence, diminished confidence and recovery-induced anxiety. One of the earliest examples of such proactive outreach was the work of the East Harlem Protestant Parish among New York City’s Puerto Rican heroin addicts in the 1950s. This faith-based program recruited addicts from the streets and enmeshed them within pro-recovery social clubs and a larger religious community within which they were welcomed and respected (White, 1998).

The proactive engagement of the RM model is particularly suited for individuals whose personal/cultural experiences have engendered an exceptionally high physical and emotional tolerance for pain and for those who have never known anyone in recovery. Proactive engagement is also important for people of color who:

- lack the knowledge, skills and financial resources required to navigate complex health and human service systems;
- fear bringing shame to their families (losing “face”) by breaking prohibitions on disclosing personal problems outside the family or kinship network--shame dramatically enhanced for women,
- have had negative experiences within or distrust formal service systems,
- bring special obstacles to accessing services (e.g., language barriers, illegal status), and
- who possess beliefs about illness and health that conflict with the explanatory metaphors of mainstream service systems.

The RM model of engagement is particularly well suited for people of color whose resistance to treatment flows from the inertia of hopelessness. Where AC models are most effective with individuals ready to take action related to their problems, RM models place great emphasis on the pre-action stages of change and the long-term maintenance stages of change (See Prochaska, DiClemente, & Norcross, 1992 and Prochaska, Norcross and DiClemente, 1994 for a description of the stages of change).⁷ The model assumes that the scales of long-term recovery are tipped not by the sobriety decision (alcoholics/addicts make many such decisions), but by the interaction of what precedes and follows such decisions.

Of all the obstacles that proactive engagement is designed to address, perhaps the most difficult in both AC and RM models is the issue of language. Key informants from many

⁷ Research on developmental stages of change is in its infancy and the emerging models tend to portray recovery for individuals and families in very linear terms. We suspect, and thank Tom Murphy for reminding us, that these processes are much more dynamic than what is conveyed in a linear, four-five step model. Recovery, particularly for historically disempowered people, may be much more comparable to the subtle patterns and surprise-revealing pathways of a Japanese garden than that of a ladder.

ethnic communities emphasized the need for more bilingual professionals and service volunteers. This language barrier will need to be overcome if RM models are to fulfill their potential within ethnic communities. The outreach and assertive continuing care functions, in particular, will require a high level of cultural and linguistic fluency. The RM emphasis on building service capacity within communities offers some hope for expanding such competence.

While this assertive model of engaging and supporting individuals through the stages of recovery is well-suited to the obstacles and complex needs presented by many people of color, great care will need to be taken with this aspect of the RM model. The values of benevolence, generosity and service co-exist with the value of noninterference in the affairs of others within communities of color. The implementation of RM models in communities of color will require considerable care to avoid violating this latter value. The key will be to use RM's assertive approach to engagement and post-treatment monitoring and support, but to do so only with the continuing consent of the community, family and individual client.

Another dimension of the RM model (emerging from its view of multiple pathways of recovery) is its respect for the power and legitimacy of transformative change as a medium of recovery initiation (Miller and C'de Baca, 2001)⁸. Non-ordinary experiences (e.g., dreams, visions, climactic conversions) have long marked a pathway of addiction recovery for people of color, particularly among those who have led religious and cultural revitalization movements (e.g., Handsome Lake, Malcolm X). In contrast to the conversion style of induction, recovery may also be marked by a reaffirmation and deepening of existing religious/spiritual beliefs and practices, as Morjaria and Orford (2002) found in their study of South Asian American men (see also Manik, et al, 1997). Where traditional AC models of treatment tend to discount the power and durability of religious experiences and the role of religious institutions as viable sobriety-based support structures, the RM model celebrates the legitimacy of these experiences and support institutions. It is clear that sustained sobriety can be a byproduct of religious and cultural affiliation and a heightened ethnic identity, whether this occurs within the Nation of Islam, the Indian Shaker Church or a Buddhist or Hindu Temple. Such recoveries involve not just a redefinition of personal identity, but a redefinition of oneself as an *Indian, African American, Latino* or *Asian* person. For example, Spicer's studies of recovery in Native American communities found that recovery initiation was associated with heightened Indian identity and the incompatibility between drinking and emerging beliefs about how Indian people should conduct their lives (Spicer, 2001). This recognition of the power of culturally mediated transformative change provides a foundation of respect upon which RM-based organizations can collaborate with religious and cultural revitalization movements within communities of color.

Indigenous Healers/Institutions and the Recovery Management Team

⁸ Miller and C'de Baca describe transformative change as dramatic alterations of personal identity and character that are "vivid, surprising, benevolent and enduring." (p.4).

Many individuals maintain sobriety only after they resume or begin regular involvement in traditional spiritual practices. --Brave Heart and DeBruyn, 1998

The persistence and revival of indigenous Amerindian healing is due not to a lack of modern treatment services, but to a need for culture-congenial and holistic therapeutic approaches. –Jilek, 1978

The AC service approach is based on the recognition of AOD problems as a biopsychosocial disorder. As a result, AC treatment interventions are delivered by an interdisciplinary team of physicians, nurses, psychologists, social workers, and addiction counselors. In contrast, the RM model recognizes other dimensions of AOD problems (e.g., economic, political, cultural, spiritual, religious) and broadens the recovery management team to include indigenous community institutions and healers. People of color utilize cultural healing therapies as alternatives or adjuncts to mainstream medicine and psychiatry, with the majority not reporting visits to alternative practitioners to their mainstream service providers (Keegan, 1996). Studies of the course of alcohol problems among American Indians have found remission/recovery rates as high as 60%, with few such recoveries attributable to formal alcoholism treatment (See Spicer, 2001 for a review). American Indians have a long history of abstinence-based religious and cultural revitalization movements, indigenous healers as mediums of alcoholism recovery, and the use of Native medicines and ceremonies as adjunctive supports for recovery (White, 2000b; Coyhis and White, 2002). Growing awareness of this history has spurred calls for culture-congenial therapeutic approaches via an integration of Western treatment methods and traditional Native American healing practices (Jilek, 1974, Weibel-Orlando, 1987, and Westermeyer, 1996). There is similar evidence for indigenous recovery frameworks in the Hispanic/Latino (Thomas, 1967; Singer and Borrero, 1984; Núñez Molina, 2001), Asian (Das, 1987; Yamashiro, & Matsuoka, 1997) and African-American communities (Leong, Wagner, & Tata, 1995). These indigenous recovery frameworks place great emphasis on the healing power of *regalos*—cultural values and ceremonies. Where traditional treatment programs question the viability and durability of these cultural and religious pathways of recovery (in practice if not in theory), the RM model is open to the inclusion of such institutions and their representatives within the recovery management team. In the RM model, the medicine man/woman, cacique (Indian healer), curandero (Mexican folk healer), Espiritista (Puerto Rican spirit healer), minister, priest, shaman, monk, and herbalist may each play a role within the RM team.

A recent evaluation of gender-specific addiction treatment programs in Illinois found that a significant number of recovering and recovered⁹ African American women are using the Black Church as their primary sobriety-based support structure, but most do so only months after initiating recovery and addressing issues of shame related to their addiction (White, Woll & Webber, 2003).¹⁰ Similar documentation exists on the use of religious frameworks of addiction recovery in other communities of color (Núñez Molina, 2001; Coyhis and White,

⁹ See White, 2002 for a discussion of the distinction between *recovered* and *recovering*.

¹⁰ The source of that shame transcends self-perceived sins of omission and commission and reaches to the very core of their identities as women and as African American women.

forthcoming). This raises an interesting point about the differences between how individuals initiate recovery versus how they sustain that recovery over time. More specifically, it suggests that some clients of color may use one institution to initiate recovery (e.g., professionally-directed treatment, Alcoholics Anonymous or Narcotics Anonymous), but use culturally indigenous institutions to sustain recovery (e.g., the Black Church). Failure to sustain recovery could thus be viewed not as a need for more recovery initiation services (the AC treatment model), but a need to find a cultural pathway of long-term recovery maintenance (the RM model).

The RM model assembles professional and indigenous service teams to meet the unique recovery support needs of each client and family. The rationales for the use of such non-traditional teams are to expand the recovery support services available to individual clients and to decrease the number of people needing professional services by expanding natural recovery supports within the larger community. The inclusion of indigenous healers and recovery support institutions rests on a simple assumption: the natural community is an oasis of human and spiritual resources that can be tapped to resolve personal and family problems (McKnight, 1995). In the RM model, the centerpiece of recovery is not the treatment institution, but the client and his or her relationship to this larger community.

The inclusion of non-traditional roles within the RM service team raises the question of credibility and credentialing of service providers within communities of color. Credibility bestowed from the dominant culture has value within communities of color only when the individual with such credentials is further vetted inside the community. This is typified by the concepts of *respeto*, *personalismo*, and *dignidad*, and *confianza* within Hispanic/Latino communities--concepts that dictate respect based on personhood rather than financial or occupational status (Soriana, 1995). Credibility in communities of color is more likely to be bestowed upon those with nonjudgmental attitudes, knowledge of the culture and demonstrated resourcefulness and effectiveness (Sue & Sue, 1999).

Credibility as a healer inside communities of color requires two things: *experiential knowledge* and *experiential expertise* (Borkman, 1976). Experiential knowledge requires wisdom gained about a problem from close up—first-hand versus second-hand knowledge. Experiential knowledge comes from having experienced, lived with, or done battle with addiction and from having participated in one's own or other's recovery. This does not explicitly require that all volunteer or paid support staff be recovered or recovering, but it does require that they have learned about addiction and recovery from close proximity. Experiential expertise requires the ability to use this knowledge to affect change in self or others. This latter credential—granted through the community “wire” or “grapevine” (community story-telling) bestows credibility that no university can grant. It is bestowed only on those who offer sustained living proof of their expertise as a recovery guide within the life of the community. Such persons may be professionally trained, but their authority comes not from their preparation but from their character, relationships and performance within the community. RM models capitalize on such experiential expertise by recruiting indigenous healers as legitimate members of recovery management teams, e.g., outreach workers, recovery coaches, and culturally-grounded therapists/nurses/physicians.

RM also turns those seeking help into sources of support for others via their involvement in mutual support groups, peer-based service models and recovery advocacy organizations. Within communities of color, there is a long history of the concept of “wounded healer” (the idea that surviving a life-threatening illness or experience bestows knowledge and an obligation to help others facing this illness or experience), and a tradition of helpers credentialed by “calling” (White, 2000b). By transforming the process of recovery from an interaction between a professional and a patient to reciprocal support among members of a community of recovering and recovered people, RM taps this wounded healer tradition and utilizes what has been christened the “helper-therapy principle” (the therapeutic effects of helping others)(Reissman, 1990, 1965). Converting service recipients into service dispensers exponentially expands indigenous recovery resources within communities of color. Reaching out to the suffering alcoholic/addict has been espoused by leaders of American recovery communities, from the Washingtonian mantra, “You’ve been saved, now save another” (White, 1998) to what Malcolm X referred to as “fishing for the dead” (Myers, 1993, p. 82). With its emphasis on transforming people who have been part of the problem into part of the solution, RM creates a cadre of people whose living example and recovery advocacy activities can help neutralize the particularly intense stigma that has long been attached to addiction in communities of color.

People of Color and the Criminal Justice and Child Welfare Systems

People of color, particularly African Americans, are over-represented within America’s criminal justice and child welfare systems. Constituting only 12.1% of the U.S. population (U.S. Census Bureau, 2000) and 15% of illicit drug consumers (SAMHSA, 1998), African Americans constitute 56.7% of those currently in state prison on drug offenses (Harrison & Beck, 2003). Studies have also shown that race plays an important role in involvement in child protection services. Although rates of drug use during pregnancy are nearly identical for African American and White women, African American women are ten times more likely to be reported to child protection authorities for prenatal drug exposure (Neuspiel, 1996; Chasnoff, Landress, and Barret, 1990). Any intervention into alcohol and other drug problems in communities of color must recognize the dominant role of the criminal justice and child welfare systems as treatment referral sources.

The AC model of intervention is strongly linked to these systems and that is itself a problem. People of color with high problem severity and complexity (e.g., multiple problems) continue to be routinely placed in brief interventions that have little chance of success and then are punished (via incarceration or loss of custody of children) when those failed outcomes occur on the grounds that “they had their chance.” The financially motivated collaboration of the treatment system in this process is altering the perception of treatment institutions from institutions of service and care to institutions of coercion and control. Masked behind euphemisms such as “treatment works” is the story of how addiction treatment programs have become an extension of the criminal justice and child protection systems within communities of color. We would argue that it is not enough to deflect people of color into treatment as an alternative to incarceration or family disintegration. The treatment received must be designed

in such a way as to offer a realistic chance of success. Punishing people with high problem severity for failing to achieve sustained abstinence following treatment within an AC model is part of a long history of “blaming the victim” within communities of color.

It remains to be seen whether RM models will offer a more viable option for people of color involved in the criminal justice and child welfare systems, but RM models do have several characteristics that make success more likely. First the longer duration of service contact in the RM model is more realistic and constitutes more of a real “chance” than treatment based on the AC model. The RM emphasis on engagement and sustained monitoring and support is very congruent with such criminal justice initiatives as intensive probation, drug courts and sentences circles. It is also congruent with the gender-specific addiction treatment models emerging within the child welfare system (White, Woll, and Webber, 2003). What RM may contribute is the birth of collaborative models that combine the surveillance functions of the criminal justice and child protection systems with sustained mechanism of recovery support and early re-intervention. Such models could span a continuum of intervention points from diversion programs to community re-entry from prison. More effective systems of intervention and support could decrease the number of people entering, and widen the doorways of exit from, the criminal justice and child protection systems. RM models could be built on the peer-based engagement and support models that have been used to reach addicted people of color within the CJ system, e.g., the Nation of Islam, Winner’s Circle.

Expanded Menu of Services and Catalytic Metaphors

Metaphors are culturally-grounded figures of speech that in their subtlety, complexity and power strike deep emotional cords that ignite processes of personal transformation. --White and Chaney, 1993

...transformations of the self and its relationship to core symbols in a particular cultural system of meaning appear to lie at the heart of how people are restored to wholeness following their problematic involvements with alcohol. --Spicer, 2001

The AC model of addiction treatment is based on the development of “programs” (a prescribed combination and sequence of therapeutic activities) that clients experience with minimal variation. Program activities and protocol focus on detoxification, problem stabilization and recovery initiation. RM models, by placing equal or greater emphasis on pre-treatment engagement and post-treatment recovery maintenance, expand the service menu considerably and, in the process, redefine the very identity of treatment institutions.

The RM service menu is based on three premises:

- 1) People with AOD problems represent multiple clinical subpopulations with diverse needs: the effectiveness of treatment and support services varies considerably across clinical subpopulations and individuals within these subgroups.

- 2) There are developmental stages of long-term recovery: the same individual may need different treatment and support services at different stages of his or her addiction and recovery careers.
- 3) There are qualitative differences between AOD problems and the processes used in their resolution within communities of color.

RM replaces the treatment “program” with a large menu of service and support activities that are uniquely combined and supplemented to meet the stage-dependent needs of people in recovery. In this model, the service menu is constructed using frameworks of healing drawn first from the client’s own cultural background, e.g., the use of specialized therapies such as the Japanese psychotherapeutic approach known as *Naikan* where the patient is sequestered for self-reflection on his or her character and relationships under the guidance of periodic visits from the therapist (*sinsei*) (Das, 1987). RM seeks to initiate and sustain recovery within the framework of cultural values using methods that markedly differ from client to client (See Flores, 1985-86). The shift toward a multicultural menu of values and service activities requires a high degree of individualization and a more sophisticated, comprehensive knowledge of the personal, intracultural and transcultural processes of long-term recovery.

RM proponents are also interested in the kinds of words, ideas, metaphors, and rituals that initiate and strengthen recovery, mark the shift from one stage of recovery to the next, and sustain recovery over a prolonged period of time. This interest is congruent with the belief in the power of words (speeches, sermons and stories) and healing ceremonies within communities of color. The following assumptions describe the potential role of words, ideas, metaphors and rituals in the addiction recovery process.

- 1) Words, ideas, metaphors and rituals can exert an enslaving or liberating effect on one’s relationships with alcohol and other drugs (White and Chaney, 1993; White, 1996).
- 2) Words, ideas, metaphors and rituals that serve as a catalyst for change in one person or cultural group may have no such power with other persons or cultural groups. There are specific ethnic/cultural worldviews and the elements of these worldviews constitute the raw materials from which pathways of resilience to and recovery for AOD problems must be constructed (Taylor, 1992).
- 3) Catalytic metaphors¹¹ evolve and recycle within cultures over time. Their use as agents of transformation rests on their contemporary power; they must resonate within the present cultural and personal experience of the individual seeking recovery.
- 4) The growing phenomenon of biculturalism suggests that individuals may be able to combine or sequence metaphors from two or more cultures to initiate recovery or shift from one stage of recovery to the next.
- 5) Addiction treatment programs serving heterogeneous populations must provide a diverse menu of organizing words, ideas, metaphors and rituals to widen the

¹¹ Catalytic metaphors are concepts that spark breakthroughs in perception of self and the world at such a profound level that they incite change in beliefs, behavior, identity and relationships.

doorways of entry into recovery and support culturally-mediated stages of long-term recovery (White, 1996).

The following observations reflect the ways in which words, ideas, metaphors and rituals have been used by historically disempowered peoples to initiate and sustain recovery from addiction.

- 1) During the peak period of contact and colonization, people of color are prohibited from drinking or provided only controlled opportunities for drinking (e.g., Slave Code prohibitions on drinking, Federal prohibition of the sale of alcohol to American Indians) and are targeted via drug prohibition laws (e.g., anti-opium ordinances aimed at Chinese immigrants, anti-cocaine laws aimed at African Americans, anti-peyote laws aimed at American Indians, and anti-marihuana laws aimed at Mexican immigrants) (See Musto, 1973; Helmer, 1975; Morgan, 1983).
- 2) Patterns of psychoactive drug use and their effects upon people of color are exaggerated or fabricated as part of a racial mythology that justifies colonization and cultural domination (e.g., Native American “firewater myths”) (Coyhis & White, forthcoming; Morgan, 1983)
- 3) People of color, in their early struggles for liberation, use the consumption of alcohol and other drugs to cope with feelings of hopeless and to deal with historical trauma.
- 4) Political and religious leaders within communities of color subsequently link AOD use to historical oppression, portray alcohol and other drugs as weapons of continued colonization and domination of their communities (Tabor, 1970; Herd, 1985), and portray sobriety as an act of resistance and liberation (Douglas, 1855; Cheagle, 1969).
- 5) Recovery mutual aid movements arising out of historically disempowered people emphasize metaphors of resistance, emancipation, and power, e.g., “I have a problem that once had me” (Kirkpatrick, 1986), “I will take control of my life” (Williams and Laird, 1992).
- 6) Heightened consciousness of racial history and identity can be a pathway of entry into recovery, or it can be part of a process of discovery in the later stages of recovery (Green, 1995).

By recognizing multiple pathways and styles of long-term recovery, the RM model embraces and works within these alternative frameworks of recovery. It views tenets of belief about AOD problems and their resolution within their historical context and in terms of their utility for initiating or anchoring recovery. This requires considerable knowledge of indigenous cultures and fluency with prevailing cultural or religious metaphors that can incite or strengthen the process of addiction recovery. The viability of a particular metaphor for understanding AOD problems and how they can be resolved varies widely between cultures and varies widely across individuals (e.g. by degree of acculturation). The question is not: Which explanatory metaphor is true? The question is: Which organizing metaphor, by

explaining things that are otherwise inexplicable, serves as a catalyst for personal, family and community healing. There are many people of color who have found recovery through mainstream treatment and recovery support organizations (e.g., AA/NA), but there are also many people of color who have recovered from addictions who do not portray themselves as having suffered from the *disease of alcoholism/addiction* nor portray themselves today as *alcoholics* or *addicts in recovery*. They have found alternative rationales for sobriety and different metaphors to explain who they once were and who they are today (see Spicer, 2001).

There is no dominant organizing metaphor for recovery within the RM model. With its operational motto, “recovery by any means necessary,” the RM model is broad enough to embrace clients who talk about their addictions in terms of:

- disease and recovery
- habit and choice
- badness (crime) and reformation
- sin (idolatry, demon-possessed) and redemption (God-touched)
- cursed (for breaking cultural taboos) and healed
- excess and harmony (balance)
- shame and honor (face)
- genocide and personal/cultural survival, or
- messed up and worn out (“sick and tired of being sick and tired”).

The goal of RM is not to impose an organizing metaphor for recovery, but to work within whatever metaphors individuals and families find most personally and culturally meaningful.

The same broad perspective applies to transformative rituals. Where the dominant AC models of intervention into AOD problems rely on rituals of getting into oneself (e.g., psychotherapy), RM models are open to other cultural frameworks of recovery that involve a process of getting out of oneself and relying on resources and relationships beyond the self. Where the former view recovery as a process of self-exploration; the latter recognize the potential of recovery initiation via processes of self-transcendence—a value much more congruent with the spiritual-focused and community-focused ethos of communities of color.

Sustained Monitoring and Support

Chronic diseases require chronic cures. --Kain, 1828

If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients. --McLellan, 2002

Communities of color have become distrustful of promised quick fixes because so many of those promises have been betrayed. Professionals come and go; programs come and go; agencies come and go. Arguments over whether addiction treatment should consist of five sessions or 25 sessions, five days or 30 days, cognitive or family therapy are all arguments inside the acute care model of admission, treatment, and discharge. The inherent brevity of acute interventions into complex, chronic problems is often experienced as superficial pacification, professional disinterest and abandonment. People of color, who tend to enter

addiction treatment at later stages of problem severity and a greater number of co-occurring problems (Bell, 2002), are ill-served by service models whose low intensity and short duration offer little opportunity for success. At a practical level, the acute model provides few options: regular readmission for detoxification and respite, demoralization and a cessation of treatment-seeking, or a search for recovery maintenance outside the realm of professionally-directed treatment.

Communities of color need stable recovery support institutions that can move beyond brief experiments in recovery initiation toward prolonged recovery maintenance. It is this very need that has contributed to the dramatic growth of AA, NA and recovery-focused ministries in communities of color. For those who need sustained professional support, RM provides a culturally viable model of addiction treatment that replaces crisis intervention with a much longer, but lower-intensity, continuum of pre-treatment, in-treatment, and post-treatment recovery support services.

A Recovery Management Partnership

Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work. --Albert Schweitzer, From Reverence for Life, 1993

The service relationship within acute care approaches to addiction treatment is based on an “expert” model of problem intervention. In this model, the service professional is assumed to have considerable knowledge, resources and power while the service recipient is assumed to suffer from one or more problems that he or she does not understand and cannot resolve. The role of the expert is to diagnose the problem, treat the problem and briefly educate the client regarding his or her continued self-care responsibilities related to the problem. Failure to resolve the problem is usually attributed to the lack of “patient compliance” with the expert’s recommendations. The service relationship within the AC model of intervention, whether in the form of an emergency room visit for a broken bone or brief addiction treatment, is hierarchical, transient and commercialized. It reflects what Eisler (1987) has christened the “dominator model” of interpersonal relationships.

The historical victimization and abandonment of people of color have left a legacy of mistrust and caution when approaching relationships characterized by high discrepancies of power, brevity of contact and paid helpers. Given this legacy, developing trust in service relationships with people of color requires testing and time, and time is the one commodity the AC model, by definition, cannot provide.

RM models provide an alternative by providing continuity of contact in a sustained service relationship, shifting the nature of that relationship from one based on hierarchy to one based on a recovery management partnership, and incorporating support relationships that are natural (reciprocal) and non-commercialized. In the RM partnership, it is assumed that strengths and weaknesses exist on both sides of the relationship, and that there is no universally effective professional intervention for severe AOD problems. Where the expert model is based on a teacher-student relationship, the partnership model assumes that learning will be mutual

within the service relationship. A number of recovery initiation and maintenance strategies are co-developed and tried within the partnership relationship until the most effective strategy is found. At any point previously successful strategies are no longer working, experiments are reinitiated to develop new more stage-appropriate strategies. This approach rests on the assumption that strategies that work to achieve stability in early recovery may not work in the later stages of recovery. Continuity of contact over time is crucial to the RM model, making the issue of high staff turnover a potential Achilles heel of the RM model.

A second Achilles heel of the RM partnership model is the danger that it could evolve into patterns of prolonged dependency that already exist in the AC model. Cultivating professional dependence and creating “system-sophisticated” clients that know how to “do treatment” and manipulate resources to sustain active addiction is counterproductive and constitutes another form of colonization (using such clients as a cash crop to run the institutional economies of service industries and sustain the careers of service professionals). The goal of RM is a habilitation process that replaces dependency on formal service systems with interdependency within a larger social and cultural community. The essential principle is that professionally-directed services are the last, not the first, line of response to AOD problems and that professionally-delivered RM services should provide only what cannot be provided within the larger network of family and indigenous community supports.

Another aspect of the RM service relationship is that the roles of service professionals within this model are multidimensional rather than specialized. In the RM model, the functions of outreach, engagement, assessment, case management, therapy, advocacy, and prevention may all exist over time within the same service role and relationship. This requires a higher level of cross-training than is necessary in the AC model. This broadening of the service role and extension of the duration of the service relationship also forces a rethinking of some of the ethical and relationship boundary guidelines that have governed the delivery of addiction treatment. Such guidelines in the AC model are based on the standards governing professional-client relationships in medicine, psychiatry, psychology and social work. As they have evolved in the modern evolution of addiction counseling, such guidelines have generally prohibited or discouraged disclosure of one’s recovery status, emotional self-disclosure, contact with clients in their natural environment, gift giving and receiving with clients, and contact with clients after the period of primary treatment (See White and Popovits, 2002). Such guidelines require rethinking in the transition from AC models to RM models, with the ultimate arbitrator of the level of authority and formality within the RM relationship defined by the cultural context and the comfort level of the individual and family receiving services (See Matsuyoshi, 2001). While RM models retain a clear sense of behaviors in the service relationship that are “never okay,” the zone of behaviors that is “sometimes okay and sometimes not okay” is significantly expanded. This requires a higher degree of supervision regarding boundary appropriateness in different cultural contexts and over the stages of a long-term recovery support relationship.

RM models may also force agencies to fundamentally redefine their institutional identities from one of a service-oriented business to a member of multiple communities of recovery—memberships that brings their own demands for accountability related to competence, consistency and sustained access to services. Providing continuity of support and

defining oneself in terms of personal and institutional membership in local communities of recovery are much more congruent with the natural patterns of helping within communities of color than are the “expert” or “business” models of delivering acute addiction treatment services.

Culturally-nuanced Research and Evaluation

Indian communities recognize all too well that the research process can be intrusive and the results invidious, divisive, and scandalous. --Beauvais and Trimble, 1992

...attempts to evaluate service program must have a dual acceptability; that is, they must be acceptable to the rigors of scientific exploration as well as the African-American ethos and worldview. –Butler, 1992

Both the acute model and recovery management model aspire to be evidence-based, but the former is based primarily on short-term scientific studies of the efficacy (what works under ideal conditions) and effectiveness (what works under real conditions) of a single episode of brief intervention (McLellan, 2002). The first change within the RM approach to research and evaluation is to extend the time frame under which judgments of efficacy and effectiveness are rendered (White, Boyle & Loveland, 2002). Evidence that short-term effects of intervention (e.g., brief periods of sobriety) predict later therapeutic outcomes (e.g. sustained recovery) (see Weisner, et al, 2003) tells only part of the story. Time-related deterioration of effects, delayed positive effects and delayed iatrogenic (harmful) effects of service interventions can only be identified via longitudinal studies. It is also possible that multiple interventions into chronic disorders may have cumulative or synergistic effects (from particular service combinations and sequences) not identifiable through the evaluation of a single service episode.

Because RM is based on a long-term health management partnership with individuals, families and communities, it calls for a heightened level of sensitivity to constituency attitudes toward scientific research. In communities of color, researchers encounter two significant issues: 1) the distrust of culturally-dominant research, and 2) different ways of knowing.

People of color and communities of color have been wounded in a number of ways by culturally dominant research studies. They have been subjected to grossly unethical research practices (e.g., withholding medical treatment from 399 African Americans sharecroppers in the Tuskegee Syphilis Study). They have been stereotyped via reports characterizing the presence or absence of AOD problems in terms of racially dictated, biological vulnerability—from the “firewater” myths of racial vulnerability of Native Americans (Westermeyer, 1974; Leland, 1976) to the myth of racial invulnerability of Asians (O’Hare and Tran, 1998¹²). They have been wounded by the assumption of universal applicability—the misapplication of

¹² The so-called “Asian flushing response” to alcohol among some Asians does not constitute a universal protective factor against alcoholism and alcohol-related problems in Asians. There is growing evidence that cultural, not biological, factors shape the prevalence and patterns of alcohol problems across highly diverse Asian populations.

research findings from studies in which no people of color were included. Communities of color have been injured by bad (“junk”) science, such as the now-discredited, sensationalist literature on crack cocaine and “crack babies” that turned the criminal justice and child welfare systems into occupying institutions within poor communities of color (See Frank, Augustyn, Knight, et al, 2001). They have been shamed by research designs and interpretations that dramatized the problems within communities of color while ignoring their strengths and resiliencies (Coyhis and White, 2002). Observers from within ethnic communities (Casas, 1992) have also been very critical of how communities of color have been used as a valuable resource to enrich individual careers and institutions in exploitive processes that returned nothing to communities of color.

Given this history, science, scientists and scientific institutions bear a continued burden of proof regarding their safety, relevance and benefit to communities of color. Achieving such credibility will require, at a minimum, the inclusion of community of color leaders and members in the design, conduct, interpretation and dissemination of research and evaluation studies (Hermes, 1998). It will require plotting the long-term pathways of addiction recovery in communities of color. It will require coming to grips with different ways in which communities of color determine what is true and what works in the addiction recovery arena. Most significantly, it will shift ultimate ownership of research from academic and funding institutions to the community being studied.

Scientific knowledge assumes that truth can be discovered through professional observation and the rational analysis of findings from controlled experiments. It is predicated upon distance and objectivity (knowledge from outside) and is judged to exist only when it has been documented in writing and subjected to professional peer review. There are two other ways of knowing within communities of color, and these exist more in oral tradition than in written words. The first, historical/cultural truth, asks, “What has been our past experience on this issue?” Racial memory is an important source of knowledge in communities of color—a source that seems alien to the highly individualist values and “now” orientation of the dominant American culture. Within communities of color, community elders rather than scientists are the ultimate authorities.

The second way of knowing, *experiential knowledge*, is based on the contemporary experiences of individuals, kinship networks and fellow community members. This way of knowing tends to be concrete, pragmatic, holistic, and commonsensical (Borkman, 1976). One of the authors (Sanders) once attended a seminar in which a renowned researcher on problem gambling declared based on his research that Blacks and Latinos did not have significant problems with gambling. This conclusion did not match my historical/cultural truth as an African American, nor the experiential knowledge drawn from my extended family and neighborhood (within which underground and state sponsored-lotteries were a prominent feature). When I asked about the nature of his research, I learned that it was based on a membership survey of Gamblers Anonymous conducted at predominately suburban meeting sites. When I did my own research using focus groups with African Americans and Latinos in urban areas, I discovered clear patterns of problem gambling within these communities.

Word-of-mouth knowledge, captured in the collective stories of a community or a people, constitutes a key source of truth in communities of color. Communities of color do not reject

science as much as require that its findings be filtered through the sieve of personal and community experience. In contrast to scientific knowledge, this way of knowing assumes that truth can only be discovered through proximity and experience (knowledge from inside). The authors have witnessed mainstream scientists speaking at “town meetings” in African American communities. When these scientists decry the lack of evidence on the effectiveness of indigenous frameworks of recovery (e.g., faith-based and other cultural mediums of recovery), they are somewhat flummoxed to see members of the audience stand to declare that they or their family members are the “living proof “ of such effectiveness. David Whiter of Recovery Consultants of Atlanta, Inc. notes, “I have watched many among the African American community begin their recovery in traditional recovery programs only to find sustained recovery in the Black Church” (Personal Communication, December, 2003). Such long-term observations over spans of time that far exceed the follow-up periods in most research studies constitute their own form of collective truth. Living stories (experiential authority) have more power and cultural credibility than statistics (professional/scientific authority) within many communities of color. Living stories are best viewed as a unique and legitimate type of evidence rather than “myths” or “folklore” (Hermes, 1998). This does not mean that the usual methods of scientific analysis are abandoned, but that voices of the community are allowed to directly reach those who hear and read about the community through the medium of scientific research.

RM models will be required to pass the litmus test of multiple ways of knowing if they are to achieve credibility within and outside communities of color. The development of evidence-based services is a fundamental tenet of RM, but in communities of color the nature of that evidence will have to be broadened via qualitative studies that capture the historical and contemporary experience within communities of color. RM models in communities of color will also have to shift from an exclusively academic to a more activist orientation (studying questions of importance to the community, focusing on knowledge that can facilitate positive personal, family and community change); enter into a research partnership with the community (e.g., control over design, conduct, interpretation and dissemination), and respect the community’s ownership of its own knowledge. We also anticipate that research in communities of color will shift from summative evaluation (measuring the effects of an intervention only after it is concluded) to formative evaluation (measuring and communicating the effects of an intervention at multiple points during and after its delivery so that it can be refined and improved).

A Recovery Management Agenda

This paper has contrasted acute care (AC) and recovery management models (RM) models of intervention into serious AOD problems. It is suggested that RM models offer advantages to communities of color in eight specific areas:

- an ecological perspective on the etiology of AOD problems
- a broadened target of intervention (including families, kinship networks and communities)
- a proactive, hope-based model of service engagement

- the inclusion of indigenous healers and institutions
- an expanded menu of culturally-grounded recovery support services and catalytic metaphors
- an extended time-frame of recovery support
- a partnership-based service relationship, and
- a culturally-nuanced approach to research and evaluation.

The reader may ask, “Where are these models of recovery management?” The answer is that there may not be any treatment organizations that have fully developed all of the elements of RM described in this paper. RM exists as an emerging model whose service elements are currently being piloted and evaluated. The RM model exists within progressive treatment programs that are experimenting with new approaches to pre-treatment engagement and post-treatment continuing care. The model exists within the growing number of experiments with peer-based recovery support services. It exists within the growing network of peer-managed recovery homes in the United States. And perhaps most significantly, its potential is demonstrated in the growing number of recovery-focused religious and cultural revitalization movements within American communities of color. That potential exists in a vibrant Wellbriety Movement in Indian Country. It exists within Glide Memorial Church where a majority of parishioners are in recovery. It exists in the Nation of Islam’s outreach to addicted African Americans in prison. It exists in the hundreds of thousands of people of color who each day use Twelve Step programs and other recovery mutual aid societies to quietly achieve another day of sobriety and wellness. The challenge is to build connecting tissue between treatment and recovery by building bridges between these indigenous recovery movements and addiction treatment institutions.

RM holds great promise in communities of color but fulfillment of that promise hinges on:

- 1) involving clients, families and service professionals from within communities of color in a process of shifting existing interventions from AC models to locally designed, operated and evaluated RM models
- 2) developing recovery management teams and advocacy coalitions via the integration of AOD service providers and indigenous institutions
- 3) confronting forces in the community that promote excessive AOD use,
- 4) enhancing “community recovery capital” (Granfield and Cloud, 1999)
- 5) increasing the presence and visibility of indigenous sobriety-based support structures
- 6) providing recovery education within communities of color, and
- 7) using recovery role models that illustrate the viability and variety of recovery pathways within communities of color.

Achieving that vision will require that the field of addiction treatment fundamentally redefine the sources and solutions to AOD problems and, in the process, redefine itself.

The authors conclude this paper as we started it, not as authorities, but students. Any errors of perception or omission in these pages stand as testimony that this learning is, and will

forever remain, incomplete. We submit this paper as a work-in-progress to the communities that helped spawn it and welcome continued guidance as we continue the task of making this alternative vision a reality in communities across America.

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Acknowledgements: Work on this paper was supported by the Behavioral Health Recovery Management project (www.bhrm.org) funded by the Illinois Department of Human Services' Office of Alcoholism and Substance Abuse (OASA). The views expressed here are the authors' and do not necessarily reflect the policies of OASA. The authors would like to thank the many individuals who commented on early drafts of this paper. The suggestions of the following were particularly helpful: Michael Boyle, Don Coyhis, Maya Hennessey, Marco Jacome, Linda Kurtz, Tom Murphy, Nancy O'Brien, Jose Ortiz, Joe Powell, Joyce Rawdhetubhai, Richard Simonelli, Arturo Valdez, and David Whitters.

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