May 14, 2014

A Black Paper

Moving the Recovery Movement into the Black Community across the United States

This paper examines the possibility that addiction, treatment, and recovery dynamics are unique for African Americans. The current a-cultural response is not sufficient to move the dial for African Americans. The social determinants of health and the socio-cultural-spiritual-economic-political characteristics of African Americans should be woven into the cultural philosophy of the recovery movement. It is time to focus our collective cultural conscience and considerable talents on strengthening recovery support and activities within our own communities.

The intent of this project is to advocate for recovery and recovery advocacy in black communities across the United States of America. The way we will achieve this goal is to organize recovery advocates, recovery organizations, and other community entities to build and strengthen Recovery Oriented Systems, Services, and Supports within the African American urban centers and communities across the nation. Simply relying on the experience and strength of Faces and Voices of Recovery has not provided the data, focus, or outcomes desired in the African American community, however this project may build upon FAVOR's model, with the goal of focusing some of that work specifically onto African American communities. FAVOR's strategic approach gives this project an experience and a framework from which to build. In the end, this project may or may not approach Faces & Voices and request they be our platform, however at this early stage that is only a question to be explored by our group.

'Recovery in the Black Community' should be defined by African American's in recovery, key recovery advocates, experts and stakeholders in the addiction, treatment, and recovery fields.

Objectives to explore:

1. Secure resources for national initiative
2. Research: African Americans in recovery
3. Research: Define Recovery from African American perspective
4. Craft Recovery Messaging language for and by African American people and community

5. Develop recovery capital, capacity, and organizations in African American communities
6. Increase African American recovery oriented systems, services, and individuals
7. Publish literature & produce audio/video media
8. Name our Movement

Considering FAVOR as a platform, provider, or as a mentor entity is one objective for our group. "*The mission of Faces & Voices of Recovery is dedicated to organizing and mobilizing the over 20 million Americans in recovery from addiction to alcohol and other drugs, our families, friends and allies into recovery community organizations and networks, to promote the right and resources to recover through advocacy, education and demonstrating the power and proof of long-term recovery*." Faces & Voices has made a significant impact on the national landscape supporting recovery, decreasing stigma associated with addiction, providing advocacy and moving policy forward in support of recovery; and has built an infrastructure that is impacting recovery in immeasurable ways. There are still gaps to be filled, and one gap that must be filled is the disparity of recovery support within diverse communities, and specifically the Black community. There has been progress in a few black communities nationally, and it is our hope to assess that progress, as well as understand more clearly where and how the Recovery Movement can improve and penetrate into Black Communities and life across the country. At the same time, we can mobilize and build a movement within our African American communities, and impact policy and resource allocation so that Black Faces & Black Voices for recovery are mobilized, that addiction is de-stigmatized in the black community, and that the recovery movement is extended into the lives and communities of African Americans across the country.

Rationale for The Black Recovery Movement

NSDUH data show slight increases for African Americans in illicit drug dependence from 2011 to 2012 (3.1% up to 4.1%), in alcohol dependence (5.2% up to 6.2%) and in drug and alcohol dependence (7.2% up to 8.9%). These data raise questions about the epidemiological need for culturally specific interventions. Is there a need, are there gaps in service and recovery models? Over time, are there moderate swings in substance use despite service and recovery efforts? Do service and recovery models effect substance use and recovery in the African American community?

Among full-time college students aged 18 to 22 in 2012, the rate of current illicit drug use was 25.6% for blacks, 22.7% for whites, 20.6% for Hispanics and 13.2% for Asians. And while SAMHSA's Lonnie E. Mitchell Policy Academy is an attempt to get HBCU's involved, data suggests that this only has a modest impact on campuses. How might a Black Recovery Movement impact HBCU and college-age recovery and culture on and off campuses across the country?

It should be noted that TEDS data reveal that among non-Hispanic blacks in treatment, only 56% discharged actually completed the treatment program or were transferred to another program. However, this number is not much different than that for whites, where the completion rate is 61% or Hispanics where the completion rate is 57%. Unless it is argued that these numbers can be influenced by racially or ethnically oriented Recovery strategies, it could be that there is no need for Black Recovery. Yet the distinction of treatment and recovery leaves our service system and our communities in an ongoing dilemma about the different ways we must approach these two critical issues.

From the Surgeon General (1999) to a great number of scholars and practitioners in the behavioral health continuum, ‘culture matters’ in the development and delivery of treatment services. While this seems to be true, the evidence leaves more to be desired than what has been converted to effective practice. This assertion may have much to do with institutional and systemic bias in policy, systems, structures and resource allocation, where all too often disparities in quality services exist, than anything else (Hernandez, M., et. al. 2006). Alternatively, it could be argued that the completion rates reveal the natural limitations of the treatment process, and regardless of race or ethnicity, additional strategies that embrace the social determinants of health need to be promulgated. Can the development and dissemination of culturally specific and targeted recovery-oriented systems of care impact the effectiveness and outcomes of substance abuse services?

Recovery-oriented systems, services and supports developed specifically for African Americans accessing and living in Recovery could/would/should be tailored to the four basic components of the social determinants of health to facilitate a more robust response to the problem of addiction and recovery in the African American community. The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national

and local levels (World Health Organization, 2011). The key principles revolve around health inequity and the distribution of resources affecting the health of people around the world.

1. Social Determinants: Black Recovery would look at insurance status (most southern states do not participate in the Medicaid expansion benefits offered under the ACA); health system access and quality (lack of funds drive African Americans to limited portals for health coverage); socioeconomics and employment status (blacks are subject to the traumas and micro-traumas of the job market and are more likely to earn much less that whites or Asians); educational attainment (black males still lag behind others in primary, higher education or technical training, thus creating tensions both intra-psychically and interpersonally); availability of housing and transportation (decreased income and red-lining affect access to these basic needs and interfere with Recovery; gender (black women endure the disproportionate responsibility of family care; while black men are disproportionately incarcerated compared to white men; black women have been achieving a higher level of education that black men, which creates tension). It should also be noted that HIV disproportionately affect African Americans, but this may be tied to discrimination and stigma associated with sexual orientation or sexual dynamics within the black community; men who have sex with men, and heterosexual dynamics within the black community where sexual orientation or experiences may be more heavily influenced by community norms or attitudes. Can high quality and culturally oriented recovery systems impact social determinants?
2. Behavioral Determinants. Black recovery would look at patterns of obesity, exercise norms, co-occurring mental illness, spiritual conflicts driven by divergent perspectives of religion and self-care. Responses to racism and economic discrimination have to be considered. Disparities of incarceration rates adversely impacts African American men and women, where estimates suggest 80% (1.4 of 1.7 million people incarcerated), and while African Americans make up less than 15% of the US population, they represent about 45% of the incarcerated population (NAACP, 2009) in the US. Young African Americans represent almost 60% of those adjudicated to the adult corrections system, and almost 50% of those detained in juvenile justice settings (Juvenile Justice Policy, 2013). Furthermore, having a felony record of any kind has unique consequences resulting in racist and discriminatory practices that disproportionately and adversely affect African

Americans. How would culturally focused recovery-oriented services impact these alarming data?

3. Environmental Determinants: Where you live and where you work affect psychological and physical factors that interact with health-related factors. According to a 2013 Minnesota Department of Health report on health equity; African Americans living in the social context of oppression, racism, and social/political/economic disparities leads to higher levels of chronic health conditions and higher premature mortality rates in Minnesota. Lead exposure, unsafe workplace factors, unsafe or polluted living conditions, and chronic health conditions such as asthma, environmental stress, and hypertension; and all these health related and environmental conditions directly and indirectly impact Recovery. Can targeted recovery-oriented services and systems impact environmental determinants? The digital divide may be a Black Recovery asset, as the larger system moves to include mobile technology and various Recovery Apps in order to facilitate Recovery. As investments increase in extending the reach of health information technology, using EHRs, Smartphones, and other technology-driven strategies, where will African Americans fit in this new paradigm of care? Tele-psychiatry, Tele-behavioral health, and Tele-recovery may also offer assistance to communities of color but will access be an issue or will access to providers of color knowledgeable about e-health and e-behavioral health be an issue. According to Pew research (2014), African Americans are closing the gap in several technology use categories: High-speed internet is at 80% for AA compared to 87% for Whites, but the margin widens when compared to home-based broad band use 64% to 72% The Affordable Care Act and the MH Parity and SA Equity acts may impact access to behavioral health and recovery services for African Americans, yet we know that financial access to care does not mean physical access to care. We do know that about 7 million uninsured non-Hispanic blacks in America, and approximately sixty two percent were at or below 118% of the Federal poverty level, 31% were eligible for marketplace subsidies, and only 6% were at 400% or above the federal poverty level. But with 25 states not being a part of the Medicaid expansion, those African Americans in TX, LA, MS, GA, TN, FL, SC, NC, OK, KS, etc. may not have financial access to treatment. Targeted recovery support for African Americans may

impact disparities in access by creating new community norms about treatment and recovery.

4. Biological and Genetic Determinants: Sickle Cell disease and Lupus create conditions that may increase the tendency to use or to relapse. HIV, hypertension, diabetes are biological conditions that affect recovery. Conversely, substance use disorders adversely impact most health conditions, and as such benefits will be realized with a culturally focused recovery orientation that integrates primary health, mental health, and chemical health into development and implementation activities. In general, people with substance use disorders and who receive substance abuse treatment also experience better primary health outcomes (World Health Organization, 2007). Because of glaring disparities in healthcare access and service quality, recovery advocacy efforts for African Americans should also focus on primary and behavioral health. Black Recovery may also hinge on visibility, The President talks about his drug use, but not about his Recovery. How many "leaders" in the Black community are willing to "come out" so that Recovery becomes a visible dynamic in the African American community? Black faces and voices advocating for recovery are needed at the community, state, and national levels to effect attitude and policy change. Will a focus on Black faces and voices, on culturally specific recovery supportive norms impact biological and genetic determinants?

The initial plan is to convene a national meeting hosted by Lonnetta Albright of The Great Lakes ATTC to initiate a dialogue with key recovery advocacy leadership. The meeting will entail a visioning introduction, a brainstorm session, a strategic feasibility development session, and a follow-up planning session.

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Appendix A: Introduction

I had a vision in a dream, of which I almost am never aware, but the vivid image of initiating a national *Recovery in the Black Community* Project seemed very real to me. I immediately discussed this vision with Lonnetta Albright from the Great Lakes ATTC, and now we're reaching out to you for your involvement.

My name is Jonathan Lofgren, and I am an African American living in long-term recovery, and I haven't used a drug or had a drink since 9/4/1987. What recovery means to me is that I raised my children as an example of someone that could in fact change, that I reconnected with my family and earn a Ph.D. and become the first Dr. in my family. Recovery also means I've had the privilege to work at Operation PAR Inc. in St. Pete, FL and create a program called the African American Center of Excellence, worked at African American Family Services in Minneapolis, MN , became a Licensed Addiction and Certified Cooccurring Disorders Professional-Diplomat. I'm a trainer, diversity champion, Motivational Interviewing Network of Trainers member, a National Drug Court Institute faculty member, and program development consultant. I served on the Great Lakes ATTC Advisory Board and am Past-President of The Florida Certification Board and The Minnesota Association of Resources for Recovery and Chemical Health. I've worked in the addictions, mental health, and education fields since 1988.

Appendix B: Key African American Recovery Advocacy Leadership and prospective participants:

- Lonnetta Albright
- Roland Williams
- Andre Johnson
- H. Westley Clark
- Bethany Otuteye
- Ijeoma Achara
- Calvin Trent
- Benjamin Jones
- Iman El Amin
- Peter Hayden
- Jonathan Lofgren
- Carl Hart
- Angela Cornelius-Dawson
- Anita Bertrand
- David Whiters
- Joe Powell
- Mark Sanders
- Ryan Springer