

Every Race, Gender And Culture Must Be Welcome In Treatment

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Mark Sanders, LCSW, CADC, is focused on patients' recovery after they leave treatment facilities. For the last five years, he's been helping to build recovery cultures. The idea is simple: Train people established in recovery to offer support in the very community where the clients are returning.

The movement requires providers and professionals to have an understanding of the neighborhoods and communities where clients live and work. "We want to know what resources exist within that community to support recovery," Sanders says.

All too often, memories can trigger patients who may not have thought about using while in treatment. People, places and things can trigger cravings once they return home. It's a problem Sanders has seen repeatedly during his 35 years as a certified addictions counselor. A consultant in behavioral health, he also has taught for more than 30 years at the university level and has authored five books. Sanders is co-founder of Serenity Academy of Chicago, the only recovery high school in Illinois, and past president of the board of the Illinois Chapter of NAADAC.

His most recent project has been the development of the Online Museum of African Americans Addiction, Treatment and Recovery, a resource geared toward frontline workers who want to work more effectively with African American clients. *Addiction Professional* recently caught up with Sanders to talk about treatment and recovery in the African American community.

AP: Can you describe the prevalence of addiction among African American communities?

Sanders: If we were to pay attention to media accounts, we might believe that addiction is more prevalent in the African American community. And yet, when you look at SAMHSA's annual statistics on drug use by race and by gender, African Americans consistently rank third or fourth on the list in terms of actual use. For middle class African Americans and those in the higher socioeconomic brackets, we can expect to see a recovery rate as high as their white counterparts in the same socioeconomic brackets. The more recovery capital you have, the greater your chances of recovery. The challenge is where race and poverty comes together.

The greater challenge is they are more likely to be arrested for possession of substances and thus more likely to wind up in the criminal justice system. There's evidence that receiving a felony has longer-term consequences than actual addiction. You can always recover. That drug-related felony arrest will follow you for a long time.

AP: What are some of the reasons behind addiction and disparity among African Americans?

Sanders: At the core of addiction among African Americans is some type of trauma, which is consistent with other groups. Among those who are economically disadvantaged or economically poor, trauma can also be connected to joblessness. What executive directors at for-profit treatment centers need to know is they may work with African Americans in corporate America, who might be dealing with trauma but also organizational stress, racism in the workplace, etc.

AP: How do you see that stress and trauma affecting African Americans' mental health, recovery and treatment abilities?

Sanders: African Americans have experienced oppression for several hundred years in America beginning with slavery, Jim Crow laws, discrimination and high disparity in detention centers. One of the reasons they're not No. 1 in terms of drug use is the protective factor. There are many factors that actually protect African Americans from mental illness and substance abuse, and it includes things like

spirituality, the sense of 'we'-ness, extended family orientation where you have a great deal of community support, the ability to utilize humor and dance and movement to help mitigate stress.

AP: Is there a danger in providers being colorblind?

Sanders: Everywhere we go as human beings, we bring our experiences with us. African American clients will then bring with them to treatments their experiences of being African American, and then you view the world through their lens. Some African Americans say, 'If you don't see color, you don't see me because my race, my culture, my ethnicity has a way of shaping who I am. So therefore, if you say you don't see color, literally, I don't feel like you see me.'

The other thing is, if we don't see color, we also may not have the opportunity to examine our own biases. We're not really thinking about that if we don't see color. Lately in the diversity literature, they've been talking about microaggressions, intentional and unintentional slights. It's insulting people without even knowing we're insulting them. We have to pay attention to these things so we don't injure someone inadvertently.

AP: If providers don't acknowledge race, are they ignoring experiences or situations?

Sanders: By not seeing race, there might be some other things programs may not see. If you're an African American and you walk into a treatment facility, the first thing you may find yourself instinctively doing is looking at the artwork, similar to the way you would if you were in someone else's house or a museum. And the first thing you might ask is, 'Do I see images of myself in the artwork?' Because sometimes the pictures on the wall at the treatment center can send a signal of who is welcome and who's not welcome in that space.

I'm a patient engagement specialist, so one program invited me to come in and help engage their clients more effectively. They said 80% of their clients were

missing their second outpatient session. I sat in their waiting room for two days to see the agency from the perspective of new clients coming in. I started going through the magazines in the waiting room. They had magazines like *O, Good Housekeeping* and *Martha Stewart Living*, but they served Latino and Hispanic gang members. There was nothing in those magazines that reflected who they were as people—and those types of things can send a signal about who's welcome and who's not welcome.

AP: What advice do you have for providers?

Sanders: Look at areas such as hiring. Does your staff makeup reflect the clients that you work with? We used to say addiction is an equal opportunity employer. Peter Bell [of Hazelden Betty Ford] said addiction is best treated when the cultural background in which it emerged is taken into consideration, meaning that treatment providers have to be willing to understand and learn something about the culture. I would say if a treatment center works with African Americans, Latinos, Hispanic or Asian clients, then they should learn some things about the communities they are serving.

When we're providing clinical services, there's something the clients bring to the table: their experiences and perceptions. Treatment providers are also bringing their experiences and their perceptions. So, not only do you need to understand the clients you're working with, treatment providers also need to understand our own biases, our own assumptions, our own stereotypes. If we begin to understand those things, we can begin to see how our own experiences might impact the clients we serve.

AP: What is one thing our readers needs to know about this issue?

Sanders: It's really critical that even if you work in a program for what we call acute care treatment—short-term treatment—for so many people, addiction is a chronic and progressive illness. With addiction and treatment, we see you for 28 days, whereupon you have what we call 'a graduation.' We often have zero to two

contacts with you upon discharge, whereas in cancer treatment, they may follow up with you for five years. At a minimum, we need to monitor people longer.

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<https://psychcongress.com/article/special-populations/every-race-gender-and-culture-must-be-welcome-treatment>

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