Recovery Capital among Migrants and Ethnic Minorities: a Qualitative Systematic Review of First-person Perspectives

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Abstract

This systematic review of 15 qualitative studies explores recovery capital among migrants and ethnic minorities (MEM). The results of the framework analysis indicate that addressing barriers to recovery and (often minority-related) root causes of problem substance use is vital to recovery among MEM, as well as building recovery capital on personal, social and community level. The review unpacks the importance of 'cultural' and 'spiritual' elements of recovery capital both inside and outside treatment, the interconnectedness of the different dimensions of recovery capital, as well as their intertwinement with root causes of substance use and barriers to recovery. The results point out the importance of offering culturally and trauma-sensitive relational support and building recovery capital through recovery-oriented systems of care. Moreover, this study highlights the need for further research concerning recovery in MEM populations.

Keywords

Framework analysis, alcohol, drugs, dependence, addiction, culture

Introduction

Migrants and ethnic minorities (MEM)[1] are often exposed to migration-related and other risk factors that can increase their vulnerability for problem substance use[2]. These risk factors relate to issues such as socio-economic disadvantages (education, employment, housing), language barriers, intergenerational conflict, acculturation issues, perceived and structural discrimination (Derluyn et al., 2008; McCabe et al., 2007; Reid, Aitken, Beyer, & Crofts, 2001). Several barriers to treatment have been reported, as well as higher drop-out rates and less successful treatment outcomes (Burlew & Sanchez, 2017; Guerrero et al., 2013; Isralowitz, Straussner, & Rosenblum, 2006; Sexton, Carlson, Siegal, Leukefeld, & Booth, 2006). Furthermore, it is broadly accepted that migration and ethnicity-related factors influence recovery processes, by, for example, limiting access to recovery resources (De Kock, 2020; Straussner, 2001; Van Hout, 2010; White & Cloud, 2008).

An important challenge in substance use treatment (SUT) services is the diverse ethnic and migration background of service users (Bhugra & Becker, 2005; Phillimore, 2011). Despite indications that recovery has a 'cultural' dimension (Sheedy & Whitter, 2009) and the need for SUT services to address the specific needs of MEM (Vandevelde, Vanderplasschen, &

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[1] In what follows we will use the term "migrants and ethnic minorities" as this combined term stresses the individual aspect and history of migration, the ''groupness'' of belonging to an ethnic minority, as well as the societal denomination and categorization by ethnicity and its consequences (De Kock, Decorte, Vanderplasschen, Derluyn, & Sacco, 2017). This terminology is also used in policy documents such as the WHO report on migrant health (Rechel et al., 2011). Additionally, this broad terminology allows us to identify how various migration and ethnicity related mechanisms influence recovery in different ways.

[2] Problem substance use prevalence is one of five key epidemiological indicators used by the EMCDDA to monitor aspects of substance use phenomena across the European Union. The implementation of this indicator is supported by resolutions of the Council of the European Union. It refers to "recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high probability/risk of suffering such harms." (Thanki & Vicente, 2013, p. 3). Problem substance use can include temporary increased use as well as for instance 'substance misuse'.

Broekaert, 2003), most recovery literature is based on Western majority populations (Bird, Craig, Leamy, Le Boutillier, & Williams, 2011; Hennessy, 2017). Systematic reviews concerning recovery have uncovered the dominance of English language literature, a paucity of research on the wider socio-environmental context and rather homogeneous study samples, often excluding MEM (De Ruysscher, Vandevelde, Vanderplasschen, De Maeyer, & Vanheule, 2017; Leamy, Bird, Boutillier, Williams, & Slade, 2011; Slade et al., 2012; Stuart, Tansey, & Quayle, 2017). This raises concerns on how voices of MEM are presented in the literature on substance use recovery.

Because recovery is seen as a deeply personal process, first-person perspectives of persons in recovery are indispensable to understand recovery mechanisms and to inform service planning (Brown & Ashford, 2019; De Ruysscher et al., 2017; Dekkers, De Ruysscher, & Vanderplasschen, 2020a). Consequently, this review aims at identifying first-person perspectives on recovery from problem substance use among MEM, which allows us to gain insight into the recovery experiences of varying MEM populations, as well as the identified recovery resources (i.e. recovery capital, see infra) and barriers towards recovery.

Substance Use Recovery Theories

A biomedical approach of problem substance use and recovery, which often equates 'recovery' to sobriety (Boeri, Gibson, & Boshears, 2014), has long dominated substance use theory and practice across the world (Harper & Speed, 2012; Vanderplasschen, Rapp, De Maeyer, & Van Den Noortgate, 2019; White & Kurtz, 2005). A growing awareness of the shortcomings of this clinical approach and the complexity of substance use recovery recently resulted in the emergence of a new recovery paradigm that describes recovery as a complex, dynamic, personal and social process of increased wellbeing and quality of life in multiple life domains. This review aimed at synthesizing available studies concerning recovery among MEM, situated on the broad spectrum of recovery definitions, including clinical, personal and

social understandings of recovery. However, since conceptual clarity is important and needed in the recovery domain (Stuart et al., 2017), definitions by the authors of the included studies as well as respondent definitions will be discussed in the results section.

To initiate, facilitate and sustain recovery, people in recovery draw on internal and external resources denominated as 'recovery capital' (Best & Laudet, 2010; Best, Vanderplasschen, & Nisic, 2020; White & Cloud, 2008). Recovery capital allows to address both the individual level and the social networks in which people are embedded (Best & Lubman, 2012; Cloud & Granfield, 2008). It is described to be linked with problem severity and plays a major role in recovery from problem substance use.

Recovery capital is analytically divided into personal, social and community recovery capital (White & Cloud, 2008). Personal recovery capital integrates physical (e.g. health & financial assets) and human recovery capital (e.g. problem-solving capacities, self-efficacy and life skills) (Neale, Nettleton, & Pickering, 2014). Social recovery capital encompasses relationships with significant others that are supportive of recovery efforts. Cultural capital, which indicates culturally-prescribed pathways of recovery, is part of 'community capital', consisting of community attitudes, policies and resources (White & Cloud, 2008). In contrast, barriers towards recovery may keep people trapped in problem substance use (Best et al., 2020; Cloud & Granfield, 2001). These barriers are assumed to be particularly present among MEM, since they often lack social resources and are confronted with additional challenges like poverty and social exclusion (De Kock, 2019a, 2020; Lowman & Fauve, 2003).

Aims and Research Questions

The aim of this review is threefold: (1) to synthesize studies focusing on first-person perspectives of recovery from problem substance use among MEM, (2) to explore how recovery is defined in these studies and (3) to identify resources and factors that are

supporting or hindering substance use recovery among MEM. Consequently, the following three research questions will be addressed:

1. How is recovery from problem substance use conceptualized in the literature by both authors and MEM respondents?
2. What recovery resources (i.e. personal, social and community recovery capital) do MEM consider as helpful for recovery from problem substance?
3. What do MEM identify as barriers towards recovery from problem substance use?

Methods

This review was conducted following the guidelines for qualitative systematic reviews (Grant & Booth, 2009; Siddaway, Wood, & Hedges, 2019) and reported according to the ENTREQ checklist (Enhancing transparency in reporting the synthesis of qualitative research) (Flemming, Booth, Hannes, Cargo, & Noyes, 2018). A review protocol was developed a priori, updated throughout the review process and is available upon request from the first author.

Search Strategy

A careful selection of appropriate databases resulted in an electronic search of Medline (Pubmed interface), Embase (embase.com interface), CINAHL (EBSCOhost Interface), Cochrane Library, PsycARTICLES (ProQuest interface), ERIC (ProQuest interface), Web of Science and Scopus, which provided us a corpus of published and peer-reviewed studies from date of inception till August 2020. The search strategy included a variety of terms concerning the core concepts 'recovery', 'problem substance use' and 'migrants and ethnic minorities' and was adapted to each interface. The full search strategy is available upon request from the first author. The search was conducted in March 2019 and repeated in August 2020.

Study Selection & Inclusion Criteria

Figure 1 presents a flow diagram with an overview of the number of retrieved studies, selection process and eligibility screening. All 2136 retrieved papers were independently screened and selected for eligibility by the first two authors of this review, using the Systematic Review web app Rayyan QCRI (https://rayyan.qcri.org/). Studies could be included, when (1) its scope was on recovery of problem substance use (alcohol and other psychoactive drugs) among adult MEM, (2) the study design was qualitative and primarily aimed at presenting first-person perspectives (i.e. from MEM with substance use recovery experiences), and (3) they included an English title and/or abstract. Doubtful cases were carefully considered and disagreements were resolved by consensus between the first two authors after discussing the relevance and criteria for in- and exclusion (Siddaway et al., 2019).

This led to the exclusion of 2124 papers based on title and/or abstract and an additional 23 were excluded based on a full-text analysis as these did not meet all inclusion criteria (see Figure 1 for exclusion criteria), or contained the same sample (in which case the most relevant study was included). One study could not be retrieved even after contacting the authors. This resulted in the selection of 15 eligible studies. Screening of the references of the included articles yielded no additional eligible studies. Bibliographic information and main features of the included articles are presented in Table 1.

[Figure 1 near here]

Quality Appraisal

Quality assessment of the included articles was carried out independently by the first and second author, using the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research: a peer-reviewed critical appraisal tool to assist reviewers in assessing the quality of

original research articles based on ten quality criteria (Hannes, Lockwood, & Pearson, 2010; Lockwood, Munn, & Porritt, 2015). The results of the quality assessment are discussed below per criterion. The full quality assessment can be requested from the first author.

All studies demonstrated sufficient congruency between (1) the philosophical perspective and the research design, (2) methods and research goal, (3) data collection methods, (4) data analysis and representation, and (5) data interpretation. Concerning the congruency between research goals and methods (2), several studies intended to elucidate cultural factors in recovery, but did not inquire among respondents to what degree they would identify with these predefined cultures or communities (Bezdek et al., 2004; Doty-Sweetnam & Morrissette, 2018; Lewis & Allen, 2017; Liat, 2016; McCarron, Griese, Dippel, & McMahon, 2018; Mohatt et al., 2008). Some of the results should be interpreted as secondary, because of a different initial research question (Matamonasa-Bennett, 2017), or because proxies were interviewed to account for the recovery of others in the community (Ehrmin, 2002; Lewis & Allen, 2017) (3). Only a minority of the studies located the researcher culturally or theoretically (6) or identified the influence of the researcher on the research results (7). However, the rigorous method description by the authors of these articles indicated minimal researcher bias. Whereas all authors represented the voices of respondents to a greater or lesser extent (8), a key characteristic of participatory and qualitative research is that respondent and researcher voices are closely intertwined and can therefore not always be disentangled. Representation of respondents' voices was sometimes limited due to a high number of respondents (Bezdek et al., 2004) or predefined premises (Bone, Dell, Koskie, Kushniruk, & Shorting, 2011; Ehrmin, 2002; Hohman, 1999) that may bias the results of this review. In some studies, it was unclear whether part of the results – mainly concerning cultural elements – were identified primarily by respondents or secondary informants (e.g. in community-based participatory research designs, such as Ehrmin, (2002)). Most authors

reported efforts to obtain formal ethical approval (9) and some engaged with communities through participatory research (Bezdek et al., 2004; Lewis & Allen, 2017; McCarron et al., 2018; Mohatt et al., 2008) or ethnographic methods (Ehrmin, 2002; Prussing, 2007). Most of the study conclusions were directly related to the findings and interpretation of the data (10), although some authors brought in new theoretical elements that were not a result of the data analysis.

Data Analysis

After data familiarization, the data were analyzed using QSR International's NVivo 12 qualitative analysis software for Windows in three iterative coding phases. The analyzed data consisted of the introduction and results sections of the included studies (including author analysis and respondent quotes). A combined inductive (phase one) and deductive approach (phase two) was used to analyze the data. In the initial coding phase, inductive or grounded codes were assigned to the results sections (Strauss & Corbin, 1994). In a second coding phase, these inductive codes were merged and assigned to the three main dimensions of recovery capital (personal, social, community), as well as to 'barriers towards recovery' through framework coding by the first author (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The framework was supplemented with 'recovery definitions' and an additional category that emerged as a result of the open coding strategy in phase one: 'root causes of problem substance use'. To reach inter-coder reliability, ten articles were independently coded by the first two authors during the first coding phase. Any discrepancies in codings were discussed and resolved between the two before starting phase two (framework coding). The assignment of codes to the recovery framework in phase two was equally discussed extensively and discrepancies were resolved between the first two authors before initiating data reporting. In addition to presenting the main findings across personal, social and community capital, a comparative approach allowed us to uncover differences across respondent characteristics. When nodes were

consistently present within certain groups this is clarified in the results, but often the results were consistent across diverse populations of men, women, younger and older respondents from varying ethnic or migration backgrounds. The third and final coding phases entailed screening the introduction sections (as opposed to the results sections in phase 1 and 2) to identify the authors' definitions of recovery.

[Table 1 near here]

Results

In this section, the results of the recovery capital-oriented framework analysis are presented. First, we elaborate on characteristics of the included studies and the way recovery is defined. Second, root causes of problem substance use are discussed, since these emerged as an important aspect in the recovery processes of MEM, followed by findings concerning recovery capital dimensions (personal, social, community). In the results section, we adopted authors' terminology concerning the targeted population, substance use, and recovery, which may not be consistent with the terminology used in the introduction and discussion. Included studies are referred to by their respective numbers in Table 1.

[Table 2 near here]

1. *Study Characteristics*

Twelve studies were conducted in the USA, two in Canada and one in Israel. Eight studies gave voice to Indigenous populations: 'Native Americans', 'Indian Americans' or 'Alaska Natives' (n=6) and First Nation populations in Canada (n=2). Other study populations were: 'African Americans' (n=4), 'Mexican Americans' (n=1), 'Filipino Americans' (n=1) and 'former Sovjet Union (FSU) immigrants' in Israel (n=1). Six studies included only women, two only men and one focussed on elderly persons.

Sample sizes varied from 2 to 1146, mainly due to methodological differences: while the study with the largest sample simply analyzed responses to two open-ended survey questions on what respondents considered helpful for recovery, the case study involving two respondents provided in-depth insight in the lived experiences of MEM in recovery.

Included studies were published between 1997 and 2019 and the majority was published after 2006 (n = 11). Six articles were published between 2016 and 2019.

2. *Defining Recovery*

Even though recovery was a central theme in all included studies, most studies did not define recovery explicitly. Authors referred to recovery as 'sobriety' (studies 10 & 15), 'getting clean' (study 5), and 'cessation' (study 9), 'reducing and quitting substance use' (studies 3 & 4) or 'changing drinking behavior' (study 1).

The fact that recovery is a process rather than an endpoint was acknowledged in most studies (studies 1, 2, 4, 6, 8, 10, 11, 12, 13 & 14), either because the authors defined recovery as a process or 'journey' themselves (e.g. studies 6 & 12) or because the narratives of the respondents addressed recovery as a lengthy process with ups and downs (e.g. studies 5, 14 & 15). Other studies acknowledged that several parallel processes are involved in recovery from problem substance use, without defining recovery as such (studies 3, 4 & 7). In contrast, respondents in study 9 were considered "recovered addicts" (p. 1103), suggesting recovery has an endpoint. This was also the case in study 14, where respondents in "stage two sobriety" considered themselves "fully recovered" (p. 211) from alcohol misuse.

Recovery processes were described as marked by both personal and social elements. Several studies demonstrated that recovery is a dynamic process of psychological transformation involving multiple life domains (studies 8 & 15). Doty-Sweetnam and Morisette for example (study 6), described how respondents differentiated between sobriety and recovery: "In their

[respondents] opinion, sobriety referred to refraining from alcohol consumption. Recovery, on the other hand, is achieved when there is a balance between the body, mind, and spirit" (2018, p. 11). Respondents in study 15 described recovery as "a socially negotiated shift in identity" (p. 521) and "a process of remembering and returning to values that she [participant] already knew" (p. 512), whereas in study 14 "stage two sobriety" was described as "life as it is meant to be lived" (p. 207).

3. *Root Causes of Problem Substance Use*

Although only two of the included studies predominantly focused on root causes for problem substance use to talk about recovery (studies 5 & 7), this theme also emerged in at least seven additional studies (studies 2, 3, 6, 8, 9, 12 & 15). Substance use was often described as a coping mechanism to "numb the pain" (study 7, p. 784) from difficult life experiences and trauma (studies 3 5, 7, 9, 12 & 15), like physical or sexual abuse (studies 3 & 7), negative childhood experiences such as growing up in a disruptive family (studies 3, 5, 7, 9, 12 & 15) or having to deal with the death of loved ones (study 15).

The narratives of respondents from six studies showed how problem substance use and family trauma were passed on from generation to generation (studies 2, 3, 6, 7, 11 & 12). This intergenerational transfer of trauma and problem substance use was described as being linked to patterns of minority-related oppression impacting families and communities, individual psychological (such as identity disruption and acculturation pressure) and practical (such as poverty) elements of life (studies 2, 3, 7 & 12). Respondents described being judged as inferior to other members of society (study 7), feeling rejected because of their skin color and how their substance use was a way of dealing with experiences of racism (study 3 & 7). A lack of connection with their family, community or culture was part of the reason that led some to surrender to the peer pressure of a substance-using social network (studies 2, 9 & 12). Addressing these root causes was deemed essential for recovery.

4. *Recovery Capital*

4.1. Personal Recovery Capital

All studies, except for study 9, addressed recovery resources on a personal level.

Specifically important to the initiation of the recovery process was a *personal reflection on the harmful consequences* of problem substance use (studies 1, 4, 8, 12, 14 & 15). Some respondents described the initiation of their recovery process as a 'turning point' that followed a 'crisis' (a key event of pain or loss) (studies 12 & 14). Others talked about how they were 'sick' and 'tired' of the drug-using lifestyle (studies 1, 4, 8 & 15) and the detrimental effect of their use on their financial situation (study 1), and physical and mental health (studies 1 & 4).

Second, several authors described how respondents searched for new *coping methods* to deal with craving, (studies 1, 4, 12 & 14) such as diversion, social activities, hobbies, chores, school (study 1), prayer (study 4) and active participation in activities that are incompatible with alcohol and drug use (study 14), like Native American cultural engagement (study 12). Hence, these coping strategies are closely intertwined with community resources.

The narratives demonstrated how finding new or rediscovering coping strategies also applied to dealing with emotionally difficult life experiences. Six articles underscored that addressing and processing unresolved issues and trauma were important steps in the recovery process of respondents (studies 3, 6, 7, 12, 14 & 15).

Third, in over half of the studies*, creating, (re)gaining or (re)connecting with (variations of) a cultural identity and the sense of belonging to a cultural community*, were indicated as facilitating elements for recovery (studies 2, 3, 6, 10, 12, 13 & 14). All these studies, except for study 3 (i.e. persons with an African American background), concerned respondents with an Indigenous background. The respondents described how reconnecting with what they considered their native culture through, for instance, what Matamonasa-Bennett (study 12)

calls ‘retraditionalization’ and engagement in cultural activities, led to feelings of belonging and purpose, which they often lacked before (studies 10, 12 & 15). Study 12 described how Native American men replaced their “alcoholic identity with a more positive view of themselves as traditional men” (p. 1147). Furthermore, respondents described how reconnecting with their culture allowed them to share their experiences with others with the same cultural background. They talked about how storytelling created a chance for them to play a role for future generations in the community, making them feel valued and creating a purpose in their lives (studies 3, 6, 10 & 12).

Fourth, *religious and spiritual acts, beliefs or experiences* were described as important elements in the recovery processes of respondents (studies 1, 4, 5, 8, 10, 12, 13 & 14). Individuals described how spiritual experiences motivated them to stop drinking (studies 5, 10 & 14), how they turned to prayer or reading the Bible when they felt urged to use and found support, guidance and encouragement through their faith and their relationship with a higher power (studies 4 & 14).

Lastly, several respondents and authors discussed how *taking responsibility and being a role model* for children, family members and others in the community (studies 1, 4, 5, 10, 12, 13 14 & 15) was a motivator and facilitator for recovery. Six studies discussed how respondents (mostly women) wanted to take responsibility for their children and set a good example (studies 1, 4, 5, 13, 14 &15). Furthermore, being clean enabled respondents to embrace responsibilities within the community and help community members by sharing their recovery experiences and traditional knowledge (studies 10, 12 & 14). In study 12, respondents suggested to expand this “role repertoire” beyond the tribal community by educating non-Natives about the tribal culture to decrease racism and misunderstanding, which helped them in developing what the author calls a “bicultural identity” (p. 1151).

4.2. Social Recovery Capital

Social recovery resources were discussed in fourteen studies. Only study 7 made no explicit reference to social recovery resources.

Eight of the studies suggested *how love and support of close family (including children) and significant others* (e.g. friends and peers) play a vital role in recovery, both as a motivator for initiating (studies 5, 13 & 14) and sustaining recovery processes (study 6). This is exemplified by the respondents of studies 13 and 15, who describe the importance of people close to them because they "check on" them, "stick by" them (study 13, p. 326) and "wouldn't give up" on them (study 15, p. 157). The respondents in the second study underscored the importance of reciprocity, enabling them to give something back to others.

Furthermore, family and significant others who have traveled the same road functioned as *role models* who inspired, guided, mentored and supported respondents during their recovery process (studies 2, 6 & 13). People could be role models for adhering to a traditional path (studies 6 & 12) or because they were able to refrain from problem substance use (studies 4 & 10). Interacting with people who had similar recovery- and/or minority-related experiences made the respondents feel like they were not alone in the struggle (studies 5 & 13). Respondents found these peers in their family (study 13), cultural or religious community (studies 6 & 13), a MEM-targeted treatment program (study 8) or group recovery resources such as Alcoholics Anonymous (study 13). In finding a positive, non-drug using and recovery supporting social network, changes in intimate relationships and atmosphere were often required (studies 1, 4, 9, 14 & 15).

4.3. Community Recovery Capital

All studies, except one (study 9), mentioned recovery resources at community level.

In ten articles, respondents mentioned how *formal treatment and 12-step programs* can be facilitating and supportive resources (studies 1, 2, 4, 6, 7, 8, 11, 13, 14 & 15). Respondents in study 13 talked about how a treatment program showed them the possibility of living a happy life and motivated them to hold on. However, Bezdek and colleagues (study 1) reported that formal interventions (including AA) were only mentioned in 4.2% of the responses on what helped the Indigenous respondents to change their drinking behavior and fell below relational (social) and decision-making (personal) factors.

Several respondents pointed out the importance of incorporating culture-specific aspects in treatment and 12-step programs (studies 6, 8, 13 & 15). These aspects differed across the diverse backgrounds of the respondents. Hohman (study 8) reported that Hispanic respondents highlighted the importance of being treated with ‘respeto’, which he identified as a cultural aspect of counseling with Hispanics. Respondents with a Native American background discussed the importance of smudging[3], praying and going to sweats[4] in the program, spiritual acts that they consider inherent to their Native American culture (studies 6, 13 & 15). They considered substance use treatment targeted to Indigenous populations, such as ‘Wellbriety’, to be beneficial for their recovery. The need to tailor treatment to specific populations was contradicted by ‘Former Sovjet Union patients’ in a not-MEM-targeted Israeli treatment setting. They argued that separate treatment would “lead to increased feelings of alienation and discrimination” (study 11, p. 259), and was therefore undesirable. Nevertheless, these respondents acknowledged the importance of awareness for cultural differences within treatment.

[3] Smudging is an Indigenous ceremony that involves the burning of sacred herbs to purify one’s self and thoughts (Browne et al., 2016; Indigenous Corporate Training Inc., 2017).

[4] This refers to the sweat lodge ceremony, an Indigenous tradition that “serves to purify those undergoing any sort of transformation or healing” (Garrett et al., 2011, p. 319).

Respondents discussed how they felt supported by their counselors because they offered them both practical and emotional support (studies 2, 8, 11 & 13). Some considered it helpful when staff had the same cultural background since it made them feel understood and therefore helped to establish a positive and recovery supportive therapeutic relationship (studies 6, 8 & 11).

Cultural and spiritual values, activities and traditions were also mentioned as important community resources in most studies (studies 2, 3, 4, 6, 10, 11, 12, 13, 14 & 15). The majority of these studies focused on respondents with an Indigenous background, except for studies 11 ('Former Sovjet Union immigrants' in Israel), 3 and 4 (persons with an African American background). In the included studies, culture, spirituality and religion are used interchangeably without a clear distinction. Therefore, these are brought together under the label 'cultural and spiritual values, activities and traditions'.

Trying to live according to the (cultural) values of specified MEM (studies 10, 11, 12, 13 &15) and adhering to related social and community role expectations (studies 4 & 14) were mentioned by respondents as facilitators, goals and motivators for recovery. They talked about wanting to be a 'human being' again (i.e. "a state of spiritual and social development in which one is living in harmony with traditional tribal values"; study 12, p. 1149), wanting to be a 'good person' as prescribed in what they perceived as their culture (study 13) and wanting to live along the lines of their ancestors (study 15).

In addition, respondents indicated how participation in cultural and spiritual activities, ceremonies and traditions was essential to their recovery (studies 2, 10, 12, 13 & 15). They explained how it helped them to "heal their wounds" (p. 1150) and cope with difficult life experiences (study 12). Respondents mentioned that engaging in cultural and religious activities was incompatible with using substances and motivated them to stay sober (studies 4, 10 & 14).

Two studies illustrated how involvement in the *criminal justice system* had a positive effect on respondents' recovery since it deterred them from using substances and motivated them to stay in treatment when tempted to drop out (studies 4 & 8).

4.4. Barriers to recovery

Barriers to recovery were discussed to a lesser extent than facilitating recovery resources. In the six articles that mentioned barriers to recovery, only one study discussed barriers on a personal level (study 6), five addressed social barriers (studies 6, 9, 11, 13 & 15) and four discussed barriers on community level (studies 9, 11, 12 & 15).

In study 6, it became clear how the use of substances is both causing and caused by *personal* feelings of guilt and shame. Respondents reported how finding new ways to cope with these feelings was essential to their recovery.

At the *social* level, the ambiguous role of the family became apparent. Some respondents talked about how a disruptive or substance-using family was one of the reasons why they began to use in the first place and impeded their recovery process (studies 6 & 11). Besides family, a substance-using social network (study 9), the social pressure to use (study 15), and a lack of recovery support (study 13) were considered barriers to recovery. Lastly, the relations between counselors and clients in treatment settings were addressed. Authors discussed how negative minority-related experiences of MEM, such as perceived labeling and judgment, could lead to feelings of power imbalance and mistrust towards health care professionals, jeopardizing their recovery process and increasing the need for counselors with the same cultural background (studies 6 & 11).

At the *community* level, being part of a substance-using (sub)culture or community could impede recovery (studies 9, 11, 12 & 15). In study 12, for example, a participant reported how she was "drinking to be Indian" (p. 1148). Furthermore, some features described as 'culture or

community-specific' were identified as hindering recovery. Liat (study 11) discussed how the importance of masculinity and respect within the Former Sovjet Union community in Israel kept respondents from talking about their problems and seeking treatment because it was considered "beneath their dignity" (p. 257). This "culture of silence" (p. 1098) due to the belief that it is inappropriate to discuss problems like substance use with others was also mentioned in relation to the Filipino community in the USA (study 9). Parallel with the importance of integrating cultural aspects in treatment, respondents mentioned how the lack of cultural sensitivity in treatment could impede their recovery (study 12).

Discussion

This review sheds light on recovery capital, barriers to recovery and the importance of root causes for problem substance use as experienced by MEM. A broad range of studies was included representing various definitions of recovery, although these were not always clearly defined. While several authors referred to recovery as 'cessation' and 'sobriety', the narratives of the respondents depicted a different view of recovery as a process stretching across multiple life domains. Even though the personal recovery paradigm, which emphasizes quality of life, wellbeing and social participation and resources, has not yet found its way into recovery research among MEM (De Kock, 2019a), these aspects appeared in the identified recovery experiences in this study.

In this analysis, we departed from the recovery capital framework by White & Cloud (2008), which allowed us to address recovery across multiple ecological levels (Hennessy, Cristello, & Kelly, 2019). The analysis highlights how clinical recovery is closely intertwined with personal and social factors and how root causes of problem substance use are interwoven with recovery processes. Additionally, we demonstrated how internal as well as external recovery

resources at personal, social and community level play a role in the initiation and maintenance of recovery from problem substance use.

On the personal level, we identified that various recovery resources documented in the broader recovery literature, are also important to MEM, such as spirituality (Chitwood, Weiss, & Leukefeld, 2008; Leamy et al., 2011), finding new coping mechanisms for craving, stress and trauma (Brown, Davis, Jason, & Ferrari, 2006; Klein, Sterk, & Elifson, 2016), searching for a (non-substance using) identity and feeling connected (Dekkers, De Ruysscher, & Vanderplasschen, 2020b; Leamy et al., 2011; White & Kurtz, 2005). The importance of *recovery supportive social networks* is highlighted in the existing recovery literature (Ashford et al., 2019; Boeri et al., 2014; Dekkers, Beerens, Wittouck, & Vanderplasschen, 2016), including the role of peers and role models in recovery (Best & Lubman, 2012; Moos, 2010). At the *community level*, the importance of positive community values (Cloud & Granfield, 2008) and the involvement in protective activities (Moos, 2010), substance use treatment and 12-step programs have also been documented (Dekkers, Vos, & Vanderplasschen, 2020; Laudet, 2008).

The main difference between the results from this review and the broader (not-MEM-targetted) recovery literature lays in the importance and specific nature of some recovery resources and root causes of problem substance use.

Problem substance use as a result of substance-related coping with MEM-specific stress and trauma, related to (inter)generational experiences of minority-related oppression, has been documented in previous research (Horyniak, Melo, Farrell, Ojeda, & Strathdee, 2016; Trummer, Novak-Zezula, & Metzler, 2010; Vaeth, Wang-Schweig, & Caetano, 2017). The fact that "treating the symptoms of ill health, including addiction and mental health is a band-aid solution that does not treat root causes" (Lavallee & Poole, 2010, p. 275) increases the need for addressing these root causes even more.

The minority-majority divide that respondents experienced, can lead to downgrading one's self-worth and identity disruption (Van Hout, 2010), the increased need to feel part of a cultural community and (re)gain a cultural identity when recovering from problem substance use. Leamy and colleagues (2011) already pointed out that religion, spirituality and belonging to a cultural group or community are particularly important for personal recovery among MEM. On the social level, several included studies mentioned how 'cultural' peers and role models can support respondents in regaining a cultural identity and in finding cultural coping strategies (Westermeyer, 1995). Also, peers and role models that respondents addressed for support, were mainly people with the same ethnic background.

The importance of what is perceived as 'culture' was also apparent at community level, where cultural and spiritual values, activities and traditions emerged as important aspects both inside and outside treatment. Although the benefits of being treated by staff with the same ethnic background were acknowledged (Isralowitz et al., 2006; Westermeyer, 1995), not all respondents considered it necessary in treatment.

The fact that MEM 'cultural communities' may also hinder recovery has been documented previously (De Kock, 2020; Murphy, Sales, & Averill, 2015), as well as the stigma that surrounds problem substance use within communities and increases barriers towards substance use treatment (Ashford et al., 2019; De Kock & Decorte, 2017; Westermeyer, 1995).

Some elements were mentioned as specifically helpful for initiating recovery, namely (reflecting on) harmful consequences of substance use and the experience of having children and motherhood (Cloud & Granfield, 2008; Tracy & Martin, 2007). This suggests that a loss or lack of recovery resources may sometimes function as a turning point that motivates respondents towards recovery (Cloud & Granfield, 2008; Hser & Anglin, 2011).

Some recovery resources were surprisingly absent in the narratives of MEM respondents. While problem substance use is often associated with involvement in criminal activities (Chandler, Fletcher, & Volkow, 2009) and 'ethnicity effects' have been reported to enhance (drug-related) detention particularly among MEM (Brennan & Spohn, 2008; Demuth & Steffensmeier, 2004; Golub, Johnson, & Dunlap, 2007), only two studies referred to respondents' experiences with the criminal justice system. Surprisingly, we observed only one study that referred to employment as a recovery resource (Hohman, 1999), while this is often seen as an essential component of personal recovery capital (Best & Laudet, 2010; Cloud & Granfield, 2008; Dekkers, De Ruysscher, et al., 2020a; Martinelli et al., 2020). Even though financial assets were not explicitly mentioned as a recovery resource by respondents, some references were made to the lack of financial resources as root cause of problem substance use (Davis, 1997; Laus, 2013).

We observed how many of the personal recovery resources mentioned by respondents are grounded in social and community resources, and that many of the personal and community resources were social in their core. (Re)connecting with respondents' cultural background, for example, was facilitated through meaningful relationships with community members. Furthermore, some personal facilitators for recovery, such as talking about trauma and personal experiences with others, are not possible without social resources (Ehrmin, 2002; McCarron et al., 2018). Community resources such as treatment and 12-step programs were often facilitating recovery because of these social interactions, such as relationships with peers and counselors and culturally-sensitive interactions (Dekkers, Vos, et al., 2020; Mudry, Nepustil, & Ness, 2019). However, the active commitment to address these recovery resources is considered a personal resource. Future research should subsequently address to what degree this active commitment is facilitated or hindered by resources external to the personal will (i.e. availability and access to treatment or broader community resources).

Implications for Theory, Research, and Practice

This review demonstrates that the recovery capital framework as described by White and Cloud (2008) is applicable to MEM, but caution is needed concerning the specific nature and importance of its constituents among MEM in recovery. The results confirm that recovery capital, as well as barriers towards recovery (Cloud & Granfield, 2008), are equally and simultaneously situated at personal, social and community level. This confirms the importance of recovery-oriented systems of care that consist of recovery supportive social networks, communities and environments (Harper & Speed, 2012). Additionally, our results align with previous research indicating that both the recovery capital framework and substance use treatment for MEM often remain blind for macro-level causes of emotional distress, such as the personal, social and political struggle as a consequence of societal power disparities (Ashford et al., 2019; Bourgois et al., 2006; De Kock, 2019a; Harper & Speed, 2012). These aspects confirm the need for what is described by Ashford and colleagues (2019) as 'recovery-informed theory', which understands recovery pathways through their intersection with social and ecological contexts and acknowledges the importance of a supportive context that offers community-based and relational support.

Even though recovery resources were clustered at three levels for analytical purposes (personal, social and community), this study affirms that these levels are closely intertwined (Cloud & Granfield, 2008). Instead of structuring personal, social and community capital as three different components, we recommend to interpret personal recovery capital as embedded in social and community recovery capital, with attention for the intersections and dynamic interplay of individual growth with social connections and community engagement (Ashford et al., 2019; Best, Irving, Collinson, Andersson, & Edwards, 2017; De Kock, 2020).

By synthesizing research focusing on MEM’s experiences of substance use recovery, we identified several gaps in the literature, such as the shortage of research conducted outside the USA (e.g. European studies) and the lack of research concerning specific MEM populations such as refugees and first-generation migrants (De Kock, 2019b). Future research should fill these gaps and focus on how migration, minority and ethnicity-related elements among diverse populations interact at individual (micro), group (meso) and societal (macro) level with problem substance use and recovery mechanisms from an ecosocial perspective (De Kock, 2020; Harper & Speed, 2012; Klein et al., 2016), as well as their intersectional intertwinement with demographic characteristics such as gender and age (Kapilashrami, Hill, & Meer, 2015; McCarron et al., 2018; Prussing, 2007). Although migration-, minority-, culture- and ethnicity-related facilitators and barriers are closely intertwined, they should be distinguished more clearly. Starting from a personal recovery approach, first-person perspectives of MEM in recovery are indispensable in both practice and research (Dekkers, De Ruysscher, et al., 2020a). Participatory research methods, as implemented in 5 of the 15 included studies, can integrate individuals’ lived experiences at all levels of research.

To increase the likelihood of stable recovery, painful life experiences and trauma need to be addressed in treatment. Treatment should enhance MEM individuals’ recovery capital, by collaborating with them, their social network, and the MEM community, investing in relationships of trust and offering empowering opportunities such as being a role model for others (Sexton et al., 2006; Van Hout, 2010). Recovery-oriented, client-centered, culturally sensitive and trauma-informed treatment is recommended (Kelly & White, 2011; Klein et al., 2016; Westermeyer, 1995). Even though collective recovery resources may support multiple persons or populations, the individual needs of each person seeking recovery need to be recognized (Dekkers, De Ruysscher, et al., 2020b).

Limitations and Considerations

Although the included studies had a broad range of study objectives covering various stages of recovery processes, some studies might have overemphasized the importance of root causes, cultural and social recovery resources. Predefined recovery premises, such as a specific focus on substance use patterns (Liat, 2016), treatment (Bowser & Bilal, 2001), social support (Bone et al., 2011; Cheney, Booth, Borders, & Curran, 2016; Laus, 2013; McCarron et al., 2018), the role of 'culture' (Bowser & Bilal, 2001; McCarron et al., 2018) or 'root causes' (Davis, 1997; Ehrmin, 2002), may have led to an overrepresentation of these elements in our analyses. Among the included studies, populations were selected primarily because of their ethnic groupness, leaving aside the individual history of migration (De Kock, Decorte, Vanderplasschen, Derluyn, & Sacco, 2017). Even in studies that specifically included first-generation migrants (Liat, 2016), migration-specific aspects were not addressed.

Because a systematic review is a type of secondary data analysis, not having all primary information at hand is often challenging. Although the studies were clear about *what* was considered helping or hindering, it was not always clarified *how* these factors facilitated or hindered recovery, which had implications for assigning resources to the personal, social or community level during the analysis. Furthermore, some important concepts were not defined within the included articles. 'Culture' emerged as an important concept in substance use recovery, but we discerned, in line with previous research (De Kock, 2019a), that none of the studies specifically defined what was meant with 'culture'. 'Culture', 'spirituality' and 'religion' were often confounded, urging us to describe these terms conjointly in the review. Hence, the complexity of these concepts could not be reflected within this review and vigilance is warranted for the complex dynamics that are interwoven with what is considered culture, religion and spirituality (Dreher & MacNaughton, 2002). Adopting the included authors' terminology to describe the results, allowed us to stay close to the data, but also

revealed to the use of some concepts that can be considered stigmatizing (Kelly, 2004). Future research should further clarify these concepts and consider the impact of the applied terminology.

Although research concerning substance use trajectories (without explicitly mentioning recovery), or grey literature could contain valuable information about recovery among MEM, these were not included in this study and could be a focus of future research. Lastly, the dominance of US research should be considered when interpreting the results. The fact that all but one study were conducted in the USA and Canada could be a result of the search strategy (English search terms) and inclusion criteria (English title/abstract). In light of the fact that English is the dominant language in social sciences (Drubin & Kellogg, 2012), it could also be an affirmation that the recovery construct and attention for this construct within minority populations is mostly developed in North America (Slade et al., 2012).

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