Published in final edited form as:

J Groups Addict Recover. 2017 ; 12(2-3): 158–176. doi:10.1080/1556035X.2017.1313147.

The *Anexo* in Northern California: An Alcoholics Anonymous-Based Recovery Residence in Latino Communities

Victor Garcia^a, Anna Pagano^b, Carlos Recarte^b, and Juliet P. Lee^{1D,b}

^aDepartment of Anthropology and Mid-Atlantic Research and Training Institute for Community and Behavioral Health (MARTI-CBH), Indiana University of Pennsylvania, Indiana, Pennsylvania, USA

^bPrevention Research Center, Pacific Institute for Research and Evaluation, Oakland, California USA

Abstract

Our ethnographic study on help-seeking pathways of Latino immigrants in northern California reveals that they turn to *anexos* in their treatment and recovery quest. *Anexos* are linguistically- and culturally-specific recovery houses with origins in Mexico and Alcoholics Anonymous and a long history in Latino communities across the United States. Drawing on the findings of our study, we characterize the *anexos* and compare them to other recovery residences using National Alliance for Recovery Residences (NARR) criteria. The description and comparison reveal that *anexos* cannot be placed into a single NARR residence category. We discuss why this is the case.

Keywords

Alcoholics Anonymous; anexos; Latinos; recovery houses; substance use disorders

Public health research has documented the importance of a safe, stable, and sober living environment for individuals recovering from substance use disorders (SUDs; Jason & Ferrari, 2010; Polcin, 2001). Without it, recovery is more difficult to sustain, regardless of personal motivation and readiness for recovery. Based on research demonstrating favorable outcomes, researchers, service providers, and policymakers have advocated for the use of recovery residences (Polcin, 2009a; Wittman & Polcin, 2014). Multiple types of recovery residences have been identified in the literature, such as Oxford Houses and California Sober Living Houses (Jason, Olson, Mueller, Walt, & Aase, 2011; Polcin, 2009b; Wittman & Polcin, 2014).

Although these well-known recovery residences have been studied for decades, there is a need for more comparative research to understand more fully their contributions to recovery for different populations. For instance, a recent study of dually diagnosed justice-involved persons found that those who lived in recovery residences after completing inpatient treatment reported significant reductions in psychiatric severity as compared to those

CONTACT Victor Garcia, vgarcia@iup.edu, Department of Anthropology, G1 McElhaney Hall, Indiana University of Pennsylvania, Indiana, PA 15705-0001.

ORCID

Juliet P. Lee <http://orcid.org/0000-0003-2330-3736>

referred to treatment as usual (Majer, Chapman, & Jason, 2016). There is also a need to include in comparative research lesser-known recovery residences such as the *anexo*, a linguistically and culturally specific recovery residence with a long history in the Latino community (Pagano, 2014).

Our objective is to characterize the *anexo*, an understudied recovery residence with origins in Mexico and Alcoholics Anonymous (AA). These recovery residences are mainly found in urban areas throughout United States with large concentrations of Mexican and other Latino immigrants. The actual numbers of anexos are unknown given that, unlike in Mexico, they are not part of a larger *anexo* association, nor are they registered with the government. In particular, we address how the *anexo* compares to other recovery residences in the United States. We apply the same criteria to the *anexo* that other researchers have used to identify and categorize recovery houses according to four levels: Level I, Peer-Run; Level II, Monitored; Level III, Supervised; and Level IV, Service Provider (Mericle, Miles, Cacciola, & Howell, 2014). The criteria, established by the National Association for Recovery Residences (NARR), comprise: (a) residence, (b) staffing, (c) administration, and (d) services (NARR, 2011, 2012). In using these criteria, we do not seek to classify anexos into one of the four levels of recovery residences. Instead, we use the NARR criteria as a heuristic tool with which to examine the similarities and differences between Northern California anexos and other types of recovery residences. These criteria will help us to determine to what extent the *anexo* represents a unique type of recovery residence.

Background

The *anexo*

Anexos are recovery residences operating in the United States, Mexico, Guatemala, El Salvador, and other countries, including Spain (Coatecatl, 2012). In the United States, they are independent AA recovery houses, and most are not registered with the International 24-Hour Movement, an *anexo* association in Mexico City that provides guidelines for these recovery residences (Movimiento Internacional 24 Horas Alcohólicos Anónimos, 2016). In Northern California, where we conducted our research, anexos were established by Mexican and Central American immigrants in Latino communities. They mainly provide their services to men, although in the past women were also welcomed; however, because of problems that arose in housing men and women together, this practice did not continue.

Anexos offer an affordable, structured, and culturally appropriate recovery support environment that incorporates AA principles and practices. The recovery program is offered in the Spanish language and draws on the cultures and immigrant experiences of the residents, serving immigrants and, to a lesser extent, second generation Latinos, or Latinos born in the United States to immigrant parents. These populations, particularly individuals experiencing stress associated with acculturation to U.S. cultural norms, are more likely to suffer from mental health problems and substance use disorders, according to a recent study (Lopez-Tamayo et al., 2016). The recovery residences are called anexos because in Mexico, they are annexed to, or associated with, a traditional AA group. They are also known as 24-hour AA Groups. In the United States, this is not the case; anexos operate independently of traditional AA groups.

Latinos, anexos, and other U.S. recovery residences

Despite their presence in the United States for at least 25 years, anexos have not received research attention. To our knowledge, our study is the first long-term ethnographic research on U.S. anexos. In Mexico, where the anexo originated over 40 years ago, there are only a limited number of studies, most of which have been conducted in the Mexico City metropolitan area. As we have addressed elsewhere, despite sharing some characteristics—especially in their adherence to AA principles and mandatory AA meetings—anexos in the two countries are not identical (Pagano et al., 2016). It is important to note that anexo participation in our research site is voluntary and corporal punishment is not used, in contrast to some anexos in Mexico that are not registered with the International 24-Hour Movement nor the government. These nonregistered anexos in Mexico operate clandestinely and do not undergo any kind of oversight (Marín-Navarrete, Eliosa-Hernández, Lozano-Verduzco, Turnbull, & Tena-Suck, 2013).

There is limited research in Mexico concerning the anexo's origins, in particular the history of the 24-Hour Movement and the rise of anexos (Rosovsky, 1998, 2009). The extant literature also identifies significant variation among anexos in Mexico according to whether or not they are registered with the Movimiento Internacional 24 Horas Alcohólicos Anónimos or the government, the organization of each anexo, and their policies in regard to being “open” or “closed” to the public (Lozano-Verduzco, Marín-Navarrete, Romero-Mendoza, & Tena-Suck, 2016; Marín-Navarrete et al., 2013; Pulido, Meyers, & Martínez, 2009). More recently, research in Mexico City has examined the unorthodox practices of some anexos that have cast a dark shadow over these recovery centers (García & Anderson, 2016). Some of the reported practices include physical restraint, verbal abuse, prolonged kneeling, and hitting and kicking (García & Anderson, 2016). It is important to note that the anexos in our research site abhor such punitive practices.

Anexos were founded on the premise that individuals with severe SUDs need a facility where they can undergo detoxification and remain for extended periods until they are ready to live independently without the use of alcohol or other drugs (Rosovsky, 2009). During their stay, residents learn about AA, the emotional roots of their SUDs, and the need to maintain their sobriety for their well-being and the welfare of their families.

In the United States, there is little research on Latinos' use of other recovery residences. This may be due in part to the fact that Latinos underutilize SUD treatment services in general as compared to other racial/ethnic groups, despite comparable prevalence of SUDs among this population (Alvarez, Jason, Olson, Ferrari, & Davis, 2007; Castro & Tafoya-Barraza, 1997). There may also be other recovery residences in Latino communities, like the anexo, that have not been identified. One study of 170 Oxford Houses across the country found that Latinos represented only three percent of residents (Jason, Davis, & Ferrari, 2007). The authors attribute the low numbers to a lack of information within the Latino community regarding the existence of Oxford Houses and other recovery houses (Alvarez, Jason, Davis, Olson, & Ferrari, 2009). Because many do not undergo formal SUD treatment, they may not receive referrals to this recovery resource. Another explanation given is that many recovery houses do not offer their services in the Spanish language or incorporate

aspects of Latino culture, making them less attractive to some Latinos with SUDs (Alvarez, Jason, Davis, Ferrari, & Olson, 2004; Contreras et al., 2012).

Despite their low numbers, two studies found that Oxford Houses contributed to the recovery of Latino residents (Alvarez et al., 2009; Contreras et al., 2012). Among the benefits identified were peer support, a sober living environment, and an emphasis on personal accountability. Intervention studies on bilingual/bicultural Oxford Houses, created by researchers to assess their effectiveness for Latinos, found that using the Spanish language and emphasizing cultural values such as *personalismo* (i.e., close and personal relationships), *simpatía* (i.e., harmonious interpersonal relationships), and *familismo* (i.e., emphasis on family) made the modified recovery residence more culturally appropriate for Latinomale residents (Contreras et al., 2012; Jason et al., 2013).

Methods

Setting and objectives

Our 2-year ethnographic study of three anexos was conducted in a mid-size city in Northern California. The main objectives of the study were to identify the help-seeking pathways of Latino males who accessed the anexos in our study; to examine the anexos' recovery-promoting practices; and to assess residents' perceptions of the benefits and drawbacks of anexo programs. We also gathered information on how the anexos are structured and organized and observed their operations on a daily basis over the course of the study. Their histories, characteristics, and recovery promoting practices were compared with one another.

Recruitment and sampling

We began to establish relationships with the anexos in our research site in 2011. Our entrée was facilitated by an anexo resident who volunteered with one of the authors at a nearby community health clinic. That author conducted ethnographic observations and exploratory interviews with current and former anexo directors as part of another project (Pagano, 2014). Three of the four anexos contacted elected to participate in the two-year study described here.

In 2014, we visited each of the anexos and gave a brief presentation on the study at their nightly AA meetings. During these presentations, we introduced ourselves and invited interested residents to speak with us if they wished to be interviewed. In all, we recruited 42 residents, three directors, two former directors, and three assistant directors or *encargados* ($N = 50$) for interviews (see Table 1). Resident numbers in each anexo fluctuated over the course of the research. In general, the first anexo had between 12 and 20 residents, the second had 12 to 24, and the third had between 30 and 50.

We also attended other open AA meetings and events at the anexos and actively recruited interviewees during these visits. Our recruitment strategy combined convenience sampling with purposive sampling, as we attempted to balance proportions of interviewees by nationality (Mexico, United States, or Central American countries), age (18–29, 30–45, 46–60, over 60), and time in the program (0–3 months, 4–6 months, over 6 months) within each

anexo (Bernard, 2006; Marshall, 1996). We oversampled Mexican residents because they were the most prevalent national group in each anexo.

Procedures

First, we conducted over 200 hours of participant observation (over 60 hours in each anexo) between July 2014 and April 2015. Observed events included anexo AA meetings, residents' and directors' sobriety anniversary celebrations, anexo anniversary celebrations, and "down time" during the day. We continually informed anexo residents, especially new residents, about our study. Participant observation sessions ranged from 1 to 6 hours at a time. After each session, we wrote up qualitative field notes detailing our observations. During our observation visits, we sought permission from the individuals present in common areas to stay and observe their activities. We did not enter the dormitories, and the men who were not interested in being observed retired to their sleeping quarters.

Second, we conducted 50 semistructured interviews (42 residents, three directors, two former directors, and three assistant directors). Our interview guide featured questions about demographics, work and migration history, use and abuse of alcohol and illicit drugs, help-seeking trajectory, experiences in the anexos, anexos' structures and routines, perceptions of the anexos' efficacy, and general access to recovery services. Interviews lasted between 1.5 and 2 hours each and were digitally recorded. About three-fourths of the interviews took place in a private room in the anexo, whereas the others took place at nearby restaurants or cafes. All but five were conducted in Spanish; these five were conducted in English or in both Spanish and English. All interviews were transcribed in their original language for data analysis purposes. Each anexo received \$400 in grocery gift cards for participating in the study. At the start of each interview, verbal informed consent was obtained and digitally recorded. Our informed consent procedures and all other human subject protection measures were approved by the Institutional Review Board of the Pacific Institute for Research and Evaluation.

Data analysis

Thematic analysis of qualitative data was guided by grounded theory (Charmaz, 2006; Glaser & Strauss, 1967). After 9 months of field work, we met on several occasions to construct a code book. The code book included a priori themes that were drawn from our study questions and ad hoc themes that emerged from repeated readings of field notes and interview responses (MacQueen, McLellan, Kay, & Milstein, 1998). Interview transcriptions and field notes were then uploaded into the ATLAS.ti software program for coding (Muhr, 2013). We continued to meet during the coding process to ensure agreement on the meanings of codes and their application to specific text passages. Emergent codes were also discussed at these weekly meetings as they were added to the code book.

For the comparison between the anexo and the NARR housing levels, we searched our coded text for information on the different aspects of the anexos' structure, organization, and operation, and categorized germane text according to residence, staffing, administration, and services. The latter four items are key criteria used by the NARR to identify and categorize the recovery residences according to four levels: Level I, Peer-Run; Level II, Monitored;

Level III, Supervised; and Level IV, Service Provider. Themes and subthemes around the four criteria were identified, and included but were not limited to residence types and the characteristics and number of residents, staffing and staff responsibilities, administration practices and policies and procedures, and the different services offered. Information on the four recovery residence levels was obtained from the literature and NARR online resources (see NARR, 2012). We compared the results of our thematic analysis with corresponding NARR information, examining the similarities and differences according to the four criteria across the three anexos and between the anexos and the four NARR levels of recovery residences. The results of the comparison were used to prepare narratives for our findings.

Findings

Our findings are organized according to the sub-elements of NARR's recovery residence levels: residence, staffing, administration, and services. We describe each of the sub-elements, as found in the anexos, and then determine how they correspond to the four NARR levels of recovery residences.

The anexo in Northern California

Similar to many anexos in Mexico and the United States, the anexos in our study consider themselves 24-hour AA groups, although they are not registered with the International 24-Hour AA Movement in Mexico or the AA Central Office in Mexico. They display a modified AA logo (with "grupo 24 horas" printed in the upper right-hand corner) on the windows or doors of their buildings and their names reflect recovery maxims, such as "Learn to Live Again" or "Give Yourself another Chance." Anexos are open to anyone seeking help with only one restriction, gender; the three anexos in our study only accept men.

The majority of residents in the three anexos are immigrants and former migrants from Mexico and Central America. Severe SUDs have disrupted the labor practices of the once-migrants, and consequently they no longer return to their countries of origin. Many have not worked for some time and thus have been unable to provide for their families in the United States or abroad. Some residents immigrated as children with their parents, and a few are second-generation bicultural and bilingual Latinos. Many of the foreign-born residents lack U.S. government authorization to live and work in the United States. Nonlocal residents learn of the anexos from relatives or friends, often coming from the San Joaquin Valley or occasionally from as far away as Nevada. The predominant language in the anexo is Spanish from Mexico and Central American countries, although some residents speak indigenous languages back home. The residents' culture is a hybrid consisting of cultural elements from their countries of origin (primarily Mexico, Guatemala, El Salvador, and for the second generation, the United States). Spanish language use and a familiar culture were reported as major reasons that the men seek out and remain in anexos. Another reason is the residents' ability to share common experiences as immigrant Latinos and support one another through challenges. Their life in the homeland, border crossings, and immigrant experiences are often themes and subthemes in their AA testimonials.

The anexo: Residence, staffing, administration, and services

Residence (physical structure)—The three anexos operate independently but collaborate and support each other by attending each other's AA meetings, group anniversaries, and other AA fellowship events. They also make referrals to each other's anexos if their residence is at capacity. All three are well-established in our research site; at the time of our study, one had been in operation for 7 years, another for 13 years, and the oldest for 17 years. All three are housed in old commercial buildings built decades ago. The buildings have large open floor areas that perhaps once served as stores or storage areas but are now used by the anexos to hold AA group meetings. They also have additional rooms that may have been offices or storage rooms in the past but are now used as sleeping quarters. The floor plans differ among anexos, as do the living arrangements. In one anexo, the meeting room and sleeping quarters are in the same area and building, while in the other two anexos, the sleeping quarters are in different but adjacent building complexes. All three meeting rooms open onto major streets in predominantly Latino urban neighborhoods.

For the sake of brevity, we will only describe in detail the largest of the three anexos. During our study, this anexo served approximately 45 residents at a time on average. Its main location, where AA meetings are held and most residents live, is a rented commercial space on a major boulevard. It occupies the second floor of this commercial space, which is organized into a common area used for AA meetings, two dormitories, a split bathroom, and a kitchen and dining area. Because of the anexo's rapid growth, which was fueled by the demand for treatment, its director also leased a single-family home in a nearby residential area. The second location houses residents who have been at the anexo for at least a year (in most cases) and can afford to pay the higher rent. Residents at this second location return to the main location for nightly AA meetings and special events. At both locations, residents share meals and chores and are generally responsible for the upkeep of the anexo. Both anexo locations are in the city's predominantly Latino neighborhood, and near public transportation.

The residences are not owned by the anexo directors or residents. Rather, directors rent anexo spaces with residents' dues and collections at the anexo AA meetings. When there is shortfall in funds, the directors cover the difference themselves. Following AA Tradition Seven ("Every AA group ought to be fully self-supporting, declining outside contributions"), the anexos are self-sustaining and do not seek or receive government assistance. Each resident contributes \$60–80 each week for room and board, but men are not evicted if they cannot find enough work to cover their stay. In some cases, residents who receive Supplementary Security Income disability or general public assistance sign their checks over to the anexo to cover room and board. However, men who are unemployed or underemployed receive free room and board until they are able to find work again. In the weeks before special events, such as individual sobriety anniversaries or anexo group anniversaries, additional donations are solicited from the residents and others who attend AA meetings at the anexo.

Staffing—True to the AA principle of service, anexo staff are former and current anexo residents who volunteer their time. The anexos have no paid staff or clinicians, as directed in

AA Tradition Eight (“Alcoholics Anonymous should remain forever nonprofessional...”). The top leadership position is that of the director, also referred to as *padrino* (literally, “godfather”), who resides off-site but is present at nightly AA meetings and house meetings. The term *padrino* is also used to refer to an AA sponsor, but when used in reference to a director it signifies his leadership, mentorship, and patronage of the group. The director is usually the founder of the anexo and is either self-appointed or invited to occupy the position when a previous director leaves his post.

The second staffing level consists of one or more encargados, or assistant directors who reside on-site and may receive free room and board. They are usually long-term anexo residents with a year or more of stable recovery, but there are exceptions to this rule. *Encargado* translates roughly as “one who is entrusted with a responsibility.” In the case of the anexo, encargados are responsible for the daily operations of the residence. They ensure that schedules are followed, meetings are attended, and house rules are enforced.

Encargados are selected at the director’s discretion following consultation with the *mesa directiva*, or board, which consists of the anexo director, an encargado, a secretary, a group anniversary organizer, and an AA literature coordinator. Not all board members reside at the anexo; some are external members who attend AA meetings at the anexo. The board primarily manages the anexo’s finances, helps to plan and organize events, such as anniversaries, and helps resolve problems that may arise.

Administration—The anexo is administered according to unwritten house rules under the direction of the director and his selected team. In accordance with AA Tradition 2, which in part reads “Our leaders are but trusted servants; they are not to govern,” the directors and encargados are facilitators rather than authoritarian figures. The residents are given the opportunity to question and make suggestions regarding the daily operations of the residence. Although directors have the final word on how their anexo is administered, they usually inform the residents of decisions and their rationales during evening AA meetings. These meetings serve as house meetings in which the men are given the opportunity to ask questions and share opinions. Decision making regarding daily operations and special events is accomplished largely through group consensus, although not all decisions are discussed or approved by the group. Examples of executive decisions made by the director include determining appropriate disciplinary action for breaking anexo rules, selecting new encargados, and choosing which residents will represent the anexo at state and regional AA conferences.

Services

The three anexos in our study offer similar services. They consist of detoxification, structured living arrangement, service to others, AA group meetings, and aftercare.

Detoxification—Anexos make no distinction between recovery from alcohol versus other drugs; they simply follow the AA program and use AA literature. Our study participants reported long histories of heavy drug use, including alcohol, crystal methamphetamine, marijuana, crank, powder cocaine, crack, heroin and other opiates, ecstasy, PCP, and hallucinogenic mushrooms. Most participants were poly-drug users, often using more than

one drug over the course of their lifetime or in a single episode. Given this heavy drug use, the anexo program often begins with detoxification. If withdrawal symptoms can be managed in-house by experienced residents, the detox takes place at the anexo (i.e., nonmedical or “social” detoxification); if they require medical attention, new arrivals are taken to a local hospital emergency department (Lapham, Hall, Snyder, & Skipper, 1996; Whitfield et al., 1978). Regardless of where it starts, anexo residents complete their detoxification phase in a room isolated from the other residents for three to seven days. This room is referred to as *colchones*, or mattresses. Newly arrived men who have already undergone detoxification do not go through the *colchones* phase. This is rare, since most residents are still using drugs when they reach the anexo.

Structured living arrangement—From the *colchones*, the men join the other residents and are assigned a bed in rooms converted into barrack-style dormitories. During the first few weeks of the program, the new arrivals are not to leave the premises without permission from the director or the *encargado*. To do so is grounds for dismissal. Restricting the men’s time away from the anexo limits their contact with drug-using acquaintances and environments where alcohol and other drugs are available. From the start, the men are encouraged to eat well, rest, and see a doctor if they have a medical problem. Free health clinics are suggested for residents who lack medical insurance. Those with criminal justice involvement are advised to seek free or low-cost legal services from Latino-serving community organizations in the area. If they need to attend a doctor’s appointment or a court hearing, they are accompanied by a resident or *encargado* to make sure they do not drink or use drugs while away from the anexo.

Residents with more time in the anexo may serve informally as *padrinos*, or sponsors, to newcomers, but it should be noted that having a *padrino* in the anexo is not a requirement. *Padrino* and “sponsor,” albeit similar on the surface, are not identical in Latin American and Latino culture. In these cultures, a *padrino* is often associated with Catholic rites, such as baptism, confirmation, and weddings, and as such he is a mentor, patron of important events, and a protector. Anexo residents who serve as *padrinos* offer the new arrivals an orientation to the anexo, advice and help in “working” the recovery program. As in traditional AA groups, a sponsor is someone who has been abstinent for a long period and is prepared to guide a newly abstinent resident in his recovery. *Padrinos* can be fellow residents with more than one year of sobriety, former anexo residents, or members of traditional AA groups.

Residents follow a structured daily schedule with specific times for sleeping, waking, eating meals, performing daily chores, and attending mandatory on-site AA meetings. The structured living arrangement also includes employment. After several weeks, new residents are encouraged and permitted to work outside of the anexo. Typically, they will obtain work either through leads from established residents or at a nearby day labor hiring zone, referred to as *la esquina* (the corner). The employment they obtain tends to be manual, unskilled labor that pays 8 to 10 dollars per hour, although some residents who perform shift work in local businesses, such as car washes, mechanic shops, or restaurants, earn slightly more. Unemployed residents help cook, clean, and maintain the anexos.

The residents are to follow house rules. Each of the three anexos have similar rules which include but are not limited to the following:

- no alcohol or drug use on or off the premises;
- no fighting or violent/threatening behaviors;
- directors or their assistants must be informed of the residents' whereabouts at all times;
- assigned chores must be completed; and
- attendance at nightly (and sometimes daily) AA meetings is mandatory.

Breaking the rules results in disciplinary action. Residents who initiate or participate in verbal or physical violence are asked to leave the anexo. Other infractions (e.g., returning late from an approved family visit, missing an AA meeting without prior approval) result in additional everyday chores, such as cleaning the restrooms, or being restricted to the facility for a short time.

Residents who relapse may be asked to leave the program, but if permitted to stay they are required to return to the colchones and start the program again. Whether they stay or leave depends on the severity of the relapse, how many times it has occurred, the level of remorse shown, and the resident's reputation in the anexo before the relapse event.

Service to others—Service is an integral part of the anexo program, as it is with traditional AA groups. According to director interviews, service promotes responsibility in the residents and occupies them so that they do not dwell on thoughts that are counterproductive to recovery. Residents can provide service in several ways, such as fulfilling specific roles at evening AA meetings. These roles include meeting coordinator, who is in charge of keeping a log of activities, calling on the men to share a testimonial, and keeping order; reader of the 12 steps and traditions and other passages of the AA literature; food and beverage server, also known as *cafetero* (coffee maker) who provides coffee upon request; and donation collector. Residents take turns serving in these positions. Service in the anexo can also involve sitting on the anexo's board (*mesa directiva*) or ad hoc committees created by the board to assist with special events, such as organizing individual sobriety and group services and planning meetings with other anexos and traditional AA groups. For more experienced residents, service may include volunteering at local community organizations, speaking at other AA groups' events, or even visiting community clinics or churches to speak about AA and recovery.

AA group meetings—The structured life of the anexo includes mandatory, nightly, 2-hour-long AA meetings. One anexo in our study had an additional mid-morning meeting for residents who did not work during the day. These meetings are open to the public and incorporate cultural elements and rituals characteristic of AA culture in Mexico and Central America, such as the use of the Spanish language; cross-talk; jokes about masculinity rife with sexual innuendo; frequent references to God, saints, and the presence of Catholic iconography in meeting spaces; and making the sign of the cross after the sobriety prayer. Some of these practices have been noted in other studies of Latino AA groups (Davis, 1994;

Hoffman, 1994; Room, 1998). Members of Spanish-language AA groups attend the anexo AA meetings to show their support and solidarity, and anexo members attend outside AA meetings, especially for abstinence anniversaries. Testimonials at anexo AA meetings center on alcohol and drug abuse, related transgressions, and group members' trials and tribulations with their recovery efforts in their homelands and in the United States. Mexican and Central American colloquialisms and regional idioms are used to make a connection with fellow countrymen. Cross-talk, or exchanges between the speaker at the podium and audience members, is common. It is used to identify with the speaker's experience, to question the speaker's sincerity, or to make jokes about something the speaker is saying or about the behavior of another resident or AA group member. Although cross-talk is discouraged in English-language AA, it is socially normative at many Spanish-language/Latino AA meetings in the United States (Hoffman, 1994).

Every month, a particular step (one for each of the 12 months) is emphasized in the group meetings, but other steps can be discussed if requested by meeting attendees. Although encouraged by directors, studying the 12 steps individually is not the main priority. The focus, rather, is on putting them into practice and discussing difficulties and successes in doing so at the group meetings. The first step, in particular ("We admitted we were powerless over alcohol - that our lives had become unmanageable"), is constantly reinforced in anexo AA meetings to remind residents of the severity of their addictions.

Aftercare—Although a 12-month stay is recommended, the men are free to leave the anexo at any time during the program. Readiness to leave is determined by the resident in consultation with his padrino, if he should have one, the director, and encargado. Although no formal assessment is used in the anexos, the resident's recovery progress is monitored. Directors shared that they assess progress using two main factors: how long the individual has maintained his sobriety, and the personal growth he has demonstrated during interpersonal interactions and testimonials. Evidence of personal growth, according to directors, includes exhibiting unselfish behaviors and thinking, taking responsibility for one's actions, and showing evidence of working the AA traditions and steps into one's daily life.

The anexo has no formal aftercare. It is up to former residents to stay committed to their sobriety and recovery. They are encouraged to continue attending nightly AA meetings at the anexo or elsewhere, and to stay in touch with their padrino. The meetings are important because, as residents and directors explained, the meetings help the individual to purge whatever is bothering him and to be in close fellowship with others who have similar struggles. Men who live nearby after their stay often continue to attend AA meetings at the anexos, and may attend Spanish-language AA groups in or near their neighborhoods. The men are also encouraged to continue their service at the anexo, either as a member of the mesa directiva or by serving as a padrino to the residents, and to the community-at-large by spreading the word of the anexo and AA.

The anexo and NARR recovery residence types

NARR identifies four recovery residence types—Level I, Peer-Run; Level II, Monitored; Level III, Supervised; and Level IV, Service Provider—using residence, staff, administration, and services as criteria (NARR, 2012). Level I are single family structures with no paid staff and are administrated democratically according to a standard manual or set of policies and procedures. Services include drug screening, house meetings, and non-mandatory self-help meetings. Examples of Level I recovery residences are Oxford Houses (NARR, 2012).

Level II are single family residences but may include other dwelling types. There is at least one paid staff member and a house manager or senior resident and a set of policies and procedures. Services consist of structured living around house rules, peer-run groups, drug screening, house meetings, and involvement in self-help and/or in house clinical treatment services. Sober living houses, similar to those in southern California, are examples of Level II recovery residences (NARR, 2012).

Level III vary in residential settings but have a facility manager and certified staff or case managers, an organizational hierarchy, oversight for service providers, policies and procedures, and licensing. Services include an emphasis on life skill development, clinical services in the community, and in-house service hours. Examples of Level III recovery residences are “social model” recovery programs, “which emphasize experiential learning, peer support, and 12-step recovery principles within a semi-structured group living environment” (NARR, 2012).

Level IV also vary in residential settings but with a more institutional environment, including paid and credentialed staff, clinical and administrative supervision, policies and procedures, and licensing. Services are clinical and ancillary programming and focuses on housing and life skill development. Examples of Level IV recovery residences include residential therapeutic communities for drug treatment (NARR, 2012).

In regard to physical residence structures, the anexos in our study include aspects of NARR Levels II and III. One anexo in our research site (not enrolled in our study) is more in line with Level I, as it is housed in a single-family dwelling. One of the three anexos in our study is housed in an old commercial building with a converted second-floor space for AA meetings and sleeping quarters. The other two anexos are housed in multiple adjacent buildings, including one where AA meetings are held and colchones residents stay, and one or more other buildings with apartments for established residents.

As for staffing, anexos are more in line with NARR Levels I and II. The staff is limited to directors and assistant directors who make decisions independently of the residents and are responsible for the daily operations of the anexo. They do not undergo any formal preparation; that is, they are not licensed, as clinicians and therapists are. The directors are either founders of the anexo or former assistant directors who took over after one of the directors stepped down. Assistant directors are selected on the basis of their longevity at the anexo, trustworthiness, and stage of recovery. Two of the three anexos in our study had staffing arrangements similar to those in Level I; that is, there were no paid staff. The other

anexo was similar to Level II in that its encargado (assistant director) was not paid, but received free room and board. This arrangement is closer to NARR Level II residences but is not common among anexos in our research site.

The administration of the anexos resembles some features associated with NARR Levels II and III. The leadership in the three anexos consists of the directors and the encargados who work closely with a board made up of appointed members. Together, the director, encargados, and board form an organizational hierarchy and run the anexos according to an internal, unwritten policy and set of procedures. Despite this top-down administrative model, the residents have opportunities to make suggestions and voice opinions at group meetings.

The services at the anexos are similar to those in NARR Level I and II recovery houses, and have some features of Level III. Similar to Level I, the anexos hold house meetings, and one of the three anexos occasionally conducts urine and breath testing of residents suspected of a relapse. Similar to Level II, the anexos provide structured living around house rules and require mandatory participation in evening AA meetings. Also, as in Level III houses, the anexos emphasize life skill development by encouraging the residents to seek and hold employment, manage resources, and to work on familial and other personal relationships.

Discussion

As described above, the anexo does not fall within a single NARR typology. The three anexos in our study have characteristics and practices found in three of the four levels of recovery residences: peer-run (Level I), monitored (Level II), and supervised (Level III). In regard to physical residence structure, the anexos are similar to Level II and III. The anexos are housed in different types of buildings, and as such do not conform to a single recovery residence type. Buildings are selected according to their location and availability, appropriate space, and affordability. The structures are located in Latino neighborhoods or nearby communities and are selected to accommodate group meetings and to house anexo residents. This space can be a single structure, as is one of the three anexos in our study, or it can be a building with a meeting hall and adjacent apartments, as is the case in the other two anexos. Rent and utilities must be affordable, given that these primary expenditures are paid in the collective by the residents, some of whom are not always gainfully employed. All three anexos are known to the local authorities, including the judicial system that accepts anexo stays as fulfillment of mandated SUD treatment. Anexos operate openly as informal, community-based recovery houses where individuals with SUDs help one another through the process of recovery.

The staffing of the anexos is similar but not identical to NARR level I. The staff are not paid, which is similar to Level I, but the anexos are not administered democratically according to written policies and procedures, as may be the case with Level I. In line with AA traditions, the anexos adhere to a self-help philosophy in which the men depend on each other for their sobriety and sustained recovery. This self-help takes the form of communal service, which excludes hiring therapists or other clinicians at the anexo and compensating staff. AA traditions also state that groups must be as self-sufficient as possible, which means not only

that they should not receive funding from outside sources, but also that they limit their recovery practices to the AA steps and traditions.

The anexos in our study feature administrative practices more in line with NARR Levels II and III. Despite their adherence to AA philosophy, anexos are not self-governed; that is, residents do not have much of a say in how the anexo should be operated, as is the case in Level I recovery residences. Anexos also are not administered, monitored or supervised by outside bodies, such as governmental agencies or licensed service providers, including clinicians. The anexos are administered by the director, a former resident who follows an unwritten but consistent set of policies and procedures, assistant directors, and board members. They run and supervise the activities at the anexo in a hierarchical fashion. Rules, directives, and reprimands are from the top down. These administrative practices are similar to those of anexos registered with the International 24-Hour Movement in Mexico.

The services in the anexo are similar to those in NARR Level I, II and III. Anexos offer a continuum of services from detoxification to aftercare under the same roof, except for detoxification requiring medical care. As with the administrative practices, these services are similar to those provided by anexos in Mexico (i.e., AA meetings, informal sponsorship, and aftercare). Together, the services address many areas of recovery in a single comprehensive program.

A major reason that the anexos are similar to more than one NARR level is that the anexos are not part of any recovery residence association in the United States or the 24-Hour AA Movement in Mexico, and as such are not subject to any of their regulations. It also is not based on residence recovery models found in the United States, but is rooted in a different cultural tradition—the 24-Hour AA Movement in Mexico—and reflects features associated with that tradition. Three decades ago, traditional AA groups in Mexico City opened anexos so that individuals who could not afford residential treatment could have a place to sober up and work on their recovery. The anexo was a grassroots response to an immediate and growing need. Today, as in the past, anexos in Mexico arise where space is available and do not operate according to a standardized set of procedures, other than putting into practice the AA program in a residential setting. The vast majority of group members are low-income with chronic substance use disorders. Private treatment is beyond their means, and government-run clinics are scarce, if available at all, in much of Mexico.

The anexo in Northern California is also a grassroots response to a community need. Latino immigrants and migrants turn to the anexos for assistance with their substance use disorders, as do second-generation Latinos. Unlike immigrants and migrants, who are not always eligible for government-sponsored recovery programs because of their immigration status, second-generation Latinos have other options. Yet, as we have discovered, some prefer the anexo over other programs. Immigrants, migrants, and the second generation share a common language, a similar culture, and often undergo similar experiences of exclusion in the United States, regardless of their citizenship status. These cultural similarities bring them together for a common cause—their recovery and the recovery of others.

Although anexos in our study approximate the anexo model of Mexico, they have made significant modifications due to different cultural and political realities in the United States, as discussed elsewhere (Pagano, Garcia, Recarte, & Lee, 2016). Unlike their Mexican counterparts, Northern California anexos are not established or maintained by a traditional AA group in the community. They are independent, and each one operates according to its own policies and procedures. The anexo is not known outside of the Latino community, and there are challenges to opening anexos that are not necessarily faced in Mexico or other countries. In these countries, discrimination, anti-immigrant sentiments, zoning laws, safety regulations, and not-in-my-backyard reactions are less of a barrier than they are in the United States. The anexos in our research site have adapted to the U.S. cultural and political contexts and have come to resemble sober living houses in some ways (Pagano et al., 2016).

Our exploratory study on the help-seeking pathways of Latino immigrants generated data that allowed us to characterize the anexo, who it serves, and how it works. Our study did not include measures on its effectiveness or comparisons of its outcomes to those of other recovery residences. Our next study on the anexos will address its effectiveness in recovery. In addition, despite our long-term ethnographic fieldwork, it is important to acknowledge that our findings pertain to the anexos in our research site of Northern California, and may not be generalizable to anexos in other parts of the United States. Although there is a well-established literature on recovery houses, up until now it has not included the anexo. More research on this understudied recovery house should be a priority.

Conclusion

Anexos provide much-needed recovery services in Latino communities and serve some of the most marginalized and vulnerable populations suffering from SUDs. Their services are affordable; do not require medical insurance; are linguistically and culturally appropriate; and are not based on immigration or citizenship status. Thus, for many undocumented residents in the United States, the anexo is their only option for recovery services. Recovery residences are often described as part of the “continuum of care,” that is, as a complement to ongoing treatment interventions or as aftercare for individuals who have graduated from a residential treatment program. By contrast, anexos are the entire continuum of care for many immigrants and other Latinos with SUDs. They admit residents, help them through detoxification, provide a structured program with incremental increases in independence, help residents to rebuild their lives by connecting them with employment, medical, and social services, and provide informal aftercare for those who complete the program. They are a self-sustaining, grassroots recovery house model that represents a community-based response to a critical gap in SUD services for a present and expanding U.S. workforce.

References

- Alvarez J, Jason L, Davis M, Olson B, Ferrari J. Latinos and Latinas in communal settings: A grounded theory of recovery. *International Journal of Environmental Research and Public Health*. 2009; 6(4):1317–1334. [PubMed: 19440520]
- Alvarez J, Jason L, Olson B, Ferrari J, Davis M. Substance abuse prevalence and treatment among Latinos and Latinas. *Journal of Ethnicity in Substance Abuse*. 2007; 6(2):115–141. [PubMed: 18192207]

- Alvarez J, Jason LA, Davis MI, Ferrari JR, Olson BD. Latinos and Latinas in Oxford House: Perceptions of barriers and opportunities. *Journal of Ethnicity in Substance Abuse*. 2004; 3(4):17–32.
- Bernard, HR. *Research methods in anthropology: Qualitative and quantitative approaches*. Lanham, MD: AltaMira Press; 2006.
- Castro, FG., Tafoya-Barraza, HM. Treatment issues with Latinos addicted to cocaine and heroin. In: Garcia, GG., Zea, MC., editors. *Psychological interventions and research with Latino populations*. Boston, MA: Allyn & Bacon; 1997. p. 191-216.
- Charmaz, K. *Constructing grounded theory: A practical guide through qualitative analysis*. London, England: Sage; 2006.
- Coatecatl, J. Alcohólicos Anónimos, con 37 años en México. *La Razon*. 2012. <http://razon.com.mx/spip.php?article135036>
- Contreras R, Alvarez J, DiGangi J, Jason LA, Sklansky L, Mileviciute I, Navarro E, Gomez D, Rodriguez S, Luna R, Lopez R, Rivera S, Padilla G, Albert R, Salamanca S, Ponziano F. No place like home: Examining a bilingual-bicultural, self-run substance abuse recovery home for Latinos. *Global Journal of Community Psychology Practice*. 2012; 3(3):1–11.
- Davis, KG. *Primero Dios: Alcoholics Anonymous and the Hispanic community*. London, England: Associated University Presses; 1994.
- Garcia A, Anderson BT. Violence, addiction, recovery: An anthropological study of Mexico's anexos. *Transcultural Psychiatry*. 2016; 53(4):445–464. [PubMed: 27535824]
- Glaser, BG., Strauss, AL. *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine; 1967.
- Hoffman F. Cultural adaptations of Alcoholics Anonymous to serve Hispanic populations. *Substance Use & Misuse*. 1994; 29(4):445–460. DOI: 10.3109/10826089409047392
- Jason, L., Olson, B., Mueller, D., Walt, L., Aase, D. Residential recovery homes/Oxford houses. In: Kelly, JF., White, WL., editors. *Addiction recovery management*. New York, NY: Humana Press; 2011. p. 143-161.
- Jason LA, Davis MI, Ferrari JR. The need for substance abuse aftercare: Longitudinal analysis of Oxford House. *Addictive Behaviors*. 2007; 32(4):803–818. doi:<http://dx.doi.org/10.1016/j.addbeh.2006.06.014>. [PubMed: 16843612]
- Jason LA, Digangi JA, Alvarez J, Contreras R, Lopez-Tamayo R, Gallardo S, Flores S. Evaluating a bilingual voluntary community-based healthcare organization. *Journal of Ethnicity in Substance Abuse*. 2013; 12(4):321–338. DOI: 10.1080/15332640.2013.836729 [PubMed: 24215225]
- Jason LA, Ferrari JR. Oxford House recovery homes: Characteristics and effectiveness. *Psychological Services*. 2010; 7(2):92. [PubMed: 20577571]
- Lapham SC, Hall M, Snyder J, Skipper B. Demonstration of a mixed social/medical model detoxification program for homeless alcohol abusers. *Contemporary Drug Problems*. 1996; 23:331.
- Lopez-Tamayo R, DiGangi J, Segovia G, Leon G, Alvarez J, Jason LA. Psychological factors associated with substance abuse and anxiety on immigrant and U.S. born Latinos. *Journal of Addiction & Prevention*. 2016; 4(1):1–10.
- Lozano-Verduzco I, Marín-Navarrete R, Romero-Mendoza M, Tena-Suck A. Experiences of power and violence in Mexican men attending mutual-aid residential centers for addiction treatment. *American Journal of Men's Health*. 2016; 10(3):237–249.
- MacQueen K, McLellan E, Kay K, Milstein B. Codebook development for team-based qualitative analysis. *Field Methods*. 1998; 10(2):31–36.
- Majer JM, Chapman HM, Jason LA. Comparative analysis of treatment conditions upon psychiatric severity levels at two sources among justice involved persons. *Advances in Dual Diagnosis*. 2016; 9(1):38–47. [PubMed: 27158265]
- Marín-Navarrete R, Benjet C, Borges G, Eliosa-Hernández A, Nanni-Alvarado R, Ayala-Ledesma M. Comorbidity of substance use disorders with other psychiatric disorders in mutual-aid residential treatment centers. *Salud Mental*. 2013; 36:429–437.
- Marín-Navarrete R, Eliosa-Hernández A, Lozano-Verduzco I, Turnbull B, Tena-Suck A. Estudio sobre la experiencia de hombres atendidos en centros residenciales de ayuda mutua para la atención de las adicciones. *Salud Mental*. 2013; 36(5):393–402.

- Marshall MN. Sampling for qualitative research. *Family Practice*. 1996; 13(6):522–526. DOI: 10.1093/fampra/13.6.522 [PubMed: 9023528]
- Mericle AA, Miles J, Cacciola J, Howell J. Adherence to the social model approach in Philadelphia recovery homes. *International Journal of Self Help and Self Care*. 2014; 8(2):259–275.
- Movimiento Internacional 24 Horas Alcohólicos Anónimos. El Movimiento Internacional 24 Horas de Alcohólicos Anónimos. 2016. Retrieved from <http://aa24horas.com>
- Muhr, T. ATLAS.ti Scientific Software. Berlin, Germany: ATLAS.ti Scientific Software Development GmbH; 2013.
- National Association of Recovery Residences. An introduction and membership invitation from the National Association of Recovery Residences. 2011. Retrieved from <http://narronline.org/wp-content/uploads/2013/09/NARR-White-Paper-111006-final.pdf>
- National Association of Recovery Residences. A primer on recovery residences: Frequently asked questions. 2012. Retrieved from <http://narronline.org/wp-content/uploads/2014/06/Primer-on-Recovery-Residences-09-20-2012a.pdf>
- Pagano A. Barriers to drug abuse treatment for Latino migrants: Treatment providers' perspectives. *Journal of Ethnicity in Substance Abuse*. 2014; 13(3):273–287. [PubMed: 25176120]
- Pagano A, García V, Recarte C, Lee JP. Sociopolitical contexts for addiction recovery: Anexos in U.S. Latino communities. *International Journal of Drug Policy*. 2016; 37:52–59. [PubMed: 27588569]
- Polcin DL. Sober living houses: Potential roles in substance abuse services and suggestions for research. *Substance Use & Misuse*. 2001; 36(3):301–311. [PubMed: 11325168]
- Polcin DL. Communal living settings for adults recovering from substance abuse. *Journal of Groups in Addiction & Recovery*. 2009a; 4(1):7–22. DOI: 10.1080/15560350802712355 [PubMed: 19424443]
- Polcin DL. A model for sober housing during outpatient treatment. *Journal of Psychoactive Drugs*. 2009b; 41(2):153–161. DOI: 10.1080/02791072.2009.10399908 [PubMed: 19705677]
- Pulido M, Meyers M, Martínez A. Algunos datos acerca del funcionamiento de una muestra de grupos de autoayuda en México. *Revista Mexicana Investigación Psicología*. 2009; 1:85–97.
- Room R. Mutual help movements for alcohol problems in an international perspective. *Addiction Research & Theory*. 1998; 6(2):131–145.
- Rosovsky, H. Diversity in unity: Studies of Alcoholics Anonymous in eight societies. Vol. 33. Helsinki, Finland: Nordic Council for Drug and Alcohol Research; 1998. Alcoholics Anonymous in Mexico: A strong but fragmented movement; p. 165-184.
- Rosovsky H. Alcohólicos Anónimos en México: fragmentación y fortalezas. *Desacatos*. 2009; 29:13–30.
- Whitfield CL, Thompson G, Lamb A, Spencer V, Pfeifer M, Browning-Ferrando M. Detoxification of 1,024 alcoholic patients without psychoactive drugs. *Journal of the American Medical Association*. 1978; 239(14):1409–1410. [PubMed: 633543]
- Wittman FD, Polcin D. The evolution of peer run sober housing as a recovery resource for California communities. *International Journal of Self Help&Self Care*. 2014; 8(2):157–187. DOI: 10.2190/SH.8.2.c [PubMed: 25477748]

Table 1Sample characteristics ($N = 50$).

Features	<i>n</i> (%)
Age (in years)	
<i>M</i> (<i>SD</i>)	40.5 (12.6)
Median	38
Range	20–75
18–24	4 (8)
25–34	15 (30)
35–44	13 (26)
45–60	16 (32)
over 60	2 (4)
Country of origin	
Mexico	34 (68)
United States	6 (12)
Guatemala	4 (8)
El Salvador	4 (8)
Honduras	2 (4)
Education (years of school)	
None	2 (4)
Elementary (1–6 years)	11 (22)
Middle (7–9 years)	8 (16)
High (10–12 years)	18 (36)
College (12+ years)	11 (22)
Marital Status	
Single	29 (58)
Married	4 (8)
Separated/divorced	16 (32)
Widower	1 (2)
Immigration status	
Undocumented	29 (58)
Permanent resident or TPS	14 (28)
U.S. citizen	7 (14)

Note. TPS = temporary protected status.