Social Model Recovery and Recovery Housing

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Abstract

Recovery housing is an important resource for many in their recovery from alcohol and other drug use disorders. Yet providers of recovery housing face a number of challenges. Many of these challenges are rooted in stigma and bias about recovery housing. The ability to describe the service and purported mechanisms of action vis-a-vis an overarching framework, approach, or orientation could also go a long way in adding credence to recovery housing as a service delivery mechanism. Several aspects of social model recovery are often explicitly built or organically reflected in how recovery housing operates, yet describing recovery housing in these terms often does little to demystify key features of recovery housing. To more fully cement social model recovery as the organizing framework for recovery housing this article aims to: review the history, current status, and evidence base for social model recovery; comment on challenges to implementing the social model in recovery housing; and delineate steps to overcome these challenges and establish an evidence base for social model recovery housing.

Key words: Recovery, social model, recovery housing, recovery residences, peer support, experiential knowledge

Introduction

Like many conditions that involve periods of recurrence and remission, addiction to alcohol and other substances requires management of different phases of the condition (McLellan, Lewis, O'Brien, & Kleber, 2000; McLellan & Woodworth, 2014). Management of these different phases of addiction is often referred to as a person being in recovery. While a number of definitions of recovery have been put forth since the early 2000's, a central feature of these definitions is that they describe personal changes that extend beyond substance use (U.S. Department of Health and Human Services & Office of the Surgeon General, 2016). More recently, the Recovery Science Research Collaborative (RSRC), convened in December 2017, defined it as an "an individualized, intentional, dynamic, and relational process involving sustained efforts to improve wellness" (Ashford et al., 2019, p.5). This definition not only highlights recovery as wellness, but also notes interpersonal processes that support it.

Recovery housing as an intervention to build recovery capital

One increasingly common type of recovery support service that has been studied more than most other support services is recovery housing (Jason, Wiedbusch, Bobak, & Taullahu, 2020; Laudet & Humphreys, 2013; Mericle et al., 2022). As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), recovery housing is "an intervention that is specifically designed to address the recovering person's need for a safe and healthy living environment while supplying requisite recovery and peer supports" (Substance Abuse and Mental Health Services Administration, 2019). These recovery and peer supports provided within the context of recovery housing can help build recovery capital (Cano, Best, Edwards, & Lehman, 2017; Polcin, Mahoney, Witbrodt, & Mericle, 2020), generally conceptualized as the resources (physical, social, human, and cultural) that individuals bring to their recovery (Cloud & Granfield, 2008).

Recovery housing can go by various names, including recovery homes, recovery residences, sober homes, sober living environments, Oxford Houses™, halfway houses, and therapeutic communities.

Further, as delineated by the National Alliance for Recovery Residences (NARR), they can vary in the type and intensity of services they provide (Mericle, Miles, Cacciola, & Howell, 2014; National Alliance for Recovery Residences, 2015). Regardless of what they are called or what types and intensities of services provided, a key aspect of recovery housing is reliance on peers living in the same environment to provide support for one another. This is central to social model recovery, which highlights the importance of experiential knowledge, peer interaction, and community engagement reflected in a range of settings clinical and non-clinical settings (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998).

Challenges and barriers to providing recovery housing

Growing numbers and an ever-expanding evidence base for recovery housing (Reif et al., 2014) has led to recovery housing being listed on the SAMHSA's Evidence-Based Practices Resource Center webpage. However, recovery housing still exists largely outside of the formal substance use continuum of care and operators of recovery housing continue to face a number of obstacles to establishing and keeping their recovery residences open. Some of these obstacles are rooted in stigma and prejudice against persons who are in recovery from addiction to alcohol and other substances, which stubbornly persist (Barry, McGinty, Pescosolido, & Goldman, 2014; Lloyd, 2013).

Negative attitudes towards individuals with substance use disorders are often rooted in misunderstandings of the nature of addiction and recovery, and this can translate into negative attitudes about the value of recovery support services like recovery housing. Misunderstanding about the nature of recovery housing—what it is and how it works, only exacerbates this. In fact, in seminal work on stigma and recovery housing conducted by Jason and colleagues (Jason, Roberts, & Olson, 2005), researchers found that knowledge of an Oxford House in one's neighborhood led to improved attitudes toward those in recovery and self-run recovery residences. Similarly, a study of sober living houses in California showed that positive attitudes toward the houses were often a result of houses

practicing “good neighbor” policies that prohibited substance use and encouraged community service (Polcin, Henderson, Trocki, Evans, & Wittman, 2012b).

Further, unlike medical and other clinical services, peer support is a key feature of recovery housing as an intervention. This may also lead to suspicion and negative attitudes from the general public and from professionals as well. Unfortunately, services delivered by peers are often seen as less valuable or important than services delivered in more traditional “treatment” settings and by doctors or other treatment providers (Jack, Oller, Kelly, Magidson, & Wakeman, 2018; Moran, Russinova, Gidugu, & Gagne, 2013). A potential antidote to this way of thinking among treatment professionals may be increasing their familiarity with recovery housing. In a study assessing attitudes toward California sober living houses among mental health and substance use professionals, Polcin and colleagues (2012a) found that knowledge about and familiarity with them was associated with more supportive attitudes. Being better able to describe the service and purported mechanisms of action vis-a-vis an overarching framework, approach, or orientation could also go a long way to: adding credence to recovery housing as an intervention/service delivery mechanism; guiding the delivery of recovery housing; and directing future research on practices within it.

Purpose and aims

Recovery housing can be critical resource for those in recovery, but it is not well understood. As noted above, several aspects of social model recovery are often explicitly built or organically reflected in how recovery housing operates. Unfortunately, the phrase “social model recovery” sometimes does little to clarify what recovery housing is or how it works. To help demystify this key feature of recovery housing, this article aims to: review the history, current status, and evidence base for social model recovery; comment on challenges to implementing the social model in recovery housing; and delineate steps to overcome these challenges and establish an evidence base for social model recovery housing.

Social Model Recovery: History and Evidence Base

History and characteristics of Social Model Recovery

Social model recovery emerged as an offshoot of Alcoholics Anonymous (AA), the 12-step/12-traditions of mutual help groups of voluntary peers; members meet in small groups to achieve abstinence and develop a new "way of living" based on sharing their "experience, strength, and hope" obtained from their lived recovery experience (Alcoholics Anonymous, 1939). The 12-steps refer to the program of personal change for individuals to self-direct their recovery journey within the context of peers who vary in the amount and depth of lived recovery experience available to guide and support them (Noorani, Karlsson, & Borkman, 2019).

The first social model entities were actually recovery homes known as "12-step" houses in California, where recovering alcoholics could live in affordable rental housing with recovering peers. Peers were thought to benefit when they provided help to their others, a dynamic Riessman (1965) referred to as the 'helper-therapy' principle. California was distinctive in the confluence of a strong AA grassroots movement as well as state and local policies and practices favorable to the development of state-wide services (Wittman & Polcin, 2014). By the 1970s, social model programs evolved to a full continuum of care, encompassing social detoxification (see O'Briant & Lennard, 1973), neighborhood recovery centers and recovery homes renamed from "12-step" houses. While individual "12-step houses" developed around the country, only California has a documented system of social model recovery services. In fact, researchers in California developed the Social Model Philosophy Scale (Kaskutas, Greenfield, Borkman, & Room, 1998) to assess therapeutic and recovery-oriented processes across six domains (physical environment, staff role, authority base, view of substance use problems, governance, and community orientation) and measure the extent to which they reflect guiding principles of the social model philosophy.

Wright (Wright, 1990) summarized the model's primary characteristics as: (1) the basis of knowledge and authority is lived recovery experience, not formal education and degrees; (2) the principle relationship is between the person and the social model recovery program, not a one-to one between the person and a therapist; (3) all participants are help givers and help receivers; (4) AA's basic principles and dynamics constitute the fundamental framework of programs; (5) a positive sober environment that protects persons from society's alcohol/drug using culture is crucial; and (6) alcoholism and drug problems are viewed as being centered in the reciprocal relationship between the person and her networks and community. Staff, if any, were more seasoned recovering peers who minimize their authority in order to remain egalitarian. Staff's role is to manage the environment, not the participants. Social model recovery also expanded from the recovering person as the focus to also consider the community at large and the institutional and policy forces that shape substance use behavior of citizens. This became known as the social-community model and included preventive efforts to limit problematic drinking and drug use in the community.

Social model leaders historically distinguished treatment from recovery support, a distinction which continues and signals a key paradigm shift. According to the social model, treatment is done by professionals and recovery is shared by people in recovery helping others in recovery. Leaders saw treatment as focused primarily on a person's functioning whereas recovery would give meaning to an individual's life as well as restoring function (Dodd, 1997). Recognizing social model recovery as an alternative paradigm to the professional models of medical/clinical treatment alerts the reader to the significantly different assumptions, language, principles and practices of the social model (Borkman, 1998).Increasing professionalization and the medicalization of addiction services as well as federal regulations and funding changes by the 1990s led to the demise of "pure" social model recovery programs and as a system of public services in California (Borkman, Kaskutas, & Owen, 2007). Sober living houses in California remained as exemplars, as they were often freestanding, financially self-

supporting and relatively unconnected to the health care and treatment environment. However, versions of "12-step" houses and other "social model" services appeared around the country wherever a strong and coherent AA fellowship developed, but they were largely undocumented and may not have explicitly been recognized as implementing social model recovery (Borkman et al., 1998). Unfortunately, much of the literature about the social model largely consists of "grey" literature from government reports, conference proceedings, or unpublished conference presentations; an edited book containing papers from social model leaders is out of print (Shaw & Borkman, 1990). Notable exceptions are described next.

Evidence for social model recovery in treatment settings

The three most methodologically rigorous studies of the social model come from treatment settings and compare social model to clinical programs in California. The first study (n=722) found that individuals in social model programs were less likely than those in clinical programs to report drug/alcohol problems at the one-year follow-up, though odds of reporting other problems were similar (Kaskutas, Ammon, & Weisner, 2003). The second study was a clinical trial of 271 individuals randomized to receive hospital-based day treatment or community-based day treatment using the social model; ethnographic observations using a checklist based on the Social Model Philosophy Scale (Kaskutas et al., 1998) showed that abstinence rates at follow-up and average costs were similar between the hospital-based program and the community-based program that continually demonstrated fidelity to social model principles (Kaskutas, Witbrodt, & French, 2004). The third study, a clinical trial of 733 SUD treatment-seeking individuals, found no significant differences in abstinence at follow-up between day treatment clients and clients in the community-based social model program (Witbrodt et al., 2007). Furthermore, cost-analyses show that stays at the residential programs were longer, but costs per day were lower (Kaskutas, Zavala, Parthasarathy, & Witbrodt, 2008). These findings underscore that, with

comparable investment in social model programs to support adequate stays in the residential care, social model programs can produce comparable abstinence outcomes.

Evidence for social model recovery in sober living homes

Three large-scale studies of sober living homes in Northern California and Southern California have demonstrated improved outcomes of individuals in these settings. The first study tracked functioning of 300 individuals residing in 20 different SLHs over an 18-month period. Results showed significant improvement on a wide variety of variables including alcohol and drug use, 6-month abstinence rates, alcohol and drug related problems, psychiatric symptoms, employment, and arrests (Polcin, Korcha, Bond, & Galloway, 2010a; Polcin, Korcha, Bond, & Galloway, 2010b). The second study assessed substance use, HIV risk and other outcomes among persons entering houses who are on probation or parole (N=330); some of whom were recruited from houses that were randomized to have participant receive a motivational interviewing and case management intervention. This study found that at 6- and 12-month follow-up, residents in both groups reported significant improvement on measures of substance abuse, criminal justice involvement, HIV risk, and employment (Polcin, Korcha, Witbrodt, Mericle, & Mahoney, 2018). The third study is currently focusing on the role of the social environment within sober living houses and neighborhood environments surrounding them with respect to resident outcomes. As part of this study, the researchers developed the Recovery House Environment Scale (RHES), which was developed by the research team to assess issues that are central to social model recovery. Higher scores on the RHES have been found to be positively associated with length of stay and negatively associated with days of substance use (Polcin, Mahoney, & Mericle, 2021). Results from this work highlight the importance of the social environment in sober living houses, particularly those most closely aligned with social model recovery principles.

Challenges to Adopting and Implementing the Social Model in Recovery Housing

Recovery housing, irrespective of geographical location or time, draws extensively from 12-step traditions and inherently reflects social model principles. It is important to note that, despite these roots within 12-step traditions, recovery housing best practices underscore the importance of evidence based-practices to treat addiction, such as pharmacotherapies specifically approved by the Food and Drug Administration (FDA) for treatment of opioid use disorder, as well as ensuring appropriate support and access to other medications with FDA-approved indications for the treatment of co-occurring disorders (SAMHSA, 2019). Further, in the past 10-15 years, concerted efforts have been made to better articulate the role and relevance of social model recovery in recovery housing as an intervention or service modality. Yet despite inherent and explicit links between the social model and recovery housing, challenges to adopting social model recovery as the organizing framework and implementing into day-to-day activities exist.

Lack of awareness or understanding of the social model is a key barrier to embracing it as an organizing framework for recovery housing. Unfortunately, many individuals who have benefited from social model programs often lack awareness of or language to describe it. For example, the term social model is entirely absent from key publications that describe and define recovery-oriented system of care (ROSC) principles (Sheedy & Whitter, 2006; White, 2008). This is unfortunate, because while the guiding principles of ROSC touch on key social model elements (e.g., the importance of peer-support and community-based recovery support), they do not capture the essence of social model recovery philosophy. A stronger link could have enriched early conversations about recovery support services and elevated the centrality of social model principles. Lack of understanding and awareness has likely also contributed to gaps in the evidence base for the social model approach, as programs or approaches that are social model in nature, such as Oxford Houses and therapeutic communities, may not be identified, conceptualized, and researched as such (Borkman et al., 2007; Borkman et al., 1998).

Ideological biases also present barriers to embracing the social model. As Polcin and colleagues (2014) note, viewing addiction and recovery in a broader environmental perspective runs contrary to cultural norms in the U.S. that view addiction as personal failing and recovery as a function of personal responsibility. Ideologies favoring physiological or biological explanations for addiction (Institute of Medicine, 1990) have also led to a number of barriers for social model programs. Policies and infrastructure at the federal, state, and local levels have not been designed to support social model programs. Instead, emerging recovery services have been expected to interface with payment models and infrastructure designed for medical and other behavioral health services. As a result, recovery support service providers are pressured to take on characteristics of these kinds of programs, such as time-based service units delivered by a credentialed provider documented with treatment notes, which may decrease adherence to the social model (Kaskutas, Keller, & Witbrodt, 1999).

Professionalization and specialized knowledge regarding how to obtain funding and otherwise ensure credibility and solvency may inadvertently undermine key elements of the social model such as resident governance, peer support, and experiential knowledge (Kaskutas, Greenfield, Borkman, & Room, 1998). Some social model programs may hire clinicians because workforce development and career paths primarily focus on addiction treatment, and it may be difficult for staff to "take their clinician hat off", which can undermine social model principles. Even hiring a certified Peer Specialist can be problematic because the peer specialist role and curriculums lack emphasis on social model competencies. Those living in recovery residences with low recovery capital and/or high service needs (disease severity/complexity) often require more support than what they can pay for out-of-pocket. This may pressure recovery residences to look for funded services, which has typically been treatment. Some may refer out to treatment; others add treatment services (Mericle, Polcin, Hemberg, & Miles, 2017). In either case, they begin to describe themselves in treatment terms because that is what the market

values. As their business model, culture, and self-identity become clinical, they can lose their social model foundation.

At the practitioner level, one of the most visible proponents of the social model has been the National Alliance for Recovery Residences (NARR). Founded in 2011, NARR is 501-c3 nonprofit organization dedicated to expanding the availability of well-operated, ethical and supportive recovery housing. NARR has established national best practice standards (the NARR Standard) and identified four general types of recovery housing, known as levels of support, which range in the type and intensity of services they provide (see Figure 1; National Association of Recovery Residences, 2011). The NARR Standard 3.0 operationalized the social model across four Domains, 10 Principles, 31 Standards and their individual rules (National Alliance for Recovery Residences, 2018). NARR has also published a compendium to the Standard 3.0, which helps readers understand how the social model recovery is referenced throughout and provides a practical crosswalk from social model principles to recovery housing practices. Figure 2 also summarizes how elements of recovery housing map on to domains outlined in the Social Model Philosophy Scale (Kaskutas et al., 1998). NARR currently supports 30 state affiliate organizations, which means that not all states receive guidance on implementing the NARR Standard, and even states with NARR-affiliated organization may be under-resourced to ensure implementation it. For example, Mericle and colleagues (2014) found that, although average scores on some subscales were high, only a small percentage (11%) of the homes studied in Pennsylvania met criteria to be considered true social model programs. Average scores on the Social Model Philosophy Scale were even lower in a more recent study examining the characteristics of recovery housing in Massachusetts (Miles, Mericle, Ritter, & Reif, 2022).

Discussion: Future Directions for Social Model Recovery Housing

In an attempt to address these challenges, fully cement social model recovery as the organizing framework for recovery housing and establish an evidence base for social model recovery housing, we

close by offering recommendations to combat lack of awareness and prejudice as well as more structural barriers leading to marginalization of social model programs. We also provide recommendations regarding ensuring fidelity and measuring social model adherence within recovery housing.

Increasing awareness and understanding

Despite its consonance with established recovery principles (Substance Abuse and Mental Health Services Administration, 2011), social model recovery has historically been undervalued and overlooked. However, as peer support workers become a more common element in addiction treatment settings (Substance Abuse and Mental Health Services Administration, 2021) and as the field increasingly recognizes social determinants of health (Braveman, Egerter, & Williams, 2011), there is an important opportunity to highlight how these are supported within social model recovery. Experiential knowledge is a bedrock of the social model as is the focus on fit between the community at large and the institutional and policy forces that shape substance use behavior. Championing and training on the social model recovery is critical to raising awareness and providing operators with tools needed to implement it. However, specific training on the social model is not readily available across the U.S. and has not been recognized or supported in the recovery movement as serving as the foundation for the peer workforce. NARR's embracing of the social model and guidelines on how to implement within the NARR Standard is an important step forward, but more is needed to solidify its place within the delivery of recovery housing and other recovery support services.

Monitoring fidelity and developing an evidence base

Even with increased awareness and understanding of social model recovery, it is critical to ensure that programs are indeed providing recovery housing that is consistent with the social model so that research on these programs can be used to establish an evidence base for social model recovery housing. It is important that recovery residences located in states lacking a NARR Affiliate to provide

certification still operate their residence in accordance to social model principles. Further, certification to the NARR Standard may not be enough to ensure that day-to-day operations are consonant with and reinforce social model principles. To that end, Polcin et al., (2014) offer a number of practical suggestions on how to enhance social model principles across a variety of scenarios and situations common in the provision of recovery housing (e.g., resident admissions, relapse, conflicts among residents, resident crises, helping residents access services, and interacting with those in neighborhood and local community). These examples may provide useful guidance and support to recovery residence operators on how to operationalize social model recovery into the home's daily activities.

It is equally important to train providers to self-assess whether the social model is reflected in the residences that they operate. Although the Social Model Philosophy Scale was designed to assess adherence to the social model approach, it was not designed specifically for recovery residences and may have inherent limitations regarding how residents experience the recovery housing environment (Mahoney, Witbrodt, Mericle, & Polcin, 2021; Mericle et al., 2014). And while the newly developed RHES (Polcin et al., 2021) shows promise, it has yet to be used to examine how recovery housing environments are experienced by residents in settings other than sober living houses in California, and it focuses on fewer aspects of the social model than the Social Model Philosophy Scale. Finally, although the NARR Standard focuses on program features that are consistent with social model recovery, the social environments within recovery residences are heavily influenced by the residents living in the home and those charged with managing the day-to-day operation of it, so assessments of the recovery housing environment should account for these factors as well. This kind of fidelity assessment is critical to linking the nature of the environment to resident outcomes, thereby identifying evidence-based practices and more generally establishing an evidence base for social model recovery residences. This sort of assessment could also help researchers identify who does best in these sorts of environments as well as how these environments may contribute to improved outcomes.

Supporting and sustaining social model recovery housing programs

Because revenue models often drive service offerings, appropriate funding policies and mechanisms are needed to support social model recovery growth, sustainability, and coordination. Since the social model setting is the service (Wittman, Jee, Polcin, & Henderson, 2014), suitable mechanisms will fund settings that uphold social model principles. Examples of discretionary and block grant programs that have supported social model recovery settings, like recovery housing, and have the capability to promote fidelity through eligibility and technical assistance requirements have included: Access to Recovery (ATR), Recovery Community Service Program (RCSP); Targeted Capacity Expansion (TCE) and Building Communities of Recovery (BCOR). Funding for social model programs may need to shift from outputs (e.g., discrete services delivered) to outcomes that can be translated into economic impact, so funders understand the return on their investment.

More than service dollars, the proliferation and sustainability of social model recovery programs requires an investment in infrastructure and workforce development that reflect its principles. Many recovery housing programs lack the infrastructure and contribution margins to cost-effectively interface with third-party billing mechanisms (Mericle et al., 2014; Mericle et al., 2017). Addressing this issue, the State of Ohio invested both state and federal dollars to: (1) fund a statewide network that coordinates recovery housing infrastructure development (strategic planning, community organizing, training, technical assistance, certification and grievances) and (2) fund recovery housing vouchers, programs and capital improvements. The use of peer-led statewide networks is reflective of social model principles and of SAMSHA statewide network programs: Statewide Recovery Community Network and Statewide Consumer Network programs.

Summary and Closing Remarks

Recovery housing has historically operated outside of the formal substance use treatment system and faces many challenges regarding lack of understanding, professional disdain, and stigma. Linking

recovery housing to an overarching service delivery approach could help in elevating it to its proper place within a robust substance use continuum of care. However, this also means increasing awareness and understanding of social model recovery, developing and using tools to monitor fidelity to the social model as it is implemented in recovery housing to enhance the evidence base for it, and prioritizing funding mechanisms that support and sustain social model recovery housing programs.

Figure 1. NARR Recovery Residence Levels Described

Level	Description
Level I (Peer-run)	Level I residences are democratically run houses where residents elect officers and vote on decisions. Residents are expected to work, share expenses, and pay rent. Although each house is autonomous, they often receive external guidance and support. Oxford House™ is the best example of these residences.
Level II (Monitored)	Level II residences are typically located in residential neighborhoods. Unlike Level I houses, they have a house manager or senior resident who is either paid or receives a reduction of rent. Beyond social model recovery and mutual support, there are typically few to no services offered on-site. Residents are usually required or strongly encouraged to attend 12-step or other mutual aid society recovery groups in the local community. Residents are expected to attend house meetings, work or go to school and pay rent. Sober living homes in California are good examples of these residences.
Level III (Supervised)	Level III residences employ and supervise certified or trained staff who provide non-clinical services, such as recovery coaching, recovery wellness planning, recovery support groups, and life skills training. Since many people cannot afford to pay out-of-pocket for this level of support, Level IIIs often solicit donations, apply for grants or leverage supplemental revenue streams. This type of residence goes by various names, and they serve individuals who need a higher level of support or oversight to remain integrated in the community.
Level IV (Clinical)	Level IV residences offer licensed residential treatment in addition to the services found in Level IIIs. Due to their longer-term nature and emphasis on peer support resident responsibilities, therapeutic communities (TC's) are a good example of level IV facilities. In Texas, some licensed supportive residential facilities are Level IVs.

Figure 2. Social Model Philosophy Domains and Key Recovery Housing Elements

Social Model Philosophy Domains	Recovery Housing Elements
Physical environment	Safe, supportive home free of alcohol/illicit drugs
Staff role	Staff and leaders are part of the community; not distant superiors
Authority base	Lived experience of recovery is credible knowledge
View of dealing with alcohol problems	Focus is on recovery, a person-driven, holistic and lifelong process
Governance	Peers play a role in decision making and upholding rules
Community-oriented	Prosocial bonds are cultivate within and outside the home

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