

# The Social Model of Recovery

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## SAMHSA's definition of recovery:

*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."*

Substance Abuse and Mental Health Services  
Administration (SAMHSA)

## NARR's definition of recovery residences:

*Recovery residences are sober, safe, and healthy living **environments** where residents are most likely to achieve recovery from alcohol, drugs, and other associated problems. We believe that recovery residences should foster the development of a sense of **community** where individuals improve their physical, mental, spiritual, and social well-being. The goal of recovery residences should be to assist people they serve to make transitions to independent, productive and meaningful lives of their own choosing.*

## Expectations:

The definitions above are loaded with **expectations** that recovery residences provide more than space, beds, dining areas, and rules and regulations for maintaining the residence:

- ✓ We engage people in a *process of change* to help them improve their health and wellness. Wellness is more than physical health. It implies mental and spiritual dimensions as well.
- ✓ We help people gain the courage to self-direct their lives in healthy ways.
- ✓ We help people find and strive for their full potential (as individuals, workers/professionals, family members, community members, and citizens of nations). Yes, we provide sober, safe *environments*, but notice that the word *healthy* is reiterated with all of its various levels of meaning (wellness, included). And think about the fact that an *environment* is most often created by a space and by the people and actions that take place in it.

- ✓ We create environments where residents "are most likely to achieve recovery from alcohol, drugs, and other associated problems." How are they "likely to achieve" unless we provide useful models, practice, support, and opportunities to learn by doing and making mistakes and getting meaningful feedback from caring, knowledgeable, and capable peer supporters?
- ✓ We promote the idea of **community**, which implies positive, productive interactions with multiple people in multiple settings. As we know, community is part of functional, meaningful family life, workplaces, living in a neighborhood, living in a town or city or state or nation. Community is part of having friends and outlets for our talents and interests as well. It is also a central ingredient in learning how to get along with people whose company we don't necessarily enjoy.

Recovery residence professionals serve as

- ❖ Caretakers
- ❖ Models of effective behavior, controlled emotions, and rational thought
- ❖ Teachers/Guides/Mentors
- ❖ Motivators
- ❖ Confidants
- ❖ Peers
- ❖ Advisors
- ❖ Monitors/Gatekeepers
- ❖ Planners

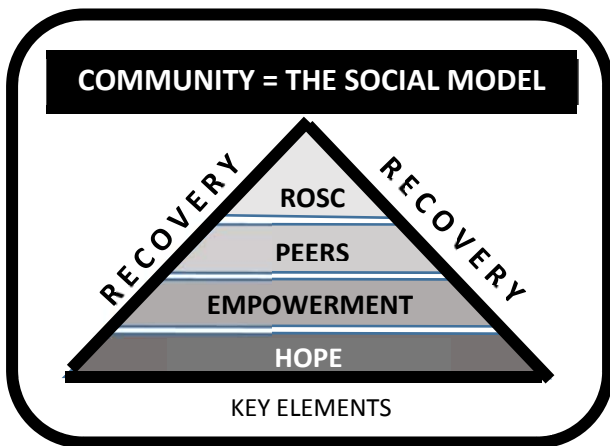
In other words, recovery professionals must be able to handle a wide range of human interactions (social exchanges).

The key to a Social Model is the power of interactions focused on helping people improve.

Most of us in the recovery professions also know that **HOW** people interact with others has profound effects on how people use their time on this planet. The people we deal with in the recovery professions come to us damaged by their use of substances and/or inattention to their co-occurring disorders and/or traumatic life experiences as

children and adults. Because of their problems, they have likely cut themselves off from most of the positive, supportive people in their lives and have found whatever human connection they can find in others like themselves who put their substance disorders ahead of positive human support networks they might have sought. We often find that the people we serve report feeling “worthless.” They have often lost faith that they are worthy of being around “decent people.” They often believe they are beyond hope or redemption.

Our reality as recovery residence professionals is that, “If they could have solved their problems on their own, they would probably have done so. They need the **support, guidance, and encouragement** of people who care about their health and welfare and **what they want and are willing to do.**” In essence, what this all comes down to is an understanding that recovery involves a human need for positive, productive, engaging social interactions. AA/NA/AL-ANON, and all the other “anonymous” as well as SMART Recovery, Celebrate Recovery, and others, have built on this concept of social interaction for a very long time. However, though these resources are effective for many people and can be a part of the recovery residence life, they don’t always go far enough to assist our residents in their day-to-day experiences.



**SOCIAL MODEL ELEMENTS**  
**(ROSC = Recovery-Oriented System of Care)**

In the Social Model, recovery is enhanced by a belief in a person’s sense of hope for a better future, and an ability to assist in and control the recovery process. Recovery is supported by a community of peers willing to share their experiences and to assist the individual on the journey to recovery, essentially becoming part of a functional family. A recovery-oriented system of care provides the individual with professional and community support services beyond a recovery residence to address the needs of the **whole person**.

**Philosophy and practices of the Social Model are different from medical/clinical-based treatment models.**

Most of us working in recovery residences are not doctors, nurses, psychiatrists, psychologists, or social workers. However, we ARE caregivers and need to be aware that we “serve and support people” as our primary mission (and we must be consistently aware that we have the potential to harm people as well if we do not do our jobs effectively). The kind of care we can give is different from what those professionals in clinical settings can give.

We must be careful not to confuse what we do with what those specialists do. However, at the same time, we do things that those specialists cannot do: we provide a **functional family**—*structure, nurturing, kindness, guidance, and unconditional positive regard*. Ideally, we work in concert with all of those professionals to provide the best possible experience we can give our residents to increase their likelihood of success.

- First and foremost, we believe that people can and do get better, particularly if they are supported by peers who are effectively prepared to assist them in the process of setting **their** goals, in determining the appropriate means for **their** recovery process, and in developing and monitoring **their** plans for improvement over time. The reality is that we spend a great deal of time with our residents probably far more than any doctor or counselor—and we get to know the people we work with very well on a **personal level** in ways clinical people seldom have time to do.
- We see residents under different conditions from what the medical and psychological professionals see. We deal with them in a **home**, not a hospital or clinical facility.
- We deal with the **day-to-day realities** of our residents’ lives over a period of time and see them sick and well, wide-awake and tired, strong and vulnerable, positive and negative, and can observe characteristics which might lead to insights that clinicians might not pick up on for long periods of time.
- Many of us are **peers** who have **lived experience** with what our residents are experiencing and can offer support and understanding in ways that physicians, nurses, psychologists may not be able to understand through means other than their training if they do not have lived experience.

- We **talk as peers**, and we **interact with our residents as peers**, not patients.
- We **use the vocabulary of peer support**, NOT clinical talk. Those we serve are “residents,” not “clients.” We do not provide “facilities”; we provide homes.” We don’t emphasize talk of “treatment,” but talk in terms of “recovery.” And we do not talk in terms of “cure,” but in terms of processes of growth and change.

**The Social Model emphasizes interpersonal aspects of recovery.**

Learning/change does not happen in a vacuum. The Social Model proposes that learning happens when people interact, when they get opportunities to explore the world, get praise for accomplishments, and gain constructive feedback as they struggle through life’s challenges. In many ways, this concept correlates with a “Strengths-Based Approach” that is so often spoken about in recovery literature. When people get feedback about their strengths and see them appreciated, they often begin to build self-esteem, and then, a willingness to try new things or revisit past dreams and to imagine a new life for themselves. In essence we provide opportunities for residents to begin to grow again by creating the structures that are ordinarily developed in functional families. In the process of working on interpersonal relationships with residents, we help them to develop a renewed sense of caring for others and assuming responsibility for their fellow residents, the recovery community and the community at large.

Support beyond recovery residences may too often be limited to a once-a-week appointment with a doctor or counselor or an occasional chat with a friend or a one-hour AA/NA meeting too far off for the person in need. This is particularly true early in a person’s recovery. People often need support when they need it: day or night, weekends, and holidays—much like one would find in a functional family.

**“Recovery emerges through socially mediated processes of social learning and social control.”**

**David Best**

**The Social Model emphasizes experiential knowledge and mutual support.**

Many people working in recovery residences are people with lived experience and have, thus, had to

overcome substance-use disorders. They know first-hand what residents are going through. They know how difficult it is to stop using, how difficult it is to change one’s life, how it feels to be cut off from friends and family, and how it feels to live in despair. They also know that it is through redeveloped **hope** that they began to recover. Hope is the foundation for recovery for the people who come to our residences . . . **if hope is there for them to find**. Hope often comes in the experience of being around people like themselves who have had substance use disorders and yet have overcome the problems they face. They are more likely to trust advice from someone who has “been there” and less likely to trust the advice of those who only have an “idea” of what it means to have “been there.”

**The Social Model supports recovery as a person-driven, life-long, and holistic process.**

As you can see, the header above has three parts. The first part (“**person-driven**”) is perhaps one of the most difficult parts of a Social Model for people who feel strongly about the methods of recovery that “worked for them.” Accepting that the residents we bring into our recovery residences are autonomous human beings can be difficult, especially early on when they are confused, struggling to understand their options, and are desperate for answers, etc. Most of us like to help, and when someone else doesn’t know what to do, our tendency is to offer what worked for us. Unfortunately, what works for one person may be absolutely the wrong thing for someone else, and what works for them might not work for the next person who walks through our doors. Some of our residents, may know exactly what works and doesn’t work for them; others will be guessing; some just plain don’t know and need time to find their way. Our goal must be to help them find **their way**.

A major emphasis in the Social Model is to empower residents to take charge of their own lives and begin making effective choices that meet **their goals**, whether or not **their goals** happen to coincide with our own ideas of what they “should” do.

For most of us in long-term recovery, we have come to know that years of abstinence do not necessarily equate with freedom from addiction. Under the right circumstances, many of us could get caught up in our old behaviors or some new variation of them. As a result, we tend to be ever vigilant and encourage others to treat their substance-use disorders as something to be wary of throughout their lifetimes. Those of us who “have been there,” recognize the destruction of our old behaviors and

the devastation they caused us, our loved ones, our finances, our careers, etc. Based on the experiences of our own observations of others in recovery and the best research available at this time, it is wise to encourage the perception that recovery is a life-long process of **becoming** recovered; **never** “**recovered.**”

The third part of the header has to do with the “**holistic**” concept. Those of us who are in recovery know that “recovery” is about much more than discontinuing use of a substance. It is about changing our lives: the ways we think, the ways we behave, and the ways we interact with others. Many of us have co-occurring disorders. Many of us struggled early on with low self-esteem. Many of us had experienced traumas that affected the ways our brains developed. Many of us were raised in families where we were not given adequate opportunities to learn things that other healthier people take for granted and perhaps where we didn’t get health or dental or psychological care. Many of us have had long-standing beliefs that we could not trust or love others and could not be trusted or loved . . . even by ourselves.

A common saying in AA circles is that “All we are asking is that you change everything!” At NARR, we recognize that people coming into recovery need far more than a safe place to live in a sober living environment; we need help that comes only from numerous wrap-around services (medical and psychological) and caring people willing to work with residents to help them sort out what has happened to them and how they can begin to move forward with their own lives as THEY want their lives to move forward.

Each human being has a right to determine his/her own destiny. We cannot determine in advance of getting to know that person what that destiny is. It is only through the ongoing social interactions of getting to know a person as deeply as possible that we can begin to help that person get where s/he is wanting to go. Crucial to this fundamental view is that healthy people may choose to go in directions different from where we think they “should” go . . . **and that’s ok.**

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### **So, does your recovery residence follow The Social Model of Recovery?**

In 2016, at the Annual Conference of the Ohio Recovery Housing organization, Jason Howell, a current NARR Board Member and a nationally recognized leader in the recovery residence field provided an excellent

outline to help recovery residence providers determine whether or not their residences were meeting the essence of The Social Model of Recovery. His presentation was adapted from Kaskutas, L.A. et. al. (1998). Measuring Treatment Philosophy: A Scale for Substance Abuse Recovery Programs. *Journal of Substance Abuse Treatment*, Vol. 15, No. 1, pp. 27–36.

#### **To what degree does it feel like a home?**

- The physical space of a social model program is vital.
- It must promote interaction between staff and participants and each other.
- Social model environments feel more like homes rather than clinical settings.

#### **To what degree are staff respected peers vs. distant superiors?**

- Social model programs encourage staff to mingle with participants.
- Some of the best insight, feedback and interactions happen in an informal or community setting.

#### **To what degree is authority based on lived experience?**

- Social model programs by and large employ persons in recovery (often alumni).
- Believe recovery imparts experiential knowledge, an invaluable resource.
- Professional knowledge is not valued over experiential knowledge.

#### **To what degree is the program recovery-oriented?**

- Social models programs have a recovery-oriented view and approach, understanding that recovery is person-driven, lifelong, and a “whole-person” process.
- Understanding that alcohol and drugs are only a part of the problem.

#### **To what degree does accountability involve peers?**

- Social model programs utilize peers to establish and enforce program rules in a significant way.
- Participants will feel more invested in the program and their own recovery and get to develop skills.

**To what degree is the community viewed as a resource?**

- Social model programs recognize that individuals must learn how to reach out and connect with a web of support in the community, including friends, mentors, social activities, employment.

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**A FEW RESOURCES:**

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Polcin, Douglas L., Amy Mericle, Jason Howell, Dave Sheridan, and Jeff Christensen “Maximizing Social Model Principles in Residential Recovery Settings.” *Journal of Psychoactive Drugs*. Retrieved February 18, 2017 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4220294/>.

Vrticka, Pascal. “Evolution of the ‘Social Brain’ in Humans: What Are the Benefits and Costs of Belonging to a Social Species?” Retrieved February 18, 2017 from [http://www.huffingtonpost.com/pascal-vrticka/human-social-development\\_b\\_3921942.html](http://www.huffingtonpost.com/pascal-vrticka/human-social-development_b_3921942.html).

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People are **social** creatures who need human interaction to drive and sustain their physical, intellectual and emotional development. The determination of who they interact with from the time of birth throughout their lifetimes is critical to who they become, how they behave, and how they are perceived (or misperceived) by others outside their immediate social environment.

Becoming immersed in new environments filled with caring, positive, empathetic, empowering people can have significant impact on people whose ability to thrive has been compromised by substance-use disorders. A properly implemented social model plan can enhance a person’s recovery process.

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