HHS Public Access

Author manuscript

Alcohol Treat Q. Author manuscript; available in PMC 2023 April 27.

Published in final edited form as:

Alcohol Treat Q. 2023 ; 41(2): 173–186. doi:10.1080/07347324.2023.2167528.

Moving Social Model Recovery Forward: Recent Research on Sober Living Houses

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Abstract

Social model recovery is a peer centered approach to alcohol and drug problems that is gaining increased attention. This approach is well-suited to services in residential settings and typically includes living in a shared alcohol- and drug-free living environment where residents give and receive personal and recovery support. Sober Living Houses (SLHs) are recovery residences that explicitly use a social model approach. This paper describes recent research on SLHs, including new measures designed to assess their social and physical environments. We conclude that our understanding of social model is rapidly evolving to include broader, more complex factors associated with outcomes.

Keywords

Recovery Home; Training; Sober Living House; Social Model; Recovery Residence; Peer Support

Introduction

It is now well recognized that many persons with alcohol or drug problems require more than acute care interventions (Saitz, et al., 2008). Mutual-help programs, such as Alcoholics Anonymous (AA), have been important because persons can stay involved as long as they wish and derive the benefits of ongoing peer support. However, some individuals live in environments that undermine their recovery efforts. Residential recovery homes are a good option for many of these individuals because they provide an abstinent living environment and peer recovery support.

Because many states do not license or monitor recovery homes, ascertaining the exact number across the U.S. is difficult. However, Mericle et al. (2022) used a variety of sources to locate 10,358 residences in the U.S. Recovery homes vary in terms of their physical

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Declaration of Conflicting Interests: The author(s) declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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settings, fees, rules, requirements for involvement in mutual help groups, staffing, structure, governance, types of services offered, relationship with formal treatment programs, and lengths of stay.

Sober Living Houses

Sober living houses (SLHs) are one type of recovery home that is particularly common in California. Relative to other types of residences, SLHs are explicit in their use of a social model approach to recovery. Conceptually, the social model perspective views addiction and recovery as occurring via a reciprocal interaction between the individual and his or her social environment (Wright, 1990). To maximize the beneficial effects of SLHs, service providers create a physical setting, social environment, and shared sense of responsibility among residents that supports recovery (Wittman, et al., 2014). Fundamental characteristics of the social model approach include a goal of abstinence from alcohol and illicit drugs, peer support, resident input into house decisions, and resident participation in household tasks such as cooking and cleaning. In addition, residents are typically required or strongly encouraged to attend mutual help groups such as 12-step programs and develop an individualized recovery plan. Professional clinical services are not offered on-site, but residents can pursue and are encouraged to access services in the community as needed (e.g., dental, medical, mental health, job training, etc.).

SLH operations are overseen by a house manager, who is typically a person in recovery and often a person who has lived in an SLH as a resident. House managers ensure rent and bills are paid, monitor compliance with house rules, and arrange for repairs as needed. However, there is variability in how involved managers are in supporting the residents' recovery. Recent survey data suggest some managers spend considerable time and effort supporting resident recovery, whereas others see their role as primarily administrative (Polcin, Mahoney, & Mericle, 2020). One concern from a social model perspective is that managers who focus on helping residents with recovery tend to meet with them individually rather than consider ways to increase peer support and strengthen the recovery environment in the house.

Descriptions of the history and evolution of social model recovery and their origins in California SLHs are chronicled in several publications (e.g., Polcin, 2001; Mericle, et al., under review; Wittman & Polcin, 2014). The earliest versions of SLHs began in Los Angeles in the late 1940's in response to housing needs among persons attending AA. Known as "twelve step" houses, they implemented a very basic version of social model recovery that required alcohol and drug abstinence, attendance at AA meetings, payment of rent, and participation in upkeep of the house. In the 1970's publications began describing the characteristics of SLHs and used the term "social model" to describe their recovery approach (Wittman & Polcin, 2014). By 1990 more publications addressed social model recovery and they expanded the theoretical conceptualization and implications for practice (e.g., Shaw & Borkman, 1990). The overarching shift was to view addiction and recovery from an ecological systems perspective (e.g., Bronfenbrenner, 1979) as interactive processes between individuals and their environments. Another way to understand the shift was articulated by Borkman (2008) in her work on self-help groups: "You alone can do it,

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but you can't do it alone." This characterization acknowledges the personal responsibility for recovery as well as the importance of mutual aid (i.e., interdependence with others). Implications for SLH service providers included a stronger focus on building recovery environments that generated peer support, experiential learning, resident empowerment, and commitment to supporting others in the household.

Identifying Social Model Services

By the late 1990's there was increased clarity about what was meant by social model in California. However, a number of questions remained. Although most SLHs and many other types of recovery homes self-identified as using a social model approach to recovery, it was often unclear to what extent they implemented a range of social model principles. For example, if a program mandated 12-step attendance and encouraged peer support, was that sufficient to be considered a social model program? If these characteristics were part of the operations of a residence but there was also a strong emphasis on clinical and medical services, should that be considered a social model program? Could a program be considered social model if there were no mechanisms in place for resident input in management decisions even if other social model characteristics were evident? To what extent was it possible to integrate some aspects of social model but not others?

A crucial step toward informing these questions was the development of the Social Model Philosophy Scale (SMPS) by Kaskutas et al (1998), which has versions for both residential and non-residential programs. The SMPS consists of six subscales that measure distinct aspects of social model: the physical environment, staff roles, authority base, view of substance abuse problems, governance, and community orientation. Data are collected from in-person interviews with program directors or residence managers.

One purpose of the SMPS is to provide an overall cutoff score that indicates whether a program meets criteria to be described as a true social model program. Another purpose is to use subscale scores to show areas of strength and weakness in the implementation of social model. Research has shown that some aspects of social model are more prevalent than others. For example, Mericle and colleagues (2014) studied recovery residences in Philadelphia and found wide variation of subscale scores. Most recovery home service providers rated their homes high on recovery philosophy but low on peer governance. Thus, subscale scores provide a way to assess different aspects of social model so recovery residences can more strategically address social model aspects that are limited.

Classifying Types of Recovery Homes

Social model recovery principles are used to varying degrees in diverse types of recovery programs (Borkman, Kaskutas & Owen, 2007), but their use might be most widespread in peer operated recovery residences. An increasing number of recovery residences are members of the National Alliance of Recovery Residences (NARR), which provides advocacy, support, training, and standards for recovery homes across the U.S. NARR's four levels of housing range from those that are peer run (Level I) to those that are clinically focused (Level IV). NARR and its state affiliates (e.g., the Sober Living Network in California) promote using social model recovery in all four levels of recovery residences

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(NARR, 2012). However, SLHs (Level IIs) are the most explicit in using social model recovery as a guiding influence for their operations (Wittman & Polcin, 2014). In addition, social model recovery has been studied extensively in these types of residences. For these reasons, we focus our discussion herein primarily on social model issues in SLHs although many of the issues and dynamics discussed may also apply to other types or levels of recovery residences. Although Oxford Houses operationalize many aspects of social model recovery, they self-identify as separate from social model. Being part of the larger Oxford House organization is viewed as an essential component of the recovery approach. For an analysis of the relative advantages and disadvantages of leadership in SLHs and Oxford Houses see Polcin, Mahoney, and Mericle (2020b).

Sober Living House Outcomes

Early studies of programs using a social model approach found outcomes were similar to clinically based programs but often less expensive (Borkman, et al., 1998). Currently, social model recovery is largely centered in residential recovery homes and most extensively evident in SLHs. Favorable outcomes for SLH residents of have been found in several studies. For example, Polcin et al (2010a, 2010b) examined a broad range of residents (N=300) entering 20 SLHs. Significant, sustained improvements were found at 18-month follow-up for abstinence, frequency of substance use, arrests, mental health, and employment. Improvements were noted across a broad range of residents and two characteristics of social model recovery were associated with better outcome: involvement in 12-step programs and substance use characteristics of residents' social networks. Although residents made improvements on psychiatric severity, higher severity was associated with worse alcohol and drug outcome (Polcin & Korcha, 2017).

A separate study examining outcomes for SLH residents (N=330) who had current involvement in the criminal justice system found higher severity of problems at entry into the house but similar improvements over 12 months (Polcin, et al, 2018). Higher levels of recovery capital were associated with better outcomes and an add-on motivational interviewing case management (MICM) intervention was effective in providing additional benefit for higher functioning residents (Witbrodt, et al., 2019).

Purpose

The current paper has paper has three aims:

1. To provide an update of recent research showing the effects of SLH social environments, architectural characteristics, and neighborhoods on resident outcomes. New measures that assess the social and physical environments in houses are described.
2. A second aim considers how SLH managers and others can use recent findings to improve services. Important questions include: How should recent research findings affect the way SLH managers think about and perform their roles? What changes and modifications should SLH providers make in response to the new research? What additional research would be helpful to house managers? To what extent should providers of other types of recovery homes consider

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implementing social model-based changes informed by recent research on SLHs?

3. A final aim is to discuss strategies for disseminating information about social model recovery to various stakeholders. We support recovery home organizations such as NARR and its state Affiliates mandating certification and ongoing training for SLH managers and staff in other types of recovery residences.

Measuring the Recovery Environment

Recent studies of social model recovery have gone beyond previous studies that described outcomes and identified individual predictors, such as resident involvement in 12-step groups, characteristics of their social networks, and level of psychiatric severity (Polcin et al., 2010a, 2010b). Using the newly developed measures described below, we are moving more toward identifying house characteristics associated with outcomes, such as the strength of social model recovery in residences (Polcin et al., 2001) and architectural characteristics of the physical setting that could influence recovery (Polcin et al., 2023).

Recent studies have also begun to assess the influence of the neighborhoods where SLHs are located (Mahoney et al., 2023; Subbaraman et al., under review). Examples of neighborhood characteristics being studied include resident perceptions about crime, community cohesion in the neighborhood, and availability of services (e.g., public transportation). Additional factors include more objective measures, such as economic status of the neighborhood, the proximity and density of mental health and substance use services as well as destructive influences (e.g., alcohol outlets). The following sections briefly overview of house and neighborhood factors and considerations for using these findings to improve outcomes.

Recovery Home Environment Scale

The Recovery Home Environment Scale (RHES; Polcin, Mahoney & Mericle, 2021a) is a new measure that assesses the frequency of social model activities among recovery home residents. Although the measure is useful in a variety of recovery home settings, it was developed and assessed using SLH residents. Eight items assess resident perceptions about activities in the house that are relevant to social model recovery, including social support for recovery, integration of 12-step work into daily house interactions, general and recovery oriented helping among residents, perceptions about the effectiveness of house meetings, and the degree to which residents have input into house operations. . Each item is rated on a 5-point Likert-type scale ranging from “not at all” to “a lot.” The scale’s psychometric properties were found to be strong, including measures of factor structure, reliability, construct validity, and predictive validity. Importantly, higher levels of social model in the houses were associated with significantly better outcomes, including longer retention in the house (Mahoney, Witbrodt, Mericle & Polcin, 2021), higher levels of recovery capital (Polcin, Mahoney, Witbrodt & Mericle, 2020), and less substance use (Polcin, Mahoney, & Mericle, 2021a).

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Recovery Home Architecture Scale

Important aspects of recovery houses that have been largely overlooked include characteristics of the physical environment in the home. To address this shortcoming, a recent study (Polcin et al., 2023) used a sample of 41 SLHs to develop a measure of architecture, the Recovery Home Architecture Scale (RHAS). The RHAS assesses the overall architecture quality in the homes and operations related to health and safety. Data are collected using observations of the home and property and are supplemented by interviews with house managers. Using the scale, the authors assessed whether physical setting characteristics of the houses were associated with outcomes. Related to that was the question of how SLHs could use mobilize architecture and maintenance procedures to improve recovery.

The RHAS consists of six subscales measuring various aspects of architecture: house maintenance, safety and security, sociability, personal and residence identity, furnishings, and outdoor areas. A copy of the instrument is available from the first author upon request. Psychometric properties included adequate levels of reliability, factor structure, and construct validity (Polcin et al, 2023). At 12-month follow-up, higher scores on the sociability subscale were associated with lower psychiatric severity (Subbaraman et al., under review). However, other subscales were not associated with psychiatric severity and none of the subscales were associated substance use. The overall scores consistently indicated a high level of good architecture and the limited variability of the subscale scores may have made it difficult to find associations with outcomes. It might be necessary to recruit houses with more varied levels of architecture to establish significant relationships.

Using the RHES to Enhance the Social Model Recovery Environment

Most items on the RHES have clear implications for how house managers can improve social model dynamics in recovery homes. For example, if RHES items addressing involvement in 12-step or other mutual support recovery groups are low, recovery homes might improve those scores using several strategies including requiring attendance at a minimum number of meetings per week, offering on-site meetings at the house with or without community members attending, encouraging groups of residents to attending meetings together, and discussing ways to use 12-step recovery principles to address conflicts among residents and manage personal crises. To address low scores on social interaction and peer support, houses could structure regular social and recreational outings for residents. Most important is creating a supportive social climate where senior peers who have been in the residence longer engage new residents in formal and informal house activities. Senior peers also need to role model peer support, including relationship skills and development of supportive social networks. The overall goal is creating household norms of inclusion and engagement also known as belonging or community (Porath, 2022; Parker, 2018).

Additional activities assessed on the RHES provide guidance about other ways residents can enhance social model dynamics, particularly a sense of commitment and empowerment. Examples include active engagement in giving and receiving general and recovery-oriented help, facilitating welcoming activities, participating in phase transitions and goodbye rituals

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that validate each individual's contributions to the community, and providing input into discussion of house issues during house meetings. Though not directly addressed on the RHES, sharing personal experiences about the successes and challenges of working a recovery program in the residence is an additional way to help other residents and facilitate one's own recovery.

Using the RHAS to Enhance the Physical Setting

Because the RHAS is a new measure and data linking architectural characteristics to outcomes have been limited to improved psychiatric severity (Subbaraman, et al., 2022), most of the considerations described below are based on observations of high-quality homes shown to have good alcohol and drug outcomes (Wittman, et al., 2014). The contents of the subscales have clear implications for house operations. For example, houses are likely to score higher on the RHAS to the extent that house managers have systems in place to arrange for repairs (maintenance subscale), secure the house and bedrooms during night hours, and monitor the quality of furnishings (safety subscale).

Provision of some characteristics of good architecture are best implemented when selecting sites for new SLHs. For example, service providers should select houses with good socio-petal designs that facilitate social interaction. Selection of houses that include green outdoor areas can provide additional space for informal social interaction, recreation, flower and/or vegetable gardening and outdoor meals. Efficient operation of SLHs requires finding sites that contain rooms large enough for the entire house to meet. Designs that could facilitate social isolation should be avoided. Other site selection issues could include finding spatial designs where entrees are transparent so that visitors, potential contraband, and compliance with curfews can be monitored.

Facilitating Interaction of Architecture and the Social Environment

Some of the architectural considerations discussed above can be implemented in ways that might facilitate social interaction and peer support, both of which are essential features of building a social model recovery environment (Polcin et al, 2023). House managers can play important roles in making architecture work not only for smooth functioning of the household, but also the quality of the social model recovery environment. For example, house managers can enhance the social and physical characteristics of the houses by mobilizing resident involvement in activities such as cooking, cleaning, simple repairs, and upkeep of outdoor areas. It is important that the manager and senior peers articulate that these activities are essential to operating a functional household, but they are also integral to building a strong recovery community. When residents follow through with tasks, fulfill responsibilities, and receive appreciation for their efforts, there is an increased sense of connection to the resident community and commitment to their peers.

It is also important for managers to consider whether they are using spaces that can accommodate the entire household to maximum benefit. House meetings involving all residents are essential to discuss updates of house operations, administrative issues, resident accomplishments, and social activities. However, house meetings also present opportunities for house managers to enhance social model dynamics by encouraging resident input into

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decisions affecting the household. In addition, senior residents can be engaged in articulating how issues discussed in house meetings are related to recovery and building a strong recovery environment in the house. Other uses of large spaces that can enhance the social model environment include calling impromptu house meetings to process important issues such as relapse, major rule violations, or unplanned leaving from the house. Some houses use large spaces in the house to offer open 12-step meetings to the surrounding community. Houses also use outdoor areas for social events or barbeques that are open to the surrounding community. From this perspective, facilitating social model environments goes beyond a focus within the household to include the interactive community context emphasized by Kaskutas et al (1998). For a description of ways that house managers can facilitate social model dynamics in recovery homes and between the home and surrounding community see Polcin et al (2014).

Social Model Recovery Across the Spectrum of Recovery Homes

Because the aforementioned studies were conducted only in SLHs, there is a need to study social model dynamics in other types of recovery houses. For example, in houses that offer on-site recovery support and clinical services (NARR Levels III and IV) the effects of social model could be independent of services, or they could interact with services in ways that facilitate or hinder recovery. In addition, the types of services offered and how they are delivered might be important as well.

Recovery homes that offer clinical services are typically governed in a more hierarchical manner where professional staff are in positions of power. This raises a concern that residents might feel less empowered, less committed to the household, and less likely to provide input into house operations and decisions. These and other characteristics of levels III and IV houses suggest it may be more challenging to implement social model recovery in these settings. However, researchers and service providers (e.g., Polcin et al, 2014) have described a variety of social model strategies that may be applicable to all levels of recovery homes. Drawing on their personal experiences operating houses, conceptual considerations describing social model theory, and existing studies, the authors articulated ways of understanding the challenges residents faced and potential solutions from a social model perspective.

Whether the leadership in a recovery residence is a house manager, treatment professional, or peer leader, problems and issues can be conceptualized from a household or program perspective more consistent with social model recovery than one focused primarily on individuals. When addressing problems from a social model perspective, residents, staff, and the residence leadership jointly consider questions that lead toward mobilization and enhancement of the social model environment. Examples include, how does the recovery environment in our household exacerbate or minimize the problem? Who among us has experienced this issue and what did we find helpful? What was counterproductive? What do the current residents experiencing the problem find helpful in terms of peer support? Emotional support? Practical help? Are there ways we should modify our household to be more responsive to this issue and improve our health and safety?

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We suggest engaging the issues and questions posed above into ongoing management of recovery homes represents new advances for the application of social model recovery across different levels of recovery homes. As social model moves forward, it will not be enough to require attendance at mutual help groups and compliance with house rules. Residents and providers will be challenged to use a more active approach that strategically facilitates social model recovery.

Broader Context: Neighborhoods and Recovery Oriented Systems of Care (ROSC)

There is a growing recognition among recovery homes and other substance abuse service providers that recovery is best understood within a broad context that considers "Recovery Oriented Systems of Care" (ROSC) (Kaplan, 2008). The idea is that persons with substance use disorders often have multiple problems and can receive help from diverse types of peer and professional resources in the community. For example, recent studies of SLHs (e.g., Mahoney et al., 2023; Subbaraman, et al., under review) showed neighborhood factors associated with favorable substance use outcomes included a higher density of substance abuse and mental health services near SLHs as well as density of 12-step groups, such as Alcoholics Anonymous.

These findings align well with other studies showing individuals more involved in AA (Polcin et al., 2010a) and less afflicted by psychiatric symptoms (Polcin & Korcha, 2017) have better outcomes. An additional analysis looked at neighborhood correlates of recovery capital among residents and found resident perceptions of neighborhood cohesion, crime, and access to transportation were associated with higher recovery capital.

It is important to note that social model strategies can be used to encourage the use of social model principles to enhance the use of local services. For example, Polcin, Korcha, and Bond (2015) described how SLH residents with psychiatric disorders can provide support to one another in terms of managing symptoms and providing information about local mental health services. In addition to sharing practical information about where services are located and how to access them, they can also share personal experiences (i.e., experiential learning) that might help residents be better prepared for what to expect.

ROSC can also include community-based resources that can help residents find work, permanent housing, social support, medical services, and legal help. In this scenario, the scope of the social model lens zooms out to include a much broader and more diverse view. For additional examples of ways that managers can mobilize good relations with the surrounding community see Polcin et al (2014).

Considerations for Training

Although social model is the essence of recovery in SLHs, many SLH providers have only a rudimentary understanding about its history and evolution. Too often recovery residences at all levels implement a limited version of social model that simply requires a goal of abstinence, attendance at peer mutual support groups, and participation in house

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maintenance activities, such as cleaning and cooking. These and other social model activities need to be better understood in terms of their relevance to the social model recovery environment and the recovery process.

We suggest knowing how, where, and why social model originated and the conceptual framework of some of the early proponents can help current SLH providers implement social model more broadly and creatively. In addition, we posit this understanding is necessary to help guide social model into the future in a manner that is informed by its origins and evolution over time. It is also necessary to understanding the extent to which social model is operating in other types of recovery homes beyond SLHs and how some modifications might be needed in some settings.

Training in social model recovery needs to be offered on a regular basis. NARR facilitates Recovery Residence Provider Learning Communities on a monthly basis. Activities include didactic presentations as well as shared learning. The importance of understanding social model dynamics is evident in in NARR's requirement that houses demonstrate the incorporation of social model principles into their operations. To succeed in fulfilling this requirement, service providers need trainings on social model characteristics described by Borkman et al (1998): 1) an emphasis on social and interpersonal connections as the foundation of sustainable recovery, 2) the value of experiential knowledge, 3) peer-to-peer, mutual aid and other recovery supportive environments in which wellbeing is the common bond, 4) active work in an individualized recovery program, and 5) an emphasis on peer-to-peer relationships that enhance recovery/wellness objectives.

The content of trainings should include coverage of recent advances in social model theory, practice, and research. In addition to didactic presentations, we suggest recovery home organizations develop interactive learning activities (e.g., learning communities or collaboratives) where house managers visit other houses and learn through shared experiences and observations of different homes. Experiential learning is fundamental to social model recovery, yet didactic presentations are often prioritized.

Guidelines for experiential learning among house managers could be developed to help focus these interactive activities on implementation of essential elements of I social model recovery in house activities, implementation of new developments in the field, and specific issues faced by individual houses. In addition, experiential learning could expand beyond service providers to include invitations for interactions with other stakeholders, such as other service providers (mental health, medical, legal, and job training), neighbors, and local government.

Competing Demands

SLH service providers often face a host of challenges that need to be addressed if they are to survive. These include NIMBY (Not in My Back Yard) forces that resist expansion of SLH services and pressure existing houses to leave the neighborhood or reduce the number of residents. Related problems include zoning restrictions and financial pressures. In addition, many SLH managers have jobs in addition to their roles managing the houses. All of this

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can leave limited time for training in social model recovery or attention to building the social model environment in the house.

When manager do seek out training or informational sessions they are often on issues with direct relevance to their survival, such as legal and financial issues. In a recent paper Polcin, Mahoney, and Mericle (2020) assessed the types of training received among 35 SLH managers. The results were concerning. About two-thirds indicated they did not receive any training relevant to their house manager role over the past year. Those who did attend some type training most often reported training focused on legal and administrative issues. Training on social model recovery was reported to be rare. Not surprising, many house managers saw their roles as primarily administrative (e.g., enforce house rules, conduct intake interviews, make sure the rent and bills are paid, and arrange for needed repairs). Some managers reported spending significant amounts of time interacting with residents, (supporting their recovery, helping residents manage crises, resolving conflicts, etc.). However, these interactions appeared to be manager interactions with individuals, rather than manager led discussions with all the residents in the household, which would be more consistent with the social model approach to recovery which emphasizes peer support and experiential learning among residents.

There was strong support for some aspects of the social model approach to recovery among managers (e.g., abstinence, 12-step involvement, and peer support among residents). But there were few examples of how house managers facilitated social model principles in the houses, beyond requiring abstinence and sending residents to 12-step meetings.

The limited ways managers thought about social model recovery in their homes is an important finding particularly considering the research on the RHES showing that the strength of social model in recovery homes is associated with outcome. As social model research moves forward, we believe the focus will be on identifying variables that enhance social model and its effects on outcome. However, to improve recovery outcomes, SLH providers will need to be exposed to this research and find ways to integrate it into the operations of their homes. To the extent the homes are focused on surviving NIMBY and financial viability, new developments will be difficult to integrate.

Conclusion

Social model recovery in SLHs continues to emphasize original, core social model principles such as shared alcohol- and illicit drug-free living environments, a goal of abstinence, peer support, and involvement in mutual help groups. Over the last decade studies of SLHs have shown residents make significant improvements in terms of reducing or eliminating substance use, arrests, psychiatric problems, and unemployment. Studies of SLHs have also shown core social model principles, such as involvement in 12-step groups and social networks that support abstinence are associated outcome. However, as social model moves forward, we are beginning to understand social model environments from a more nuanced and complex perspective.

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Recent studies have created new measures (i.e., the RHES and RHAS) designed to assess characteristics of social and physical environments of SLHs and their relationships with outcomes. While this work has only recently begun, it represents a shift in focus that may help service providers better understand the social model environment and maximize the most crucial elements. However, for these types of studies to have an impact, the effective dissemination of information to providers and other stakeholders is required. The current paper provides considerations for dissemination of new study findings and highlights the critical importance of experiential sharing of new knowledge among house managers and residents. Sharing experiences of implementing new research findings in SLHs will be vital to advancing the field.

The current paper focused on social model recovery in SLHs because these houses are the most explicit in their adoption of the social model approach to recovery. However, integration of social model principles exists to varying degrees across all four levels described by NARR (2018).

Generic strategies purported to enhance social model dynamics in houses across all four NARR levels have been described by Polcin et al (2014). However, most current suggestions are based on provider experiences and conceptual considerations. While these are essential, studies that link characteristics of social model recovery (e.g., the RHES and RHAS) to outcomes in different types of recovery residences are needed.

As social model research and theory moves forward, it will be important to consider the mechanisms of how it promotes recovery at different time points. While individuals still reside in SLHs, the daily encounters and connections they have with other residents, the support, and the giving and receiving of help within the household may be paramount. However, research suggests most residents sustain their improvements after they leave the house (Polcin et al., 2010a). Understanding this transition could further strengthen long term outcomes.

It seems probable that part of what successful residents do when they leave SLHs is to reestablish aspects of social model in their post recovery home life. They attend 12-step or other types of mutual support meetings, seek out alcohol- and illicit drug-free living environments, and build prosocial networks that support recovery. They may also carry aspects of social model into their post-residence lives that are less obvious but equally impactful. Examples include internal recovery capital assets that residents acquired during their time in the SLH, such as self-confidence, self-efficacy, empowerment, spirituality, citizenship, and purpose in life. From this perspective, social model influences move beyond the boundaries of the residence and benefit previous residents and their communities. Examining these transitions and how they play out for different residents and their communities represents critically important new directions for social model research.

Funding:

This article was supported by the National Institute on Drug Abuse (Grant Number DA042938) and the National Institute on Alcohol Abuse and Alcoholism (Grant Number AA028252). The funding organizations had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

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