Maximizing Social Model Principles in Residential Recovery Settings

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Abstract

Peer support is integral to a variety of approaches to alcohol and drug problems. However, there is limited information about the best ways to facilitate it. The “social model” approach developed in California offers useful suggestions for facilitating peer support in residential recovery settings. Key principles include using 12-step or other mutual help group strategies to create and facilitate a recovery environment, involving program participants in decision making and facility governance, using personal recovery experience as a way to help others, and emphasizing recovery as an interaction between the individual and their environment. Although limited in number, studies have shown favorable outcomes for social model programs. Knowledge about social model recovery and how to use it to facilitate peer support in residential recovery homes varies among providers. This paper presents specific, practical suggestions for enhancing social model principles in ways that facilitate peer support in a range of recovery residences.

Keywords

Recovery Home; Sober Living House; National Alliance of Recovery Residences; Social Model; Peer-Help; self-help

Most programs for alcohol and drug problems emphasize the importance of peer support, which is sometimes known as “mutual aid” (Borkman 1999) or “self-help” (Kurtz 1997; Reissman & Carroll 1995). Peer support involves interpersonal sharing of information and personal experiences, offering practical help, and interacting in ways that enhance emotional and social well-being. However, the strategies for facilitating peer support within alcohol and drug programs vary. Some programs build peer support primarily by offering group counseling or on-site 12-step meetings, such as Alcoholics Anonymous (AA). Other programs require that participants attend outside 12-step or other types of mutual aid meetings in the community. Less common are well conceptualized ways of enhancing peer

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influences within programs. The “social model” approach to recovery (Wittman & Polcin in press; Shaw & Borkman, 1990; Borkman 1983) provides a starting point for understanding peer influences and facilitating peer support in residential recovery settings.

Social model recovery emerged in California primarily as a grassroots movement that was built upon the principles of AA (Wittman & Polcin in press; Borkman et al. 1998). Although there is limited professional literature on social model recovery, a number of studies have shown favorable outcomes. Programs that self-identified as social model were shown to have similar or better outcomes than clinically oriented treatment programs that were typically more expensive (Kaskutas et al. 2008; Kaskutas, Ammon & Weisner 2003–2004; Borkman et al. 1998). Studies of sober living houses (SLHs) that used a social model approach showed significant resident improvements on a variety of outcomes that were maintained at 18-month follow-up (Polcin et al. 2010). Moreover, these studies found factors central to social model recovery (i.e., involvement in 12-step groups and social network characteristics) were related to outcome.

The purpose of this paper is threefold. First, we provide a brief overview of the history and principles of the social model approach to recovery. Second, we describe four different levels of recovery residences based on standards developed by the National Alliance for Recovery Residences (NARR 2012). Finally, we provide guidance on how aspects of social model can be used to address challenges encountered across all four levels of NARR residences. Examples include house meetings, decision making, establishment and enforcement of house rules, and admission and termination of residents. We also emphasize using social model as parallel social processes among providers and between providers and the surrounding community. Conceptualization of peer support and suggestions for enhancing it draw upon 11 years of research on recovery homes and decades of experience among co-authors operating recovery homes and recovery home organizations.

History of Social Model Recovery and Basic Concepts

Although the term “social model” did not emerge until the 1970s, the basic elements of this approach were being practiced as early as the 1940s (Wittman & Polcin in press). Social model recovery emerged as a grassroots movement in California, largely as an offshoot of Alcoholics Anonymous (AA). Many individuals attempting to abstain from substances through attendance at AA lacked an affordable alcohol free living environment. Their efforts were often undermined by destructive living environments that promoted substance use. In response to this need, recovering persons involved in AA created group living environments, which they called “twelve step” houses. Drinking and drug use was prohibited and residents were expected to work a 12-step recovery program. Because residents typically shared bedrooms, owners were able to keep rents affordable. By the 1970s 12-step houses became known as “sober living houses” (SLHs).

Beginning in the 1970s conferences and publications in the addiction field began to use the term “social model” to describe SLHs and similar programs (O’Briant & Lennard 1973). The primary rationale for this term was that it emphasized social and interpersonal aspects of recovery rather than approaches that were more individually oriented. It also emphasized

peer to peer rather than practitioner-client relationships and replaced the concept of treatment plan with “recovery plans” (Borkman 1998). The latter term emphasized actions the person will take to achieve and maintain recovery instead of the types of professional services they will receive. The primary characteristics of social model recovery programs were summarized by Wright (1990) as follows:

- There is an emphasis on experiential knowledge gained through one’s recovery experience. Residents draw on that experience as a way to help others.
- Recovery operates via connections between residents, not between an individual resident and a professional caregiver.
- All residents are consumers and providers, both giving and receiving help.
- As with the early twelve step recovery houses, involvement in AA creates the basic framework for recovery.
- A positive sober environment that encourages support for abstinence is crucial.
- Alcoholism is viewed as being centered in the reciprocal relationship between the individual and his or her surrounding social unit.

Social Model Recovery Scale

A variety of residential programs, including those offering formal treatment, adopted different aspects of social model into their approaches. Kaskutas, Greenfield, Borkman and Room (1998) developed the Social Model Philosophy Scale (SMPS) as a way to assess the extent to which programs used a social model approach to recovery as well as what aspects of social model were used. The 33-item SMPS has been shown to have high internal reliability (α= 92). The SMPS assesses six program domains:

1. Physical environment - the extent to which the program facility offers a homelike environment.
2. Staff role – the extent to which staff are seen as recovering peers.
3. Authority base – the extent to which experiential knowledge about recovery is valued.
4. View of substance abuse problems – the extent to which residents view substance abuse as a disease and are involved in 12-step groups.
5. Governance - the extent to which the program empowers residents in decision making.
6. Community orientation – the extent to which the program interacts with the surrounding community in a mutually beneficial manner.

Although the SMPS was based on data obtained from California social model programs, the principles are relevant to a variety of recovery home models throughout the U.S. Some of these models are reviewed below along with initial research examining services offered and outcomes.

Social Model Recovery in Other Residential Recovery Settings

There are a variety of residential approaches to recovery that emphasize characteristics similar to social model principles. One example is the Oxford House model, which began in 1975 (O'Neill 1990). Like SLHs, Oxford Houses offer long-term recovery in a residential, homelike environment that is free of alcohol and drugs. They are financially self-sustained by residents and do not offer on-site formal treatment services. Although they do not have individual house managers or operators, Oxford Houses are supported externally through a system of regional managers responsible for the welfare of groups of homes. All residents are required to have some type of a recovery plan and most attend AA or other 12-step groups.

A study of individuals who had been residing at Oxford Houses for varying lengths of time (several days to over 10 years) showed good longitudinal outcomes at 4-month follow-up intervals (Jason, Davis, Ferrari & Anderson 2007). Oxford Houses have also been found to be effective as an aftercare service for clients who completed long-term residential treatment (Jason et al. 2006). Today there are more than 1,500 Oxford Houses nationwide; SLHs in California that are affiliated with associations such as the Sober Living Network and California Association of Addiction Recovery Resources number close to 800.

A heterogeneous mix of other types of recovery residences has emerged throughout the U.S. that use social model principles to varying degrees. Mericle, Miles, Cacciola and Howell (in press) used the SMPS to assess the extent to which recovery residences in Philadelphia used practices that were consistent with social model principles. While only 11% met criteria as social model recovery residences using a cutoff score on the SMPS, some characteristics of social model were strong across most houses (e.g., view of substance abuse problems and authority base) and others were relatively weak (e.g., governance).

National Alliance of Recovery Residence Levels

The Mericle et al investigation was unique in that it assessed social model recovery principles across different levels of recovery residences as defined by the National Alliance of Recovery Residences (NARR). Briefly, NARR (National Association of Recovery Residences 2012) describes four levels of recovery residences:

- Level I residences are peer-managed houses located in residential neighborhoods. They are democratically run by the residents themselves and there are no paid staff members or on-site services. Although most residents are involved in 12-step recovery groups, attendance is not mandatory. Oxford Houses (Jason, Olson & Foli 2008) are a good example of Level I residences.
- Level II residences are also typically located in residential neighborhoods. Unlike Level I houses, they are managed by a house manager or senior resident who is either paid or receives a reduction of rent. There are typically no services offered on-site and residents are usually mandated or strongly encouraged to attend 12-step recovery groups. California Sober Living Houses (Polcin et al. 2010) are good examples of Level II residences.

- Level III residences employ paid staff who provide on-site services, such as linkage to resources in the community, recovery wellness planning, recovery support groups, and life skills training. In California, these residences are required to be licensed as treatment programs. Mericle et al (in press) pointed out that these can be considered hybrid programs that combine social model recovery and additional services delivered by trained staff. A recovery approach that has become known as the “Florida model” combines intensive outpatient or day treatment services with residence in a sober living house. Some Level III residences exist as private households in residential neighborhoods while others operate in multifamily, commercial or other environments.
- Level IV residences are best understood as residential treatment programs that are more structured than level III and that provide a variety of on-site clinical services. Although some staff may be in recovery, Level IV’s employ licensed or credentialed professionals. A number of social model characteristics are emphasized: 1) peers support, 2) resident involvement in upkeep of the facility, and 3) resident input into establishing and enforcing rules and policies. Therapeutic communities (De Leon 2000) are a good example of level IV facilities. These facilities are typically not zoned as ordinary housing in residential neighborhoods.

Each of the subheadings below addresses ways that social model principles can be implemented within and across the four levels described by NARR. Particular emphasis is placed on using social model as a way of understanding issues in recovery residences and mobilizing peer support to address them.

Conceptualizing Issues across NARR Levels

Central to a social model perspective is maintaining a focus that emphasizes the quality of the household as a recovery environment rather than a focus primarily on individual residents. Although there are some differences related to understanding and addressing issues between NARR levels, much of what promotes social model is relevant to all four levels.

Fostering a Culture of Recovery

Viewing issues from a broader, environmental perspective requires deliberate focus. In the U.S. there is a cultural norm to view alcohol and drug problems as a personal failing. “Individual responsibility” is an often repeated term among government officials at all levels as well as by the general public as a way of conceptualizing and addressing multiple problems, including those related to alcohol and drug use. That approach to alcohol and drug problems results in lost opportunities to mobilize community and peer influences that can have a strong salutary impact.

The social model approach to alcohol and drug problems shifts the focus to the household and community environment as a way to foster a culture of recovery. Residents are invited to draw on the strengths of the household and utilize peer support to shed their addictive lifestyle and reconstruct their self-identity as a person in recovery. Because recovery is a reality that is exemplified by recovering peers and their staff, recovery grows out of hope

and results in a process of self-redefinition and the rebuilding of a life in the community. The success of this approach is dependent upon the household's ability to address issues within a framework that enhances peer support within programs. It also requires successful collaboration with neighbors, outside service providers, and the local community. Each section below advocates for a vision of issues in recovery residences that includes broad ownership of problems and solutions to the benefit of residents and the surrounding community.

Facilitating Social Model Perspectives among Residents and Staff

Whether the leadership in a recovery residence is a house manager, treatment professional, or residents who function in rotating leadership positions, social model can be facilitated by the leadership articulating problems and issues from a household or program perspective rather than one focused primarily on individuals. All four levels of NARR residences have expectations and rules that apply to individuals (e.g., abstinence, attendance at house meetings, and participation in house chores and upkeep). However, from a social model perspective it is important that residents understand rules and expectations in terms of how they impact the overall community as a group of recovering persons. When expectations and responsibilities are ignored the residence does not function as a successful household or as a forum that facilitates recovery. The ultimate goal is to create an environment where residents articulate that perspective themselves rather than relying on the leadership to do it. In this scenario, developing a recovery lifestyle is conceptualized among residents as more than avoiding addictive substances and improving personal health, it is characterized by citizenship -- the importance of living one's life with regard and respect for those around you (Betty Ford Institute 2007). Doing one's fair share in terms of contributing to the household as a recovery environment and recognizing how one's behavior affects that environment is a key tenet across all social model programs.

Developing and maintaining a social model environment cannot be a function of the leadership alone. Residents must play a central role in helping each other understand household operations and dynamics from a social model perspective and translate that understanding into action. Most residents will have had experience with 12-step or other mutual help programs and can draw on recovery principles used in those programs as a guide. Like 12-step programs, there is an informal "oral tradition" process that occurs where residents who are more experienced with social model programs (sometimes called "senior peers") pass their knowledge on to new residents. The leadership in the program needs to consistently emphasize and reinforce these processes. As new residents observe how issues in the household are understood and addressed they sharpen their social model skills. As they learn more, they are empowered to contribute more to the welfare of the household and the individuals who live there.

Understanding House Meetings from a Social Model Perspective

Mandatory house meetings are a staple of all types of recovery residences. They offer opportunities for residents and staff to understand and discuss issues from a social model perspective and reinforce a recovery oriented culture. Typically, a variety of individual, interpersonal, and house issues are presented. Regardless of the NARR level, it is important

that persons in leadership positions (e.g., house manager, treatment professional, or peer leader) avoid being overly directive or offering solutions to problems pre-maturely. Instead, residents should be engaged in a collaborative process where various perspectives can be explored. Peer empowerment and support are strengthened when residents are involved in defining problems, identifying options, and implementing plans to resolve them. Peers with more experience take leadership roles in helping to guide conversations and decisions. Peer involvement in decision making creates a sense of resident ownership and connection to house operations that counteracts an “us versus them” mentality dividing residents and staff.

When interactions in house meetings are limited to a sole focus on individual issues and behaviors or the meeting gets bogged down in interpersonal struggles it is important for the facilitator to shift the discussion toward a broader, social model perspective. As issues are discussed, the facilitator should consider questions such as how does this issue impact the overall house? How can house members be mobilized to address the issue? Should we discuss changes in house rules or operations to address the issue? How would such changes affect the recovery culture of the household? Addressing these types of questions facilitates shared ownership of problems and reliance on the resident community as a way to address them.

House Rules and Policies from a Social Model Viewpoint

Maintaining a recovery supportive community requires house rules, recovery oriented social norms, and peer accountability. These are frequent house meeting topics in all types of recovery residences. Often they are brought up in terms of complaints about individuals being noncompliant. The result can be administration of consequences or warnings about noncompliant behaviors. However, there is an opportunity during these discussions to articulate the purposes of rules and policies from social model perspective that links them to household functioning and principles of recovery. Examples include linking policies and rules to issues such as safety, maintaining an alcohol and drug free environment, and the role of accountability in recovery.

Rules and policies can also be linked to AA principles such as “giving back” to the community from which one receives help, accepting powerlessness over some situations, taking an inventory of one’s weaknesses or flaws, and asking for help from others. Not everyone in recovery residences works an AA or other type of 12-step program, but the majority in NARR levels I and II residences are involved in some type of 12-step program (National Association of Recovery Residences 2012). In addition, some programs not explicitly identified as 12-step oriented (mostly NARR levels III and IV) have similar recovery concepts that can be related to program rules and policies. For example, therapeutic communities (TC’s), like 12-step oriented programs, emphasize the importance of “giving back” to newcomers, demonstrating commitment to the community through one’s behavior, and taking responsibility for the ways that one contributes to problems and conflicts. Ideally, the residents themselves would take the lead in these discussions. Programs with relatively newer residents and those in early recovery will need role modeling of this process from senior residents or staff.

To the extent that residents have input into formation, modification, and enforcement of house rules and policies they are more likely to feel ownership and a commitment to their implementation. Creating a social model environment in which peers hold each other accountable to house rules and social norms is the ideal. NARR level I and II programs are likely to allow for significant input into rules and policies through discussions in house meetings or other forums. Although level III and IV houses are likely to have paid staff who are ultimately held accountable for implementation of rules and policies, most have forums where residents can have input into modification and enforcement of rules and policies. For example, therapeutic communities often have some version of a resident government that helps enforce rules and make recommendations to staff for modifications.

Using Social Model to Address Specific Issues

Recovery residences provide individual level interventions for a variety of issues (e.g., noncompliance with house rules, referral to outside services, and development of individual recovery plans). However, the leadership within houses can work to create a context where individual issues are also addressed by drawing upon the strengths of the resident community, or what Laudet and White (2008) have referred to as “recovery capital.” In this section we describe ways to mobilize peer support to address issues commonly encountered in residential recovery settings, including relapse, resident conflicts, and personal crises. This section also addresses the advantages of mobilizing residents to influence two of the most important decisions for any recovery residence: when to admit a person as a new resident and when a resident should be asked to leave due to noncompliance.

Applicant Interviews and Resident Evictions

Few decisions are more important to a recovery residence than who is allowed to enter and who is asked to leave. NARR level I houses typically make these decisions by democratic vote of residents. Level II houses will involve the house manager or owner, but there may also be a mechanism for resident input as well. Similarly, decisions about admission and termination among level III and IV houses will involve paid staff, but there also may be mechanisms for residents to have input.

From a social model perspective there are advantages to including residents in these processes. First, it empowers residents to take part in a critically important household decision. Second, admissions that include current residents in the process can help create a sense of commitment to the new person. Finally, it facilitates the new person feeling a sense of accountability to the entire household, not just individuals in leadership positions. A practical consideration is that involvement of current residents draws upon the perceptions of the entire community, not just one individual who may not recognize potential problems or assets.

There are similar advantages to involving current residents in decisions about involuntary eviction. It helps create a sense that each resident is accountable to the community, not just to the staff, house manager, or others in leadership positions. It also invites discussion about the importance of maintaining an abstinent living environment.

Relapse

One of the most difficult issues faced across all types of recovery residences is alcohol and drug relapse. At the individual level, there are a variety of responses that might be implemented. Depending on the circumstances and the facility, the individual who relapses may be asked to leave the residence. A temporary eviction is the policy of most houses. However, there may be an invitation to reapply for admission after some minimum period of time has passed. In some circumstances the individual might be referred to a different type of setting, particularly one with more structure and oversight that might prevent additional relapses.

The recovery field has moved away from stigmatizing relapse toward viewing it as part of the addiction process. At least some individuals in the household will have experienced relapse at some point in their recovery. Social model recovery suggests that it can be helpful for these individuals to share their experience of relapse and how they were able to resume recovery. Importantly, it can help decrease the sense of self-loathing experienced by some persons who relapse and refocus their energies toward reestablishing abstinence.

Relapse is also a household issue because it affects other residents. It therefore needs to be discussed in house meetings or other forums. There may be expressions of fear, anxiety, loss, anger, guilt or increased vulnerability about residents own potential for relapse, all of which need to be met with empathy and understanding. There might also be discussions about ways residents can enhance the recovery environment and increase support for sobriety. The social model concept of mutuality (i.e., everyone is a consumer and provider of help) is important here. Each resident is a giver and receiver of help and to the maximum extent possible there should be cultivation of norms in the house that reinforce asking for and receiving help. Putting an emphasis on the importance of residents recognizing and responding to vulnerability in themselves and others is imperative. In this way an individual relapse can be mobilized to influence the household in ways that enhance recovery.

Resident Conflicts

Residential recovery settings invite a certain amount of interpersonal conflict and thus offer opportunities to practice recovery skills as they emerge during day to day activities. Conflicts occur as a result of sharing a room, failing to complete assigned chores, personal jealousies, and a host of other reasons. These are opportunities for residents to apply 12-step or other recovery principles to real life situations. Newer residents and those in early recovery can benefit from senior residents with longer recovery sharing examples of how they worked the steps and applied other recovery principles to similar situations. This might involve consideration of recovery concepts such taking an inventory and owning one’s part in the conflict, making amends, and accepting powerlessness over other people and situations. In level I and II residences these activities are most likely to be implemented among peers. In level III and Level IV houses they may be implemented by staff or peers.

It is important to facilitate a house-wide perspective that the emergence of conflict is expected and an ordinary part of life. The task in developing a recovery lifestyle is to manage conflict in healthy ways that enhance or at least do not undermine recovery. To the

extent that residents are able to resolve conflicts and apply 12-step or other recovery principles to them, the household will function more efficiently and the quality of the house in terms of a source for recovery will be stronger. In addition, learning conflict management skills helps residents learn valuable life skills that will help them outside the house as they manage their recovery across their lifespan.

Resident Crises

Resident crises are not uncommon in recovery residences and can include relapse, onset of psychiatric symptoms problems such as suicidality, family crises, problems with intimate partners, or loss of a job, just to name a few. The community of residents can be mobilized to help residents prevent or cope with crises. Just having awareness about the issues residents are going through is important. Simple things like being available to talk and showing concern can be helpful. Whether one is part of the household as a peer or staff member, sharing of one's own experiences in dealing with similar problems is important, especially in terms of the application of recovery principles to manage the crises. As residents help others prevent and cope with crises they also prepare themselves for how to deal with their own future crises.

An additional way that peers and staff can assist residents who are in crises is through suggestions for accessing outside services. Assistance can help in terms of sharing practical information, such as providers with whom they are familiar who may be helpful, suggestions for transportation to services and options for paying for services. Most importantly peers who have used the needed service can share their experiences and help the individual understand what to expect.

Training and Interactive Learning

Recovery organizations in California (e.g., the Sober Living Network and the California Association of Addiction Recovery Resources) have for many years recognized the need for managers of SLHs to receive training in how to facilitate social model dynamic within houses. As such, they offer regular workshops that cover essential aspects for understanding and implementing social model. However, there is also an appreciation for the value of experiential knowledge gained as a result of having lived in a SLH and the knowledge gained from managing houses. In this way there is a type of parallel social model process that occurs at the manager as well as resident level.

While yearly conferences are one such mechanism for sharing experiences, more systematic and regular peer trainings might be even more beneficial. Facilitating manager visits to other sober living houses on a regular basis beyond formal inspections each year might be one way to increase cross fertilization of ideas and experiences. Without interactive learning on a regular basis there is a significant danger that houses can become disconnected, unfocussed, and out of date in their approaches as well as noncompliant with network standards. Thus, social model needs to be conceptualized beyond the resident level to include the larger recovery community.

Interacting with the Neighborhood and Local Community

Social model posits that drug and alcohol problems operate in a reciprocal fashion between individuals and their surrounding environment (Wittman & Polcin in press). It suggests that low income, high crime communities with high densities of alcohol outlets and readily available access to drugs contributes to substance use among individuals. In turn, substance use contributes to destructive characteristics of the environment (e.g., crime, availability of drugs, unemployment). We posit that recovery operates in a similar manner. Individuals in residential recovery settings need to use positive characteristics of their community environment that can benefit recovery. In addition, supporters of residential recovery services need to show positive impacts on the local community, which, in turn, can contribute to more support for recovery residences.

Accessing Community Services

Although social model programs emerged in part as an alternative to formal clinical and medical treatments, they need to view themselves within a larger continuum of community-based services. Historically, social model programs avoided offering on-site services, in part to elevate the peer support aspects of recovery. Instead, there was an emphasis on helping residents access needed services in the community. This continues to be the approach taken by NARR level I and II residences.

NARR Level III and IV residences provide on-site services beyond peer support, although few programs meet all of the needs that residents present. Because persons with alcohol and drug problems frequently need help in a variety of areas, all of which cannot be met in one setting, it is important for residences to have good relationships with service providers in the surrounding community. Conversely, many of these providers serve persons in the community with alcohol and drug problems who could benefit from residence in a recovery setting and can therefore be sources for referrals.

Disseminating Beneficial Impact of Recovery Residences

Despite the existence of research showing favorable outcomes across all four types of recovery residences (National Association of Recovery Residences 2012), NIMBY (not in my back yard) resistances continue to plague many residences. Community resistance occurs despite documentation that recovery residences do not decrease property values or increase crime (American Planning Association 2003). In addition, research on level I and level II residences show they enjoy supportive relationships with neighbors (Heslin, Singzon, Aimiuwu, Sheridan & Hamilton 2012; Polcin et al. 2012; Jason, Roberts & Olson 2005). These studies show when neighbors are familiar with the recovery homes in their neighborhoods and the residents who live there they tend to be more supportive. Professional treatment providers have similar responses. A study of mental health professionals and certified addiction counselors found those who were most familiar with recovery houses were most supportive (Polcin et al. 2012).

Resistances to recovery homes is often based on stigma from persons who have little or no experience with the houses or residents who live there. Stigma feeds upon negative news reports in the media about problem houses, even if these are rare exceptions. There is

therefore an urgent need for recovery residences at all levels to be associated with peer based associations that monitor health, safety and operational standards, such as NARR. Advocacy organizations have procedures in place to address problem residences quickly, especially complaints from neighbors. They also have resources to advise houses about their legal rights and advocate for houses that are targeted by NIMBY groups.

Because familiarity is associated with improved perceptions, there is a need for advocacy groups to organize formal interaction between operators of residences and key stakeholders: 1) neighbors of residences, 2) the general public, 3) local and state officials and 4) mental health and other service provider groups. Examples of such interaction include dissemination of information about the goals and operation of recovery residences, advice to persons in the community who have family or friends suffering from addictive disorders, education about addiction and recovery more broadly, and encouraging house residents to volunteer for community service activities (neighborhood clean-up, holiday events, etc.) (Heslin, et al. 2012; Polcin et al. 2012). Interaction of recovery homes and recovery home organizations with surrounding communities is another example of how social model dynamics need to occur as parallel processes across different levels of social interaction, including residents, staff and managers, and the larger community.

Conclusion

Recovery residences for alcohol and drug problems universally emphasize peer support. However, few papers have provided suggestions for how to maximize positive peer influences in recovery settings. The California Social Model approach to recovery provides a framework for understanding and addressing issues in residential settings from a peer based perspective. This paper has drawn on social model principles to develop specific suggestions for how recovery residences can involve and empower residents to address critical issues, such as applicant interviews, involuntary eviction, management of house meetings, resident conflicts, and a variety of crises. Additional work is needed to better understand how facilitation of peer support varies among different level of recovery residences as defined by NARR (2012). In addition to using social model concepts to improve peer support within recovery home settings, social model theory can be used to enhance interaction within recovery home organizations and with the surrounding community.

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