The Social-Experiential Recovery Paradigm: A reformulation of the social model of alcohol and other drug recovery

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Executive Summary

The social model of alcohol and other drug (AOD) recovery provides foundational concepts for NARR (National Alliance for Recovery Residences) and is an important alternative to the prevailing medical and clinical treatments of alcohol and other drug disorders. The model is not widely known, much less understood.

This paper introduces a new paradigm – the social-experiential recovery paradigm (SERP); paradigm implies a coherent and interrelated set of beliefs, practices and methods about a branch of science or how to tackle and resolve a common life problem. Viewing SERP as a paradigm shift shows how significantly different this approach is from the dominant medical/clinical models of AOD treatment. I rename the social model as 'social-experiential' since the central element is the experiential knowledge of recovery (i.e., what recovering peers regard as valid and credible knowledge of recovery resides in peers with lived experience of AOD recovery and in the collective recovery communities).

Current practices of defining social model recovery lists its principles or domains which fails to convey its dynamism or show crucial linkages that create synergistic relationships. The paradigm presents the model more abstractly so that it is not so concretely tied to specific programs or kinds of organizations and uses social science theories to increase its legitimacy and universality. As one of the few academics who researched the California social model, which was the most complete and complex version in the US in the 1980s/1990s, I witnessed its evolution and demise--except for the still extant recovery residences. On the basis of my

academic and lived experience (participating in 12-step/12-tradition groups for 47 years) I developed this paradigm based on those elements I see as crucial.

The paper defines the SERP in broad and general terms as: an adaptation of AA's and other 12-step/12-tradition group's principles and practices to a (usually) nonprofit formalized organization that can obtain public and philanthropic funding for physical facilities and staff to provide services and to operate in the market economy arenas of treatment and health services. Social-experiential recovery programs (SERPs) are initiated and directed by experientially knowledgeable and seasoned persons with lived experience of AA and/or other 12-step/12-tradition recovery groups who expect a salary and make a career in the field.

The paper first describes how the four critical elements of the paradigm operate in the voluntary Alcoholics Anonymous and other 12-step/12-tradition groups. Then, the issue of how these critical elements need to be modified and adapted for a more formalized SERP which is often a 501C3 nonprofit organization is covered. Organizationally there are large differences between AA and other 12-step/12-tradition voluntary groups that have no sanction mechanisms except peer pressure and voting with your feet and the formalized SERPs that receive public funding, acquire facilities, and hire staff. SERPs especially need quality control measures to ensure funds are properly disbursed, participants receiving services are appropriately cared for, facilities and staff not mistreated, and applicable local, state, and federal regulations are followed.

While it has become important to emphasize that recovering individuals choose their own avenue to recovery from among multiple pathways and types of recovery, some people seem to ignore AA and other 12-step/12-tradition groups as passe. In fact, historically SERP was developed by AA members who wanted to help others beyond AA's restrictions. SERPs are

built on and dependent upon recovery communities that are the repository of their experiential knowledge of recovery. It is likely that as other non-12-step/12-tradition recovery pathways develop substantial recovery communities or blend with existing communities, that non-12-step/12-tradition based SERPs will be developed.

The four critical elements of recovery borrowed from AA (and other 12-step/12-tradition groups) are: (1) defining the peer role; (2) utilizing the transformational social learning method in the recovery community, which in turn (3) creates the "gift economy," the major engine of dynamic change; and (4) erecting a protected setting within which the other three elements can prosper.

(1) Helping roles are restructured as peers in AA and other 12-step/12-tradition groups. The peer is defined as a person with similar experiences who is of equal standing. Peers recognize their commonality of experience and identify with each other as peers through sharing stories or narratives with each other. Valid and credible knowledge of recovery is seen to reside in one's peers who are successful and competent in their recovery. The peer becomes a social role with (an often implicit) social identity of peer, separate from any identities as patient or client. Peers are seen as self-determining, capable of full agency, and helpful to others even as newcomers. Helping peers is reciprocal, not unidirectional.

(2) Transformational social learning in the recovery community. Two theorists whose concepts of social learning are applicable are Mezirow (1991) and his idea of transformative social learning; and Etienne Wenger (2000, 2009) and his idea of "communities of practice" that can change social identity. Both theorists referenced Alcoholics Anonymous either as an exemplar of transformative changes or of

"communities of practice." Mezirow's transformative learning emphasizes that when one interprets an old experience from a new perspective (such as the 12 steps and principals of AA) it can be transformative and one also learns to be critically self-reflective. The social in social learning can be understood as Wenger's "community of practice," a group with a common purpose that learn together how to do it better. Being in recovery means practicing recovery with one's recovering peers. One's identity changes from a drinking non-alcoholic to a nondrinking alcoholic [alcoholic is not stigmatized but a positive identity within the community of practice]. The paper presents a short case study from a sociologist's research (Barrows, 1980) of how a man in a recovery residence changed his interpretation of "speaking out forcibly at a meeting" through the informal interactions with peers who praised him for not getting angry; he eventually recognized how he had changed and had not gotten drunk over the incident. Since the collectivized knowledge of recovery resides in the recovery communities, it is vital to transformative social learning within the "communities of practice" that SERPs develop regular and extensive contacts with the local and larger recovery communities.

(3) The "Gift Economy": A metaphor. The concept of a 'gift economy' was developed by anthropologists studying preindustrial societies who had no concept of money.[1] They gave gifts such as food or armshells freely to other tribes who in turn gave gifts to those tribes and other ones which developed a circle of gift giving; the gift giving created obligations to give to others, to reciprocate, and to accept gifts. I relied on Hyde's (2007) contemporary formulation of the 'gift economy' which he applied to

[1] See Hyde, 2007.

current artistic groups, etc. Voluntarily given gifts create relationships between people which does not occur in the market economy where goods and services are sold for money. Reciprocal gift giving which occurs in 12-step/12-tradition and other groups initiates relationships which build on each other to create recovery communities. The gifts in self-help/mutual aid groups are honestly sharing one's experiences of substance use and recovery, service to the group, helping other recovering peers, befriending and caring about others. These dynamic voluntary mutual relationships are engines of motivation to maintain sobriety, give to others, and participate in recovery communities. Newcomers are often skeptical of the gift giving: is the kindness for real? why are peers being so kind? offering to take me to meetings? helping me so much?

(4) A protected setting: Insulating the 'gift economy' from the market economy is vitally important in at least three major ways. Shielding recovering substance users from temptations of using alcohol and recreational drugs found in the conventional society that emphasizes their usage; protecting the 'gift economy' by minimizing the 'problems of money, property and prestige' that is an inherent part of the market economy; and designing the architecture of SERPS to be congruent with their social principles.

In conclusion, SERPs are a paradigm shift away from professionally-based medical/clinical models for three major reasons. First, the relevant knowledge and authority in SERPs comes from the experientially knowledge of successfully recovering substance users and their larger recovery communities. Second, the guides or elders of newcomers have peer relationships of equal standing with them, and newcomers can help others immediately. Third,

the major method of social learning within a community of practice of experientially similar peers changes identities, ways of living, and social networks; the dynamism of the voluntary gift economy multiplies the effects of helping relationships where friendships and contacts are formed, sobriety is enhanced, and recovery communities are built. How and what services SERPs develop within the paradigm are not covered in the paper but will constitute the next analysis to be done. Future analyses of NARR's four levels of recovery residences in relation to the paradigm will also be fruitful.

INTRODUCTION

The social model of alcohol and other drug (AOD) recovery provides foundational concepts for NARR (National Alliance for Recovery Residences) and is an important alternative to the prevailing medical and clinical treatments of alcohol and other drug disorders. However, the model is not widely known, much less understood. This paper represents a good faith effort to reformulate and reconceptualize the social model of AOD recovery as a social-experiential paradigm shift.

Two issues need to be addressed. First, viewing the model as a paradigm shift is quite different from how it is currently presented in the literature or by NARR; for example, in an important paper on recovery residences, Polcin and colleagues (2014) refer to it as a model. Historically, the California version of the social model was sometimes referred to as an approach or model, and only occasionally as a paradigm. This paper introduces a new paradigm—the social-experiential recovery paradigm (SERP). The advantage of viewing the approach as a paradigm shift directs the readers' attention to how significantly different is the paradigm from the dominant medical/clinical models of AOD treatment. Second, casting the social model as a

paradigm it will be renamed 'social-experiential' since the central element is the experiential knowledge of recovery (i.e., what recovering peers regard as valid and credible knowledge of recovery resides in peers with lived experience of AOD recovery and in the collective recovery communities). Recovering peers are the 'teachers,' guides, role models, and inspiration for AOD recovery; this fact is key to understanding the paradigm.[2] When the model is defined solely as "social", the criticality of experiential knowledge to the paradigm is minimized. Further, professionals, whose knowledge dominates the landscape, either do not acknowledge "lived experience" as credible knowledge or they are threatened by peers' experiential knowledge as being in competition with them.[3] "Social" is a generic word that means so many things it becomes meaningless; an example of that is the recent paper by Scoles (2021) that defined the social model by using a mix of California's social model of recovery, AA, positive psychology, integral psychology and integral spirituality (whatever the latter means).

THE SOCIAL-EXPERIENTIAL PARADIGM

What is a paradigm and how will I be using the term? Paradigm implies a coherent and interrelated set of beliefs, practices and methods about a branch of science or how to tackle and resolve a common life problem.[4] The social sciences now use the term as a set of beliefs about the nature of some aspect of the world and the boundaries and relationships within it.[5] For example, a simple way to illustrate the difference between the medical/clinical and social-experiential paradigms is how the individual with the problem is regarded: in the

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[2]Professional social workers, psychologists or physicians are respected and utilized especially for specialized problems or treatment.
[3] Borkman, 1976.
[4] Thomas Kuhn in the *Structure of Scientific Revolutions* (1962) first publicized the concept of how paradigm shifts in science occur which has generated years of debate.
[5] Guba & Lincoln, 1994; Nelson, Lord & Ochacka, 2001, pp. 9-16.

medical/clinical models, “John is a patient,” while in the social-experiential model of recovery “John is a peer.” As a consequence of being a patient, university trained and licensed professionals emphasize John’s diagnoses in order to plan and implement a course of treatment for him; he is likely to be known by staff by his diagnoses. The emphasis is on improving his condition within the limits of known scientific treatments. In contrast, in the social-experiential paradigm, individuals recovering from AOD disorders develop experiential knowledge of how to recover by practicing recovery within the context of learning from the collective knowledge of the recovery community; as John’s peers they get to know him as a unique individual while guiding and showing him how to deal with his substance abuse and, as importantly, learn to have and sustain a meaningful and useful clean and sober life. The emphasis is on giving him self-responsibility to become an active agent in his life.[6]

Why reconceptualize the social-experiential recovery model as a paradigm rather than an approach? The current practice is to list the principles of social model programs (e.g., Polcin, et al., 2014) or domains as found in the ‘social model philosophy scale’ (see Kaskutas et al., 1998). These ways of defining the paradigm are not inaccurate, however, they fail to convey the dynamism of the model, or to show the crucial linkages that create synergistic relationships. I am aware of only one example that somewhat captures the dynamic quality of the social model: David Best (2022) talks about the peer process of recovery as creating “social contagion.” However, social contagion is misleading as it implies that recovering peers are positively “infected” by the sheer presence of other peers. The social-experiential paradigm emphasizes that recovery is both self-help and mutual aid, that the more the recovering individual participates in recovery activities and in helping peers, the more the individual gains in

[6] California social model emphasized self-responsibility following AA principles; Segal and Hayes (2016, p.140) describe mental health recovery as ”the giving of agency to participate.”

understanding and agency.[7] A dynamic paradigm captures the multiplier effect of people helping others without expectation of return which in turn prompts those recipients to help others in an upward spiral of reciprocity and voluntary "gift giving".

Current definitions of the social model of recovery are open to misunderstanding, trivialization, and dismissal by its critics as someone trying to get paid to have coffee and shoot the breeze. A current paper (Mericle et al., 2023) uses the social model of recovery as the organizing framework for recovery housing but a close reading shows that the social model of recovery is only vaguely and ambiguously defined.

Finally, I am interested in presenting the model more abstractly so that it is not so concretely tied to specific programs or kinds of organizations where one can lose sight of the underlying principles and dynamics or how the model has been creatively adapted to fit various organizational environments and types of populations. Recognizing the social-experiential model of recovery as an alternative and specific paradigm to the professional models of medical/clinical treatment alerts the reader to its significantly different assumptions, language, principles and practices (Borkman, 1998).

I was one of the few academics who conducted research on California's social model programs in the 1980s and 1990s and witnessed its evolution and demise.[8] Recently, I reengaged with social model ideas through my participation in NARR Summits in 2021 and 2022, with social-experiential recovery colleagues and as a researcher on Amy Mericle's grant on the impacts of Covid19 on recovery residences. As a sociologist I have researched self-help/mutual

[7] See Maton, 1988; Borkman, 2020.
[8] See Borkman, 1983; see Shaw and Borkman, 1990; special issues of *Contemporary Drug P*roblems, Winter 1998, *Journal of Substance Abuse Treatment*, 1998; Borkman, Kaskutas & Owens, 2007.

aid groups like AA and many others since the 1970s and recently completed a thorough review of the English-language research literature on them (Borkman, 2020). I personally have participated in 12-step/12-tradition groups for the past 45 years. On these bases - academic and lived experience - I am presenting a formulation of the social-experiential recovery paradigm that rests on elements that I see as most crucial.

As I struggled to reconceptualize social model recovery as a paradigm, I explored various ideas developed from research on self-help/mutual aid groups and organizational analysis, and from fields such as community psychology, sociology, and other social sciences. The formulation offered here is my own and draws from many sources including the original research and literature on California's social model, current developments in NARR publications and summit presentations, discussions with colleagues, and various social science sources. I decided to conceptualize it in abstract and metaphorical terms using social science theories in order to increase its universality and legitimization. This paper is intended for social-experiential recovery program practitioners, potential funders, or interested professionals and allies; it is not intended to be a work for newcomers to recovery nor is it written for a peer-reviewed professional journal. I use a minimum of references and place most of them in footnotes. My explanation may not resonate with some social model practitioners as I chose some unfamiliar concepts from anthropology and sociology with which to describe it. This draft is a work in progress; I welcome comments, suggestions and critical statements.

The paper is organized as follows: first, I define the social-experiential recovery paradigm in broad and general terms which includes its foundation in the values, principles, and practices of Alcoholics Anonymous and other 12-step/12-tradition groups and how it differs organizationally and in other ways from those groups. Second, I describe the four key elements

that I see as fundamental to the paradigm: these are discussed in terms of how they operate in AA which sets the stage for understanding how these elements need to be adapted for the more formalized social-experiential paradigm. The four elements include: (1) defining the peer role; (2) utilizing the transformational social learning method in the recovery community, which in turn (3) creates the "gift economy," the major dynamic engine of change; and (4) erecting a protected setting within which the other three elements can prosper. The final section, the conclusion, summarizes the main points of the paper and raises questions about how the elements can be and are implemented in various programs and in NARR's four levels of recovery residences. The issue of hybrid programs will need to be introduced when NARR's levels 3 and 4 (containing clinical features) are considered. Further, I raise the question of what the parameters of a social-experiential recovery program are. Addressing these questions awaits another paper.

GENERAL DEFINITION OF THE SOCIAL-EXPERIENTIAL RECOVERY PARADIGM

I use the California's social model of recovery as the standard on which to base the social-experiential paradigm as it is the most complex and complete version of the model and the one on which the most research has been done. [9] The social-experiential recovery paradigm is (as the California social model) an adaptation of AA's and other 12-step/12-tradition group's principles to a formalized (usually) nonprofit organization that can obtain public and philanthropic funding for physical facilities and staff to provide services and to operate in the market economy arenas of treatment and health services. Social-experiential recovery programs (SERPs) are initiated and directed by experientially knowledgeable and seasoned persons with

[9] A brief history of the social model of recovery is found in Appendix A.

lived experience of AA and/or other 12-step/12-tradition recovery groups who expect a salary and make a career in the field.

Newcomers without "lived experience of recovery" may be distrustful of their peer staffs' experiential knowledge and only trust the familiar medical and clinical approaches. Many in recovery go through stages of development of trust and utilization of lived experience of recovery until it becomes certain and respected knowledge for them.[10] In her research with various self-help mutual aid groups including 12-step/12-tradition groups Borkman (1999) found that valuing and trust in lived experience of recovery usually goes through three stages of recovery: Stage 1, Newcomer, often reacts like a "victim" whose lived experience is raw and incoherent. By stage 2 the "survivor" utilizes and trusts lived experience, including their own. The third stage, "mature," was divided into the "thriver" with open-minded confidence in their knowledge and the close-minded "dogmatic".[11]

California's literature on the social model of recovery also described three stages of recovery: primary, supportive and sustaining through which individuals progress as they develop confidence in their understanding of recovery, develop self-responsibility and how to maintain recovery. Accompanying these stages of individual recovery are levels of residential service: "primary" is an orientation and introduction to recovery, "supportive" is defined as a situation in which the individual has obtained part-time education and stabile housing that enables employment. "Sober living" is characterized by a stable cooperative living situation for the employed person with continuing income. See Table 1, Appendix B, for the similarities of stages

[10] Borkman, 1999.
[11] Borkman followed AA's description of the "bleeding deacon", the oldtimer who was close-minded and not open to learning.

of trust in experiential knowledge, California social model stages as individuals develop agency to guide their own recovery activities, and corresponding levels of residential service .

The paradigm borrows key elements of recovery from AA that include: (1) the structuring of the peer role; (2) transformative social learning within the recovery community (i.e., a community of practice) as the method of change; (3) the "gift economy"--the dynamic multiplier of help giving that nurtures sobriety, solves problems of living, shapes new identities, and enhances the recovery communities; and (4) creating a protected setting so the recovery dynamics of points 1-3 above can operate unimpeded by the external forces which are set in motion by the market economy. These four features will be described in some detail in subsequent sections of the paper.

Several primary differences between the 12-step/12-tradition group and the recovery paradigm are: the basis of participation, the organizational form, and quality control issues. The 12-step/12-tradition group is an informal group with no facilities, no paid staff, and a minimum of rules, regulations, and money; participation is voluntary and unpaid. Newcomers and seasoned members are equal in status although old timers may have more influence. In contrast, the SERP is more formalized, usually as a nonprofit organization, and acquires a facility, paid managers and staff who abide by the organization's rules, obtain substantial funds and follow accounting procedures and relevant rules and regulations. Even though they are all in recovery, managers and staff have a different role as employees of the organization than participants who are, in effect, residents receiving recovery services. Managers' and staff's primary service functions are to create and manage the social-experiential recovery environment, not to control participants who are not regarded or treated as patients or clients. Newcomer participants to a SERP may or may not enter voluntarily or be required to pay fees or contribute monies.

Important differences in operation occur between the voluntary and informal 12-step/12-tradition groups and the formalized SERPs that accept third party funding; the informal groups were designed with no quality control measures and there are no mechanisms to sanction or eject rule breakers except peer pressure and members voting with their feet.[12] In contrast, SERPs with third party funding need to be cognizant of quality control issues. NARR's emphasis on standards is one example of attention to quality control.

The managers and staff are usually in sustained recovery themselves and have confidence in their experiential knowledge. They use their experiential knowledge to develop the four elements such as the 'gift economy' in their SERP. The element "restructuring the peer role relationship of staff member to newcomer resident" is especially sensitive and important because the paid staff develop some organizational authority based on their relationship with the organization and the peer-ness of equal standing is thereby lost. Equality is critical for relationships to be built and the connections with the recovery communities to be made. The issue of diminishing the hierarchical distance between paid staff and participants was dealt with in the California SERPs through increasing participants' role in governance (Borkman, 1998) and various means staff used to diminish their authority (Room, 1998). The guide or "sponsor" role whereby the senior person tells their story or makes suggestions to the new resident is especially sensitive. Kaskutas and colleagues (1998) recognized inappropriate peer staff behavior in a study of California social model programs and withdrew the case from their research as it did not meet fidelity standards. Funders, for example, want to know the quality of guidance the staff person gives to the resident.

[12] Histories of AA explicitly discuss the lack of sanctioning; see Kurtz, 1979.

Quality control issues are large and important for SERPS and they cannot be covered here but should be addressed in other papers. The mental health peer literature considers some quality control issues (see Brown, et al., 2006) and has models for training paid peers how to interact as equals (two of which are described below) of which AOD programs should be aware. The problematic loss of "peer-ness" that occurs between paid peer staff and participant peers is recognized in the peer-reviewed *mental health* literature. The typical reaction noted that paid peer staff default to behaving as untrained and inappropriate clinical counseling of the resident.[13] This is a familiar cultural trope of those subscribing only to the medical/clinical models.

I am familiar with two training programs in *mental health* peer services addressed to teaching paid peer staff how to interact with residents that maintains the peer relationship and is non-directive: Intentional Peer Support and SHARE!s—the Self-Help And Recovery Exchange Peer Toolkit.[14] Intentional peer support trains paid staff to develop a co-learning approach with the junior peer in which both are engaged in problem solving, not one directing or advising the other.[15] SHARE!'s Peer Toolkit is undergoing a research evaluation to "help peers effectively draw from experiential knowledge to support others in their recovery journey." (Brown, 2023).[16]

Social-experiential recovery programs vary extensively in degree and kind of formalization, types of population served, function, and other parameters. In function, California had social model detoxification programs, primary, supportive and sustaining programs, recovery residences, and neighborhood recovery centers[17]. Single rented houses that serve as a

[13] See Davidson et al., 1999; Myrick & del Vecchio, 2016; Salzer, 2010.
[14] I do not know of any equivalent programs in substance abuse. Mead, 2014; SHARE!, 2018
[15] See Mead, 2014.
[16] L. Brown, (2023) SCRA Symposium Strengthening Peer Support: Evaluations of the Self-Help and Recovery Exchange (SHARE!) Peer Toolkit
[17] See Shaw & Borkman, 1990.

recovery residence are less complex and less formalized programs. More formalized are the legally constituted nonprofit or other organizations that have to comply with housing regulations, tax rules, and other rules and regulations. Another example of formalization is the large nonprofit organization that provides multiple programs. Nonprofit organizations such as 501C3s are required to have a hierarchy of Board of Directors, Executive, officers, and members. These hierarchies clash with the egalitarian emphasis of the social-experiential recovery paradigm. Many programs counter the hierarchy partially by selecting people in recovery to fill these positions.

All formalized organizations need some or extensive knowledge of accounting, legal, regulatory and tax issues. Again, many programs select people with professional skills who are also in recovery. The clash between the social-experiential recovery paradigm and organizations on these issues and other issues can be severe and there does not appear to be easy answers other than begin by staffing with recovering personnel. Today, many funders require services or paperwork based on clinical parameters that are antithetical to and damaging of social-experiential recovery practices. These issues need to be addressed but are beyond the scope of this paper.

This abstract paradigm with the metaphoric "gift economy" was not formulated to discuss specific services any SERP would offer; services would be based on the funding, mission, types of residents or participants and their needs as well as other local factors. In many SERPS services would evolve over time in partnership between the funders, peer staff, and participants.

FOUNDATIONAL CONCEPTS AND PRACTICES FROM AA

I found that I had to return to the source of the social-experiential model, that is, the heart of the approach that lies within the principles, practices, and dynamics of AA (and other 12-Step/12-Tradition groups) meetings within small group grassroots settings. In practice, the social-experiential recovery paradigm is a living entity that varies depending on its practitioners and their situation; it realistically evolves over time as new practices are developed within the recovery community and relevant new science develops about addiction and its treatment. The practitioners and residents who do it "know it" best, but their knowledge is experiential and tacit, and often not easy to articulate in abstract terms.

Today it is widely accepted that people in recovery have the right to choose from multiple pathways to recovery. This concept of choice for the recovering individual is a logical extension of regarding the recovering individual as a self-determining primary agent rather than a professional being the primary agent who decides what treatment is warranted as found in the medical/clinical models. The federal government's SAMHSA (Substance Abuse and Mental Health Services Administration) has promoted this inclusive and diverse democratic view of recovery pathways. Important thinkers such as William White and Ernest Kurtz (2006) echo this view of individuals choosing their recovery pathway. Indeed, White and Kurtz (2006) describe many styles, approaches, pathways, and types of recovery without further characterizing those pathways (e.g., how many people are involved, how large or geographically available they are, or how established and effective they are). In the process of this democratization of recovery pathways, some people do not mention AA or other 12-step/12-tradition groups as if it were inappropriate or even taboo to include them.

It is my understanding that a SERP needs to be integrated into a substantial recovery community that provides relationships, activities, and the experiential knowledge beyond the

SERPs staff. We know from years of experience and research that social-experiential recovery began with volunteers from AA who utilized its principles and practices from about the 1950s on. By the 1980s, other 12-step/12 tradition groups such as Narcotics Anonymous, and Cocaine Anonymous developed in large enough numbers of groups around the country that they too were included in the principles and practices guiding social-experiential recovery programs. We know that the 12-step/12-tradition recovery communities are large, geographically widely available in the US, are effective for sustained recovery for many people and have become part of the popular culture as represented in novels, TV shows, movies, and songs (Room, 1992,1993). We know that social-experiential recovery paradigm leaders and managers utilize AA and other 12-step/12-tradition groups as recovery communities in their SERPs and personally in their recovery.

There is no research to my knowledge that discusses how many recovering individuals participate exclusively in non12-step/12-tradition groups or what kinds of recovery communities these groups develop. It is likely that as other non12-step/12/tradition pathways develop substantial recovery communities or blend with existing ones, that non12-step/12-tradition-based SERPs will be developed.

Alcoholics Anonymous was the basis of the original social model of alcohol recovery and the basis of the California social model recovery program that I have researched. I selected four of AA's principal mechanisms that are foundational to the social-experiential paradigm, the first of which—the helping role—is discussed next.

I. Restructuring Roles as Peers: Helping Relationships, Credible Knowledge, & Identity: In conventional society major helping roles are typically the professional/client as in the medical/clinical models of treatment, or philanthropist/recipient or do-gooder/supplicant as in

civil society. In these relationships, the helper is superordinate (and somewhat superior) because they are regarded as more knowledgeable and resourceful, among other reasons, while the receiver is subordinate (and somewhat inferior) because they lack knowledge and resources, among other reasons. Helping is unidirectional from professional to client or do-gooder to supplicant. Most adults in the US know and have occupied the patient role and the client role at one time or another.

Helping roles are restructured as peers in self-help/mutual aid groups in several important ways. This is especially the case with AA and other 12-Step/12-Tradition groups. The peer is defined as a person with similar experiences in the core issue of the group who is of equal standing. Peers recognize their commonality of experience and identify with each other as peers through sharing stories or narratives with each other. Valid and credible knowledge of recovery is seen to reside in one's peers who are successful and competent in their recovery. The peer becomes a social role with (an often implicit) social identity of peer, separate from any identities as patient or client. Research on AA has shown how sharing one's story of alcohol/drug use and recovery with one's peers is importantly involved in the change of personal identify from drinking alcoholic to nondrinking alcoholic (Lave & Wenger, 1991; Cain, 1991).

The basis of peer-ness is similarity of experience. Accordingly, people with mental health challenges are not peers of recovering AOD peers although some people have co-occurring substance abuse and mental health issues but who they identify with varies and is relatively unstudied.[18] Outsiders often do not recognize that recovering peers view each other as knowledgeable or expert about their recovery. Outsiders often fail to recognize that recovering

[18] Dual identities can occur in those with co-occurring mental health and AOD issues; 12-step/12-tradition groups have developed for these such as Double Trouble in Recovery-see Laudet et al., (2004).

peers draw from a collective body of knowledge developed by their recovery communities, especially their 12-step/12-tradition groups.[19]

Peers are seen as self-determining and capable of full agency even though as newcomers to recovery they are viewed as knowing little about recovery (this is somewhat analogous to a family where the child is a full-fledged member while recognized as being young, knowing little, and needing to learn). Since peers are equals with commonality of experience, everyone can be a helper as well as receiver of help; even newcomers to recovery are viewed as both helpers and givers. Helping other peers is reciprocal, not unidirectional. Frank Riessman, a social scientist who studied such groups, regarded this restructuring of the helping role whereby peers were not only receivers of help but also helpers per se as an innovative and monumental shift in social services (1990). Riessman (1965) also coined the term, the "helper-therapy" principles that those who help others may receive more benefits than the recipient.

II. Transformational Social Learning within 12-step/12-tradition Groups

What alternative means are available by which individuals can intentionally make significant changes in a short period of time (excluding outside events such as war or natural disasters)? Various kinds of treatment or education are the primary methods.

Education is usually thought of in terms of school and book-based learning, but other forms of learning are actually more common. School may prepare a person in general but most companies do on-the-job training to teach workers the specific skills required for a job. Many occupations, especially trades such as carpenter, electrician, or plumber, learn through apprentice

[19] AA, for example, is the best researched and studied self-help/mutual aid group; it has 87 years of thousands or millions of members practicing and developing a robust body of knowledge (Borkman, 2020). Most of this knowledge is not in written form but in the behavior, practices,

and journeyman processes. New mothers learn how to be a mother by taking care of their baby, along with other information. Self-help support group members learn through social learning and stories expressed as 'sharing one's experience, strength and hope with each other' in meetings or other interactions. The social-experiential recovery programs use social learning within recovery communities as the method of assisting people to change.

Social science has developed various theories of social learning, many of which focus on learning that occurs inside one's head (e.g., Bandura, 1971). Two theorists of special interest here focus on how people learn from other people. One is Jack Mezirow (1991) and his idea of transformational adult learning; the other is Etienne Wenger (2000, 2009) and his ideas of social learning that can change identity in "communities of practice." Both of these sets of ideas apply to the social-experiential recovery paradigm and help explain how individuals change through their commitment to and participation in recovery programs; both Mezirow and Wenger reference Alcoholics Anonymous as an exemplar of transformative changes.

How do individuals change their perspective, reinterpret past behavior, reevaluate childhood experiences, and become more self-reflective? "Learning always involves making a new experience explicit and schematizing, appropriating, and acting upon it." (Mezirow, 1991, p. 11). "In transformative learning, however, we reinterpret an old experience (or a new one) from a new set of expectations, thus giving new meaning and perspective to the old experiences." (Ibid. p. 11, Mezirow).

Transformative learning within the 12-step/12-tradition group context means interpreting past experiences of drinking and using (e.g., while dancing or driving) within a new recovery framework (principles & practices of staying clean and sober within the 12-step/12-tradition program of recovery or its equivalent). The program of recovery is better understood by

seasoned peers who have practiced it longer.[20] AA is a powerful expediter of transformative learning (Mezirow, p. 183). Mezirow emphasizes that individuals learn to question and reexamine their behavior which he refers to as a "critical self-reflective mode." (Ibid., p.183). The process is enhanced by an individual's commitment to live by an explicit set of principles (e.g., the 12-steps and 12-traditions, a mentor-protégé relationship [i.e., sponsor-sponsee relationship]) and participate in a "self-revelatory group in which members share their common experiences." (Ibid., p. 183). Mezirow left out the many social occasions AA members have to practice these principles in meetings, friendships, and social events.

How does the social in social learning take place, of what does it consist, and how are the recovery communities constituted? Lave and Wenger (1991) have a useful formulation: the learning community is referred to as a "community of practice," defined as a group of people who share a concern or passion for something they do, and learn how to do it better as they interact regularly." (Wenger, 2009, p.1). I will first explain their ideas in recognizable terms and then introduce their concepts. Their focus is on situations where people learn a trade or skill, or participate in some passion (e.g., training for the Olympics) through doing it or practicing it; the practice changes their behavior and attitudes and their identity. The doing and practicing are done within a community of experienced and skilled learners who are also practicing and doing. They studied tailors, midwives, naval quartermasters, meat cutters, and Alcoholics Anonymous. In defining "community of practice" there are three important features: (1) domain of interest, (2) community, and (3) the practice. (1) Domain refers to a shared area of interest; membership implies a commitment to the area and a shared competence that distinguishes members from other people. (2) The community involves engaging in joint activities and discussions, helping

[20] Noorani, Karlsson, & Borkman,2019

each other, and sharing information. (3) Members of the community are practitioners. "They develop a shared repertoire of resources, experiences, stories, tools, ways of addressing recurring problems—in short a shared practice." (Ibid., p. 2). According to these characteristics, the 12-step-12-tradition recovery communities are "communities of practice". [21] NARR (The National Alliance for Recovery Residences) is also a "community of practice" (or becoming one) from what I have observed.

"Communities of practice are the basic building blocks of social learning because they are the social 'containers' or the competencies that make up such a system." We develop with each other what constitutes competence in a given situation: being a reliable doctor, popular student, astute poker player or street-smart gang member. Communities of practice define competence by combining three elements: first, to be competent is to understand the joint enterprise well enough to be able to contribute to it. Second, the community is developed through mutual interactions. To be competent is to be able to engage with the community and to be trusted as a participant in the interaction. Third, they produce a shared repertoire of communal resources. To be competent is to have access to this repertoire and to be able to use it appropriately (Wenger, 2000, p.229).

AA (and other 12-step/12-tradition groups) constitute a "community of practice," that is of recovery from substance abuse and learning to live a calm, useful and joyful life clean and sober. Being in recovery means practicing recovery. As one attends meetings and social events and develops relationships, one also learns the language of recovery, mode of dialogue in

[21] As previously mentioned, little or no research has been done on recovery communities. Consequently, we do not know how many 12-step-12 tradition communities there are or if people who engage in alternative pathways such as Women for Sobriety or LifeRing have separate recovery communities or if they are part of the 12-step/12-tradition communities.

meetings, how to reflect upon one's behavior and tell your story of substance use and recovery. One's identity changes from drinking non-alcoholic to nondrinking alcoholic.[22] The terms 'alcoholic' and 'addict' come to have a specialized, positive, and non-stigmatized meaning within the "community of practice." AA and the other 12-step/12-tradition groups are such exotic collectives and so different than the mainstream market economy that people who are introduced to them with their differences explained are more likely to continue participation and have better outcomes.[23]

A snapshot of how newcomers are practicing recovery within a recovery residence is illuminating. David Barrows (1980), a sociologist who observed interaction in a male recovery residence provides a vivid and concrete example of peers helping the newcomer reinterpret his reactions, and witnessing his subsequent change in how he interpreted them. Barrows shows how conversation in the recovery residence was far different than among men in general who tend to discuss intellectual topics such as politics, sports, money and women, but avoid personal topics. In contrast, in the informal interactions in the residence, the recovering men discussed personal topics in the form of stories related to their drinking and using: "they reminded themselves of difficulties which had resulted from their drinking. They discussed plans and goals. They discussed problems and the way they handled their problems." (Barrows, 1980, p. 5.). Their perspective in solving problems was the 12-step/12-tradition principles.

Barrows' example of personal reinterpretation of one's behavior and how it affects identity within a framework of recovery shows transformational social learning in action:

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[22] Cain, 1991; Jensen 2000, O'Halloran, 2008; Borkman & Munn-Giddings, 2017.
[23] Project MATCH's (1997,1998) experimental condition of using AA was called Twelve Step Facilitation which introduced people to AA. Later efforts of MAAEZ (making AA easier) by Kaskutas et al. (2009) or Subbaraman et al. (2011) used experientially knowledgeable recovering people to make the introduction.

"Through listening to stories which residents told about themselves, it was sometimes possible to detect changes in their self-images. For instance, at one group session, one resident expressed disappointment with himself because he 'had given someone the power to get to him'---he had gotten angry at another resident who had been ranting at the morning meeting. Other residents who had witnessed the incident reassured him. They thought that he had been quite assertive; they had experienced similar feelings but only he had expressed them. On two subsequent occasions, I heard this individual recounting the same incident. Each time he had a more positive image of himself. Initially, he indicated he had been disappointed and upset; later, he realized that he had experienced and expressed his anger in a nondestructive manner; that is, he had not gotten drunk." (Barrows, Ibid., p. 6).

Barrows highlighted the importance of storytelling in these informal healing interactions: "Hearing stories of others often reminds residents of similar incidents in their own backgrounds and may promote reflection upon and reinterpretation for revealing and negotiating identity and identity-change." (Ibid, p. 9). An important reason to highlight that peers with lived experience of recovery are critical to the social-experiential model is that only they have the stories of recovery that inform and guide constructive recovery. Peers with similar life experiences usually identify with each other and trust their peers' experiences as valid and reliable.

As repeatedly emphasized, the knowledge base of recovery is the lived experience of those in recovery and especially the experientially knowledgeable seasoned peers. Since the collectivized knowledge of recovery resides in the recovery communities, it is vital to transformational social learning that SERPs develop extensive and regular contacts with the local and the larger recovery communities. Many SERPs' residents are relative newcomers to recovery with little lived experience of it (their body of experiential knowledge is how to use alcohol and

other substances). As a group they have limited lived experience of recovery and their social learning is increased to the extent that they have contacts with seasoned members from the recovery community.

The early social model programs in California were well aware of their dependence on the larger AA community. "Community" meant several other entities in addition to the recovery community in the research on SERPs in California in the late 1990s (Journal of Substance Abuse Treatment, 1998). In the well-known Social Model Philosophy Scale (Kaskutas et al., 1998) the domain "community" had items referring to (1) the recovery community including clean-and-sober social events, (2) local community services such as health care, employment, and legal issues; and (3) the local neighborhood, business and civil society. Barrows' (1998) analysis of two qualitative evaluations of social model programs (one for males, the second for females) showed similar meanings of community as found in the Social Model Philosophy Scale. Residents were required to attend a variety of outside AA or NA meetings, and meetings were likely to be held in the social model facility. Alumni programs were instituted to ensure that previous residents would regularly return to the residence, help newcomers and be role models. Residents were expected to have developed a stable social support network in the local recovery community by the time they left the SERP.

Oxford Houses have been very explicit about the necessity of residents being involved in a robust recovery program and in the importance of involving their alumni regularly as part of a recovery community. The historical changes Oxford House has undergone in requiring specific recovery programs reflects the larger historical context of an increasing number of recovery pathways. Oxford House began in the 1970s with nine traditions which are modeled after AA's 12 traditions but adapted to fit the social-experiential recovery paradigm. Their Tradition four

developed in the 1970s states:"…only active participation in AA and/or NA offers assurance of continued sobriety." (Jason, Olson, & Foli, 2008, p.167). Tradition 9 pertains to encouraging previous residents to continue participating as alumni and states: "…members are encouraged to become associate members and offer friendship, support and example to newer members." (Ibid., p. 173). Interestingly, Oxford House has changed its requirements over time as other 12-step/12-tradition programs have proliferated and as alternative recovery pathways have become popular. In 1976 AA was primarily available; by or before 2008, NA was added, and by 2020 and later, others were available. Now Oxford House residents are required to have a recovery program but the content is unspecified (although their website cites the average number of AA meetings attended per week based on a survey of residents).

I am concerned that the foundation of social-experiential recovery as based on the 12-step/12-tradition recovery communities is becoming minimized or lost in recent interpretations of the social model recovery program. For example, a recent article on the community context of recovery residences (see Polcin et al, 2012) stressed that local business, health and treatment agencies' need to accept SERPs in order for them to survive, but the importance of recovery communities disappeared from view. Another current article (see Mericle et al, 2023, p. 5) described the recovery housing elements of the "community" domain of the social model philosophy scale in such vague terms as "Prosocial bonds are cultivated within and outside the home." Translating social-experiential recovery programs' community emphasis into current psychological terms such as prosocial bonds diminishes its meaning. It is important for the recovery home to have many and strong ties with recovery communities because the large source of their experiential knowledge resides there.

A recent case demonstrates the necessity of SERPs to have strong connections to a substantial recovery community. Dr. Ronald Harvey, trained by Leonard Jason and colleagues in community psychology at DePaul university, conducted research on Oxford Houses for his graduate work and Ph.D. dissertation. Harvey (2016) got a grant to open an Oxford House in Bulgaria, a formerly communist country, that had very few addiction-related self-help/mutual aid groups such as AA or NA. Despite having money, connections and all needed resources, Harvey was unable to create a sustainable Oxford House. He attributes the failure to two primary reasons the first of which is the lack of local 12-step/12-tradition groups or of a recovery community. (The second reason was that Bulgarians could not imagine living with strangers.)

III. The "Gift Economy": A Metaphor

The concept of a 'gift economy' was developed by anthropologists and sociologists studying pre-industrial societies that had no concept of money; they observed gift giving economies among Trobriand Islanders, and potlaches among Northwest Indians, among others. Contemporary examples are found in the Burning Man in Nevada (Chen, 2009) or an art colony created out of an abandoned warehouse in Italy, and other creative endeavors as Hyde describes in his book *The Gift (*2013) on which this formulation relies.

Mauss, a sociologist who originated the concept of gift economy in 1924, stated that "gift economies tend to be marked by three related obligations: the obligation to give, the obligation to accept, and the obligation to reciprocate." (Hyde, 2013, p. xxxvii). These obligations tend to create a relationship between the individuals involved which does not occur in selling goods and services for money. "Furthermore, when gifts circulate within a group, their commerce leaves a series of interconnected relationships in its wake, and a kind of decentralized cohesiveness emerges." (Ibid, p. xxxxvi). Reciprocal giving between two individuals is the simplest form of

gift exchange but is less relevant here than circular giving which involves three or more people as found in self-help/mutual aid groups and social model programs. "Circular giving differs from reciprocal giving in several ways. First, when the gift moves in a circle no one receives it from the same person he gives it to. I continually give armshells to my partner to the west, but unlike a two-person give-and-take, he never gives me armshells in return. The whole mood is different….When the gift moves in a circle, its motion is beyond the control of the ego, and so each bearer must be a part of the group and each donation is an act of social faith." (Ibid, p. 19). The fundamental nature of gifts is that they move, circulate and their value increases with the passage. (Kimmerer, 2013).

From the point of view of the individual, the gift comes to them freely; it is not a reward; you cannot earn it. "Your only role is to be open-minded and present." (Kimmerer, p. 23-24). The gifts are not usually material but can be frequently social or creative. The gifts in 12-Step/12-Tradition groups are: honestly sharing one's experiences of AOD use and recovery, giving service to the group, helping fellow recovering peers, befriending and being befriended, caring for others. Newcomers are often skeptical and question the motives of the gift-giver. Why are my peers being so kind to me? Offering to take me to meetings? Helping me so much? What's their angle? Newcomers then learn that these are voluntarily given gifts with no strings attached.

One fascinating aspect of the mutual aid groups is that the gift giving is within an open social setting of peers who are similar to each other in terms of the core commonality, trying to learn from and help each other and have similar goals of improving their lives in some ways. The social learning therefore is not in a sterile or limited situation like a school but a small group where relationships form, sponsoring or coaching relationships can develop, social events can be

held, and friendships develop. Instead of a typical bounded educational session, the social context of the group nurtures relationships, activities, obligations and friendships.

In contrast, the dominant market economy turns gifts into commodities and hoards rather than circulating its outputs freely. A vital market economy exists when money, goods and services are constantly circulating and labor is fully employed. Banks loan money to businesses to produce goods and services from the workers' labors, and the goods and services are sold in the marketplace. Workers buy goods and services thereby creating a market for production of further goods and services. Businesses return loan money with interest to the banks who can then loan out the money to other businesses in a circulating merry-go-round. But buying and selling are transactions that do not create relationships in the process. Each tries to obtain the most value for the lowest price. The market economy fuels consumerism in which more is better.

IV. A Protected Setting: Insulating the "Gift Economy" from the Market Economy

As previously stated, the 12-step/12-tradition groups operate within the prevailing market economy but its organizational traditions shield it extensively from the market economy. SERPs need to be protected from the market economy in a number of ways three of which are discussed here: first, to shield newly recovering individuals from the opportunities and temptations for alcohol and drug use of conventional society; second, to protect the voluntary 'gift economy;' and third, to use the architecture of physical settings as a direct and subtle signal that the SERP is not a medical or clinical facility and to provide an informal setting for the "gift economy".

The first way SERPs need to protect themselves from conventional society is to maintain an abstinent and psychoactive-drug free facility. Conventional US society, along with many other societies, is oriented toward alcohol and recreational drug use while celebrating birthdays, holidays, and other special events. The alcohol and drug industry employs smart advertising

campaigns to increase usage; alcohol outlets abound in many places. An increasing number of states are legalizing recreational marijuana use. SERPs need to maintain an abstinent facility to further recovery. There are many horror stories of recovery residences where one alcohol-using resident led to the relapse of all residents, a story which also illustrates the importance of enforcement of quality control measures.

The second need for insulation from the market economy is the 'gift economy' which is relatively fragile and is susceptible to being overtaken. The dynamic, circulating, and voluntary gift giving needs to be protected from the dominant market economy. Through their early experiences, AA members developed ways of protecting themselves from contamination by the market economy. (Similarly, as part of this, their peer model of helping which contrasts with the expert/patient model also needs to be protected from the dominant health care system.) AA isolated its groups through organizational principles known as the 12-Traditions (Kurtz,1999) that were codified and officially approved about 15 years after its founding.[24] Three traditions were especially important according to historian and AA member Ernest Kurtz. Tradition 5 emphasizes focusing on helping fellow peers instead of adding other goals such as running hospitals, selling services, or other enterprises. Tradition 6 cautions no endorsement or involvement in outside enterprises "lest problems of money, property and prestige" deflect us from our purpose. Tradition 7 emphasizes being self-supporting and rejecting outside money. Kurtz recognized the importance of these traditions in keeping the market economy at bay. "AA's early experience hammered out what became its singleness of purpose, non-involvement in outside enterprises, and self-support. By establishing these traditions AA avoided the trap of becoming itself a commodity." (Kurtz, 2008, p. 157). Thus, 12-Step/12-Tradition groups

[24] AA's book *The Twelve Steps and Twelve Traditions* (1952).

maintain some independence by (1) focusing only on one purpose; (2) renting but not buying or owning property; (30 being financially self-supporting and refusing external monies; (4) remaining detached from outside enterprises, causes, and belief systems. This independence allows them to create and maintain a "gift economy" in which voluntary gift-giving can occur freely, stimulating honest relationships leading to enduring and flourishing communities of recovery. The gift giving promotes relationships which in turn develops friendships and networks of other relationships; this fusion drives the circle of giving that leads to involved participants finding sustained recovery, friendships, and recovery communities.

AA's small group format makes it relatively easy to insulate the program from external forces. However, SERPs that rely on money and need a facility to operate, among other things, have a far more complicated and complex problem of developing a protected setting in which a "community of practice" can develop into a lively "gift economy." The third way that SERPs focus on protecting their settings is through architecture. SERPs signal both directly and subtly that they are not medical hospitals or clinical facilities through the choice and use of architectural elements. By having home-like settings instead of institutionalized ones, SERPs create an informal atmosphere where peer staff and peers can interact in social learning to gain understanding of recovery. In the process, the homes signal non-medical and non-clinical approaches. California's social model movement was fortunate to have a socially-oriented architect, Fried Wittman (1990), who was articulate and persevered throughout; In 2014 he and Doug Polcin wrote and edited a special issue titled "Architecture enhances mutual aid in sober living houses" of the *International Journal of Self-Help & Self-Care*.

CONCLUSION

This paper has presented the social model recovery programs as a paradigm and renamed it the social-experiential recovery paradigm (SERP) in order to emphasize that the knowledge of the SERP is the lived experience of recovery from alcohol and other drugs. The paradigm was defined in general terms as programs that adapt AA and other 12-step/12-tradition group principles, practices, and traditions within a formalized organization. The organization, led and directed by peers, seasoned and experientially knowledgeable about recovery, can receive public funds, has a facility and provides social-experiential recovery services. SERPs vary extensively in formalization, functions, size, and other features. The bulk of the paper is devoted to explaining four key elements of recovery SERPs borrowed from AA---the peer role, transformative social learning within a recovery community of practice, a "gift economy," and erecting a protected setting within which the other components can function with integrity.

The social-experiential recovery programs (SERPs) are a paradigm shift for three obvious reasons. First, in sharp contrast to the dominant medical and clinical models of treatment that required professionally trained and degreed personnel, the SERP is based on the experiential knowledge of recovery of successfully recovering substance abusers and their larger recovery communities. Second, the guides or elders who know more about recovery are peers of equal standing with newcomers and not hierarchically superior which reinforces status inequities as in the dominant models. Third, the major methodology of transformative social learning with in a community of practice changes identities, ways of living and social networks. The emphasis is on developing supportive abstinent social networks to counteract the emphasis on alcohol, marijuana, and other recreational drug use in conventional society. In presenting SERPs as a paradigm shift, its dynamism is revealed in the operation of a voluntary gift economy that multiplies the effects of helping relationships. Individuals who help others gain extensively from

their voluntary and free gift giving and in the process develop relationships and friendships that further recovery and connect them to substantial recovery communities, the repository of much experiential knowledge.

How the elements of the paradigm are interpreted and implemented in services in current SERPs is not covered in the paper and doing so will constitute the next analyses that need to be done. This will be a major task in light of NARR's four levels of recovery residences. NARR's level 1 (Oxford House is an exemplar)[25] and level 2 (Sober Living houses in California are an exemplar)[26] are relatively straight forward in meeting the criteria of a SERP since they are relatively informal at the level of the local residence (and Oxford House explicitly follows many of AA's traditions).[27] NARR's levels 3 and 4 are more formalized and contain clinical features which raises the issue of whether they are hybrid programs, not SERPs. What is the impact of various clinical features on developing a transformative social learning "community of practice"? Or in creating a vibrant "gift economy"? These and many other questions are raised by looking at how SERP's features can be implemented and with what quality in the various NARR levels of recovery residences. Answering these questions awaits other analyses and papers.

Appendix A

[25] See Jason, Olson, & Foli, 2008
[26] Polcin et al., 2010.
[27] See Jason, Olson & Foli, 2008.

Origin and History of the social model of AOD recovery

Various mutual aid groups, clubs, and unions for alcoholics preceded the 20th Century Alcoholics Anonymous and later 12-step/12-tradition groups. White (1998,2009) has described American Indian tribes who initiated mutual support efforts in the 1700s; fraternal temperance societies, reform clubs, and other mutual aid efforts in the 1800s such as the Washingtonians had elements of contemporary self-help/mutual aid groups but they were not sustainable. AA, founded in 1935, developed and evolved the combination of personal recovery (i.e., the 12-steps) and organizational elements (i.e., the 12-traditions) that have been sustainable for 88 years! AA's founders learned from these earlier mutual aid efforts, especially the Washingtonians, whose multiple goals of alcoholic sobriety and public advocacy as part of the temperance movement were unsustainable.

Alcoholics Anonymous had enough groups and was established in many communities around the US by the 1950s. Members often wanted to help their homeless peers have safe and sober housing, among other benefits, which the small group format did not permit. They started programs and services that were inspired by AA's values, principles and practices but were outside the auspices of AA (in keeping with AA's organizational traditions). Over time, these efforts remained small and localized in many places in the US due to an indifferent or inhospitable policy and funding environment among other factors. However, in California a significantly positive funding and policy environment emerged that allowed the growth and development of what became known as social model programs for individuals with alcohol problems. By the 1970s and 1980s, California's social model programs had developed a full continuum of care with social model detox, intensive programs for newcomers, community recovery centers, and recovery residences (See examples in Shaw and Borkman, 1990). As drug

use blossomed alongside alcohol problems, the social model adapted their services to include the drug addict. California counties and the state funded social model programs, conferences were held, and a social movement to protect and expand the model developed. In the 1990s the federal funding and policy environment changed with more medicalization and professionalization of treatment programs; California's social model did not survive except in isolated pockets or in Sober Living houses and other recovery residences.

The social model recovery, based on the values, principles and practices of AA, are not only copied by other 12-step.12-tradition programs but have also been adopted in part by some other self-help/mutual aid groups such as Women for Sobriety and Secular Organizations for Sobriety (SOS) (see Borkman, 2020). The 12 steps/12 traditions constitute a strong program of individual growth and development that is a vital aspect of the social model recovery paradigm. Over the years, social model of recovery was expanded and broadened to include ideas and principles from other self-help/mutual aid groups, spiritual practices, and pathways to recovery that became communities of recovery (White & Kurtz, 2006). Little research has been done on members in any of these other pathways. However, since the 12 steps/12 traditions groups are disproportionately the largest, oldest, best developed, and best researched, more is known about them than other communities of recovery.

Appendix B

Table 1

Similarity among three stages of development of (1) trust in experiential knowledge, (2) gaining mastery in individual recovery, and (3) levels of California residential services.

Stage	Develop trust in experiential knowledge[28]	CA social model: stages of mastery of individual recovery[29]	CA social model: levels of residential services[30]
1st	Newcomer acts as "**Victim**": whose experience is raw and incoherent; does not value & distrusts lived experience of recovery	**Primary:** individual introduced to and oriented to recovery; basic education about recovery	**Primary:** orientation & introduction to recovery services for those who need to stabilize & benefit from full time services
2nd	"**Survivor**": develops trust in one's own and others' experiential knowledge; helps others	**Supportive**: individual begins to depend on their self-capabilities to guide recovery activities.	**Supportive**: after orientation, can enter employment. Needs a part-time educational service in their living situation.
3rd	"**Mature"** either open-minded thriver or close-minded dogmatic	**Sustained:** individual's recovery is independent, self-directed use of resources	**Sober Living**: Provide stable cooperative living situation for stabilized person with continuing income

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[28] Borkman, 1999.
[29] Martin Dodd (1990) p. 17
[30] Ken Schonlau (1990) p. 69-70. An additional preliminary stage is social detoxification which allows the substance abuser to get dry and become capable of paying attention. These levels of service were also used by the California Dept. of Alcohol Prevention, Treatment and Rehabilitation in 1975-1976, Guidelines for Alcoholic Recovery Home Programs.

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