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Social Model of Recovery: A Civic and Political Right

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Abstract

For many, "recovery" has become a civic as well as a political and medical challenge. The social model of recovery is one manifestation of an evolving consumer empowerment model of care. A growing body of knowledge in the health care field believes recovery should be more of a philosophy than a specific model. Challenging the psychiatric view that substance use.

"Symptoms" are the most significant variable in treatment has led to a shift in focus where long-term recovery remission is embedded in the experience of consumers of service, which de-emphasizes the traditional professional perspective. Healing through social model programs emphasizes a community engagement process of learning by providing positive role models for people in recovery. Since the social model of recovery did not develop in response to diagnostic criteria, it appears to provide significant advantages over the medical model by building a strong and lasting social support network, with a commitment to the assets of individuals, families, and communities. A social model of recovery aims to incorporate the social determinants of health beyond the counselor's office and into the community so that counselors begin to eliminate or drastically reduce episodes of behavioral health problems and achieve personally fulfilling and socially contributing lives in their community.

Keywords: Empowerment model of recovery ; Social determinants of health; Social model of recovery

A Comprehensive Model of Recovery

A comprehensive recovery model is an approach to substance use disorders that emphasizes and supports a person's potential for a positive resolution of health disparities. Recovery disparities are set activities that involve supportive relationships, empowerment, social inclusion, coping skills, and the development of meaning. The recovery process envisions symptoms and their resolution as a continuum of normal evolving coping behaviors. In generally this process of recovery avoids the dichotomy of sanity *vs* insanity. The model is comprehensive, balanced, multi-phased, and a multi-disciplinary approach to the treatment of and recovery from substance use disorders. It's philosophy is derived from integrating a 12 Step abstinence-based methodology [1], with positive psychology [2], and Wilber's Integral Theory [3,4]. This model of recovery proposes that treatment facilities, therapists, people in recovery must work with this population, to become more proficient, effective, and consequently have higher success rates by becoming an integrated wholistic process [5]. It is suggested that the low success rate for current addiction treatment is due to substance abuse programs applying partial and or outdated treatment models [6].

A more comprehensive six-dimensional approach of recovery would be defined as

Physical (the physical and neurological aspects of recovery), mental (the cognitive aspects of the recovery process), emotional (the emotional and therapeutic aspects of recovery), spiritual (the spiritual and existential aspects of recovery), social (interpersonal, cultural, and social relationships of the individual), and environmental (the administrative, legal, monetary, and environmental aspects of the individual's life) [5].

Recovery as a Consumer Empowerment Model

For many, recovery has become a civic as well as a political and medical challenge. The social model of recovery is one manifestation of an evolving consumer empowerment model of care. In an empowerment model, a person's behavioral health challenges are not necessarily permanent. Recovery from behavioral health challenges must embrace a holistic approach that focuses on

1. Stress in the overall community.
2. Environmental factors such as divorce, death, and illness.
3. Support and provide better housing, increased employment opportunities, and family activities.

Without attention to these social determinants of health, one will continue to live in a negative environment or a neighborhood in decline that becomes a toxic waste land for individuals, their families, and the community [7-9]. The continued historical neglect of a broader perspective on health care concerns is traced partly to the bio-medical movement of the helping professions that sought to mimic the medical and or psychiatric models of health with its focus on assessment, diagnosis, and treatment. The need for a more

environmentally sensitive classification system, which acknowledges the role that cultural and community factors play in behavioral health issues, and how that information impacts clinical judgments and treatment plans, continues to be a topic of much debate. When taken out of their ethnic or cultural context, certain behaviors and personality styles have been viewed by more traditional diagnosticians as deviant or dysfunctional when, in fact, they were congruent with standards within an ethnic or cultural community and considered "normal". These dissonant standards have increased pressure for clinicians to become more knowledgeable, comfortable, and skilled in working with individuals from different cultures, ethnic backgrounds, sexual orientations, genders, gender identities, and religious/spiritual orientations. The current Diagnostic and Statistical Manual (DSM-5) discusses no real distinct cultural and ethnic patterns that could influence the recovery process and, in turn, restricts an evaluator from pursuing these social patterns of influence. The DSM-5 does not adequately address cultural variations in maladaptive behavior expression, even though the individual's culture and ethnic background do influence symptoms [10].

Throughout the DSM-5 developmental process, the Cultural Issues Subgroup made a concerted effort to modify culturally determined criteria to be more relevant across different cultures [11]. Incorporating an introductory chapter on cultural aspects of psychiatric diagnosis and a revised Cultural Formulation Interview and a glossary on distress's cultural concepts was added to the DSM-5. Also, incorporated into the description of each disorder was directly related to culture [12]. However, even with these additions' clinicians continue to focus primarily on intra psychic matters and relegate social, environmental, and cultural concerns to minimal diagnostic consideration. What we do know is that biological and environmental exposures affect how people describe their lifestyle.

Few diseases result from a change in a single gene or even multiple genes. Instead, most behavioral disorders are complex and generally evolve from an interaction between a person's biological foundation (genes) and one's social and cultural environment [13]. Differences in one person's genetic/biological foundation can cause an individual to respond differently to the same environmental exposure as another person. What is significant about an individual's biological foundation is that in many cases a person's genes do not determine health. Small differences in one's genetic makeup can allow individuals to respond differently to the same environmental exposure. This translational approach represents a path from the biological basis of health and disease to interventions, both medical and social that improves the health of individuals and the public. (ncats.nih.gov/translation/spectrum).

The above biological and psycho-socio-cultural concerns of diagnostic labeling continue to filter into the treatment community regarding recovery and *"evidence-based practice"* models. The critics of self-help models have been charged with undermining consumer rights and failing to recognize that the AA/NA model is intended to support a person in their journey. Full recovery is more than the individual. It is also a social and political issue of support and empowerment [14]. A significant obstacle to self-directed care initiatives has been the stigma and discrimination attached to substance use disorders. The dominant culture is a powerful influence and often a source of stigmatization. The narrowly medically oriented definitions of behavioral health challenges such as drug and alcohol use and abuse have contributed to the public's notion that individuals with substance use are irrational and irresponsible to direct their care [15]. Many persons continue to view addiction as a moral and personal weakness that, in some way, lessens society's responsibility to treat the condition. Some who hold these views have an irrational belief that one's fear of incarceration is enough to reduce one's addictive behaviors. The semis connected fear tactics have the potential to severely limit the achievement of self-directed care [16]. Also, health outcomes are often *"invisible,"* making it difficult for people to see recovery success stories. Without the visibility of *"faces in recovery,"* it will be difficult to sustain the changes necessary for self-direction care [17].

A growing body of knowledge in the health care field believes recovery should be more of a philosophy than a specific model [18]. This emphasis on alternative models of support is becoming increasingly more independent and, in many ways, becoming unique alternatives to the traditional medical/psychiatric view point. As more non-medical specialists work in addiction and health, there is an increased emphasis on alternative perspectives on problem-solving healthcare disparities [19]. Challenging the psychiatric view that substance use *"symptoms"* are the most significant variable in treatment has led to a shift in focus where long-term recovery remission is embedded in the experience of consumers of service, which deemphasizes the traditional professional perspective [20].

In primary care and public health, a lack of improvement in Social Determinants of Health (SDOH) indicates a high correlation among social inequalities and health disparities [21]; thus, these disparities confound our ability to improve the health of a community [22]. What studies have found is that increases in income, educational opportunities, and accessible housing have the largest positive effect on the development healthy populations [23], and that social spending, not healthcare spending, is significantly associated with improvement in mortality rates [24]. The Social Determinants of Health (SDOH) focus on the social, environmental, and cultural concerns impacting children, adolescents, and adults who are members of diverse populations within our society [25]. *"Where we live, work, learn and play is as significant as our genetic code"* [22].

The current behavioral health system with its focus on acute disorders continues to be inadequate in helping our communities and its members to develop healthy lifestyles. Thus, professionals in varied disciplines, medicine, education, psychology, social work, nursing, etc., are seeing greater evidence that a person's individual health cannot be separated from an individual's community health [24]. Moreover, a lack of attention to these social determinants contributes to the overall *"community pathology"* and low rates of individual therapeutic success [26]. Therapeutic healing catalyst can be found in addressing those social determinants that influence many lifestyle choices. Thus, from a community health perspective, healing the community heals the individual, understanding that one inherently does not exist without the other. Environmental and social exposures to factors such as high-crime and drug infested areas, domestic violence, as well as lack of access to parks or playgrounds, transportation, quality education, social services, and mental health care create a significant impact on lifestyle choices and trajectories. Therefore, from a behavioral health perspective, population health focus would best be defined by the advocacy effects to intervene upon and influence these complex social, behavioral, and environmental factors by actively working to engage, community organizations, families, schools and individuals in efforts to create and shape positive and healthy environments in which all members can thrive. Practitioners have been moderately successful in the treatment of individual disorders, but most often are ignorant to and neglectful of the interplay between one's *"pathology"* and the community within which he or she resides. The recognition that an individual's health is to a community's overall health is the missing link

to consistent and efficient treatment. Without clinicians engaging in a comprehensive evaluation of the concomitant Social Determinants of Health (SDOH) to which communities and its members are exposed, a long-term successful solution to the individual's behavioral health challenges can be nearly impossible. Incumbent upon the field of behavioral health is the obligation not only to influence an individual's therapeutic choices toward making healthy lifestyle changes, but also to remain active in their communities. Professionals must simultaneously help shape the community perspective of what changes need to occur within and among their existing micro and me so systems to foster more positive and healthy lifestyle factors for all residents who reside within.

Research over the past decade has revealed that health and lifespan in humans are reduced with social adversity. The strength of these links has drawn attention from researchers in both the social and natural sciences, who share common interests in the biological processes that link the social environment to disease outcomes and mortality risk [27].

Social Determinants of Recovery

A population health recovery perspective focuses on social determinants of health in which recovery becomes front and center. Housing, employment, education, family and social relationships, recreational opportunities, and physical, mental, or spirituality are health concerns of equal importance to an individual's alcohol or drug use patterns [8,28]. A social model of recovery makes no real distinction between the individual's health and the overall community. The *"pathology of the individual"* is the *"pathology of the community"*; they coexist and commingle. Provider agencies exist within the community. They are members of the city. Therefore, they are responsible for participating and improving a person's individual psychiatric/medical issues and their neighborhood's overall health. A counselor cannot just live in his/her office and be an active change agent. He or she must embrace therapeutic strategies that support and empower the community. Trauma-informed initiates like the Sanctuary Model approach healing that supports community concerns by helping individuals and their families develop skills for coping with cravings and avoiding high-risk situations. By exploring the positive and negative consequences of continued drug use, recognizing desires early, and identifies conditions that might put one at risk for use. For example, Cognitive-Behavioral Therapy (CBT) strategies focus on the theory that learning processes significantly influence one's maladaptive behavioral patterns. By applying many skills, one can learn to inhibit drug abuse and address various other problems. A central element of CBT is helping individuals identify related issues and develop self-control through effective coping strategies [29]. The Sanctuary Model allows children who have experienced the damaging effects of interpersonal violence, abuse, and trauma to heal. Trauma includes substance abuse, eating disorders, depression, and anxiety. The model is for use by residential treatment settings for children, public schools, domestic violence shelters, homeless shelters, group homes, outpatient and community-based settings, juvenile justice programs, substance abuse programs, parenting support programs, and other programs aimed at assisting children [30].

Active trauma-informed services embrace a holistic, comprehensive approach that integrates a social support network perspective that focuses on environmental stress in the overall community by providing better housing, increased employment opportunities, and positive family activities. Without attention to these communal interventions, one will continue to live in a static environment or a neighborhood in decline, which become dysfunctional for individuals, their families, and their community. The need to view *"pathology"* from a broader wellness transformative perspective is particularly relevant to behavioral health challenges and the development of resilience and protective factors in children and adolescents. A wellness perspective helps people recognize the more comprehensive worldview that one must create and make a part of their neighborhood reality. This new world view system brings a different mindset to an otherwise narrow life amid mental health, alcohol, and other drug use patterns [31].

Elements of a Social Model of Recovery

While some disorders' etiology may be the imprint of a person's DNA, they are frequently the result of or compounded by psychosocial, environmental, and cultural factors. What is known is that deterioration of social determinants of health in neighborhoods is a predictive factor in a person's chances for recovery from addiction, trauma, and other behavioral health challenges [8,28]. Although everyone's healing journey and transformation are deeply personal, this personal consumer process of recovery involves developing hope, empowerment, social inclusion, and meaning [32].

A social recovery model is based on concepts of strengths and empowerment, indicating that individuals with behavioral health challenges can have greater control and choice in their healing [33]. Options are the hallmark of a strength-based strategy (social model of recovery) that gets interpreted in a person-first assessment and planning process of healing. The emphasis on choice implies that various community resources effectively manage their behavioral health challenges and arrange their lives following their preferences. The experience of consumer choice of service deemphasizes but does not eliminate the professional perspective [34,35].

The strength-based perspective of direct engagement is a paradigm shift from the historical treatment emphasis on psychopathology, disease, and disorder. When one only looks at the biological reasons for behavioral health challenges, the assumption is that getting well and overcoming deficiencies is a function of the individual rather than the system of care [36]. This kind of narrow perspective has contributed to a behavioral health delivery system that continually struggles to provide an integrated care model that attends not only to personal deficits but accents resilience, strengths, and capacities. Our ability to shift the focus away from individual blame and towards a more positive, personal acceptance means that we must limit the influence of singular explanations to explain behavior. When we embrace a multifaceted account of our lives, we may more fully empower ourselves to challenge life more holistically [37].

The strengths perspective is a philosophy or way of interpreting information about our body, mind, and spirit that redefines self-defeating behavior, guilt, feelings, and dysfunctional relationships. The strengths approach is a more positive framework in which an individual's life struggles are healthy, intelligent, and emotional responses to life events such as unwelcome incarceration, psychiatric hospitalizations, prejudicial ethnicity/nationality issues, cultural differences, etc.

The goal of all interactions is to assist with the identification of the individual's strengths and resources. There is an expectation that advantages exist both in the person and in their broader environment and that the individual and their supporters know best how to utilize these resources [38]. Long-term addiction recovery is not merely about the relationship between the individual and the treatment program. It involves access to a range of personal and social opportunities, such as a meaningful job and healthy social relations - that occur independently of professionals' actions and beyond treatment.

In a social model recovery person's first programs, the choice becomes a critical core value. Learning through social model programs emphasizes a community engagement process of learning by providing positive role models for people in recovery. The social model programs are rooted in the mutual self-help concepts of Alcoholics Anonymous. Twelve-Step groups provide members with a new set of values that are, in some ways, distinct from the benefits of the main stream culture. Many of the importance of A.A. and other 12-Step groups are embodied in rituals in meetings and daily lives.

White (1998) lists four ritual categories

- Centering rituals help members stay focused on recovery by reading recovery literature and taking regular self-assessments or personal inventories each day.
- Mirroring rituals that keep members in contact with one another and help them practice sober living together. Attending meetings, telling one's story, speaking regularly by phone, etc.
- Acts of personal responsibility include being honest and becoming time-conscious and punctual. Activities include creating new daily living rituals related to sleeping, hygiene, and other self-care areas while also being reliable and courteous.
- Acts of service involve performing rituals to help others in recovery. Acts of service recognize that people in recovery have something of value to offer those still abusing alcohol.

These rituals aid personal transformation processes and build resilience and integration into a new social and cultural group.

Borkman TJ [39], commenting on the difference between medical and social models of recovery, concludes that, although both recovery planning and treatment planning serve similar administrative and programmatic functions, the role of staff and client (recovering person) in the planning process is significantly different between the two models. In both cases, the planning process is related to the philosophy and treatment model or recovery. The persons who conduct the planning in both approaches as the responsible agent that "directs" client change: in one, the staff; in the other, the person in recovery. In both models, the planning process is an integral part of the intervention intimately linked with the other components, such as assessment, program activities, record keeping, and satisfying external third parties. It is, nonetheless, a significant finding that the administrative and programmatic functions of treatment and recovery planning are similar.

Since the social model of recovery did not develop in response to diagnostic criteria, it appears to provide significant advantages over the medical model by building a strong and lasting social support network, with a commitment to the assets of individuals, families, and communities [40]. Rather than believing that a psychiatric label is the person's entirety, the social model believes it is but one aspect of a person who otherwise has assets, interests, aspirations, and the desire and ability to continue to control their own lives [18,41]. Focusing solely on deficits without a thoughtful analysis of strengths limits an individual's recovery. An essential component of a person-first or family-first assessment is the focus on strengths and capabilities.

People in recovery and their families have demonstrated incredible resilience and coping to overcome the obstacles in their path thus far to be where they are. Often professional assessments have not explored these unseen strengths. Strength-based assessment (which leads to strengths- based planning) is fundamental to the "Strengths Model" developed by [42].

1. **Using the Key Ideas in the Strengths Model means**

- Recognizing that successful people use their strengths to attain their aspirations and goals.
- Exploring and respecting the person's abilities, beliefs, values, support systems, goals, achievements, and resources.
- Identifying, using, building upon, and reinforcing the inherent strengths of the individual or family.
- Limiting the impact of societal problems, family dysfunction, and individual disease by building new coping skills, new interests, community involvement, etc. (recovery capital, protective resilience factors)
- Putting the consumer at the center and focuses interventions not just for the individual but also on improving availability, access, and adaptation of resources in the community [41].

A social recovery model that supports a strengths perspective is not solely focused on correcting a person's deficits, disabilities, or problems (the medical model). It attempts to balance that activity and builds on an individual's resiliencies and capacities by recognizing their strengths, both internally and externally, to enhance their chances of success [8,28].

2. **Guiding Principles in Support of the Social Model of Recovery**

Principles identified by Drake and colleagues in 1994 [43], as well as the Center for Mental Health Services Managed Care Initiative Panel in 1998 [44], and the Comprehensive Continuous Integrated Systems of Care described in many Treatment improvement Protocols (SAMSHA-TIP 1998,2005) [44-46] have led to the below comprehensive guiding principles:

- **Employ a recovery perspective:** Recovery is a long-term change process, and one must recognize that these fundamental changes proceed through various stages.
- **Adopt a multi-problem viewpoint:** Treatment should address immediate and long-term needs for housing, work, healthcare, and supportive and network services.
- **Develop a phased approach to treatment.** Many helpers view individuals in recover as progressing through a variety of phases or stages. Generally, they include engagement, stabilization, treatment, and after care (continuing care). These phases are consistent with and parallel to steps identified as ineffective recovery planning.
- **Address specific real-life problems early in treatment:** All interventions must incorporate case management services to help individuals find housing or handle legal and financial matters. Recovery must help individual develop specific skills and approaches needed to perform various roles, such as student, employee, community member, etc.
- **Plan for an individual's cognitive and functional impairments:** The need to focus on practical life problems is generally beneficial.
- **Use support systems to maintain and expand treatment effectiveness:** The use of self-help groups, the family, the faith community, and other resources within the recovery person's life is necessary for a successful recovery. Mutual self-help principles are widely recognized as essential components of treatment.

Conclusions

A social model of recovery aims to incorporate the social

determinants of health beyond the counselor's office and into the community so that therapist begins to eliminate or drastically reduce episodes of behavioral health problems and achieve personally fulfilling and socially contributing lives in their community. The counselor's ability to recognize, support, and implement social, environmental, and cultural concerns impacting children, adolescents and adults who are members of diverse populations within our society are significant [24]. "*Where we live, work, learn, and play is as significant as our genetic code*" [22]. With its focus on acute disorders, the current behavioral health system continues to be inadequate in helping our communities, and its members develop healthy lifestyles [8,28]. Long-term outbreaks of symptoms and frequent episodes of trauma will continue until health care services integrate the individual in the office with the community they return to after they leave the clinic. The helping professions can make a difference by broadening their perspective to include a better balance between biology, environment, social conditions, and spirituality [47]. A comprehensive counseling intervention strategy needs to view treatment more as a community-based activity. It must acknowledge that all intervention strategies are a partnership, whose successes will be judged by the service consumers, the recovery communities. Human service professionals must incorporate in their view of healthy people, knowledge about governmental policies, and legislation that affects our ability to work with consumers. Social service professionals must include advocacy at the political level as a part of the healing process. Behavioral health challenges and civil and political rights are a necessary part of counseling.

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