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EDITOR'S NOTE

The current issue features an unusual and typically ignored aspect of self-help/ mutual aid: **architecture** and how the use of space can facilitate or complicate mutual help. I thank Douglas L. Polcin for Guest Editing this special issue which features architectural aspects of sober living houses which evolved with the California social model of recovery. Sober living residences are houses, totally free of alcohol, illicit or psychoactive drugs in which recovering alcoholics/drug addicts live together as self-governing peers. The California social model of recovery flourished throughout the state from the 1970s to the 1990s; many counties chose social model programs for their publicly funded alcohol/drug abuse programs. The model evolved into a full continuum of care (see Wittman & Polcin in this issue, pp. 157-187) that was analogous to the professionalized treatment system consisting of medical detox, intensive inpatient treatment, outpatient treatment and halfway houses. Despite these seeming parallels, the two systems were strikingly different—social model was based on self-help and mutual aid especially as informed by the 12 step, 12 tradition format of Alcoholics Anonymous.

I became well acquainted with the social model substance abuse recovery approach as it was my second adventure into self-help/mutual aid after my first research on groups for people who stutter. In 1978 I was invited to be a visiting researcher at the Division of the National Institute on Alcohol Abuse and Alcoholism in Rockville, MD. Besides opportunities to site visit innovative alcohol treatment programs for women, Latinas and American Indians that were funded by the Division, I was asked to check out a recovery program in California that the Chief of the unit was considering defunding. The program would complete data forms about the organization but not about individual clients arguing that they had no clients and that their participants self-managed their own recovery. On a site visit I recognized that the recovery organization was a self-help organization based on adapting the principles and traditions of the 12 step program of Alcoholics Anonymous within a 501C3 nonprofit structure

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with paid staff. I explained to the Chief of the unit that the program did not have "clients" in the usual sense and the protests of the Executive Director were real; they maintained their funding.

Subsequently, as part of my visiting research work, I, along with a psychologist, studied that and another similar program; California had hundreds of these programs which they themselves referred to as "social model" recovery programs. They constituted a social movement which had existed since the 1940s in other states but which were destroyed by the forces of professionalization and medicalization. When I attempted to describe the "social model" recovery programs using professional treatment terminology it distorted the phenomena. Then, I described the programs using the language of self-help/mutual aid, experiential learning, and social learning theory finding that I had a new paradigm that had very different premises and suppositions than professional services. NIAAA published the monograph titled "A Social-Experiential Model in Programs for Alcoholism Recovery: A Research Report on a New Treatment Design" (Borkman, 1983).

The "social model" proponents were extremely happy with the monograph; it gave them the concepts and a language not only to explain but also to understand, in greater depth, what they were doing. Over the next 15 years I was a part time sympathetic professional researcher, translator, and bridge; I was also a critic of the social model proponents for what I saw as deficiencies and vulnerabilities in their approach due to the ever increasing professionalization and medicalization of alcohol and drug addiction treatment services. At their conferences and in publications, I criticized their lack of training the next generation of leaders; the absence of a management style that was consistent with the principles of self-help and mutual aid; their vulnerability to demands of government funding that called for more professionalized expertise; their lack of outcome research to provide evidence of their effectiveness, etc. Sadly, in 2007 colleagues and I published an analysis of the demise of the social model alcohol recovery movement in California in an article in the journal *Alcoholism Treatment Quarterly*. Social model movement leaders thought that the sober living houses remained the true peer-run aspect of the social model movement that retained the mutual help ethos and practices.

SOCIAL ENTREPRENEURS

The mutual help 12 step group Alcoholics Anonymous has a self-organizing design driven by a culture of experiential learning that results in an organization with the capacity to adapt, innovate and evolve as the context and environments change (Zohar & Borkman, 1997). Asaf Zohar and I developed that thesis in a 1997 publication. Among other aspects, we discussed AA's organizational principles known as the 12 traditions and the 12 concepts (Alcoholics Anonymous World Services, 1986, 1990) that guide local groups and its regional and national

level organizations. The principles give local groups autonomy within the general framework to react and adapt to local circumstances and challenges—tradition 4, for example, states "Each group should be autonomous except in matters affecting other groups or A.A. as a whole" (Alcoholics Anonymous World Services, 1990).

Here, I propose a corollary thesis: that the self-organizing design and culture of experiential learning of the entire organization not only allows local groups to adapt and innovate but also fosters an environment in which members can learn these self-organizing principles and apply them innovatively to new forms of organization or work. Some members become innovative social entrepreneurs utilizing the self-design principles to develop new forms. A second major ingredient for individuals to evolve into social entrepreneurs is probably the 12 step principle of helping fellow alcoholics in order to stay sober. "To keep it you have to give it away." The idea is that to maintain continuous sobriety over the long run one has to help fellow alcoholics with their sobriety.

This issue features one such innovative social entrepreneur, Don Troutman, who developed Clean and Sober Living which began as one sober living residence and subsequently expanded into a network of recovery services over many years; his experience report was described by one reviewer as a "wonderful example of what Donald A. Schoen called 'reflective practice.' He theorized in context, using experiential learning methods to acquire knowledge he gained both from formal classroom learning and workshops and from his personal experiences. He was driven to become an expert in a number of professional areas by solving problems he encountered and through persistence and critical thinking he invented an alcohol and drug treatment system that obviously works for a particular cohort of alcoholics and addicts." Clean and Sober Living had participated in research on the effectiveness of sober living and was selected in part because of this participation to be a case study of Friedner Wittman, architect, and his colleagues who have contributed the major article in this issue titled "The Setting is the Service: How the architecture of sober living residences supports community based recovery."

Sober living residences based on 12 step/12 tradition principles spring up here and there having been independently invented or copied since shortly after Alcoholics Anonymous was created in 1935. AA groups have no property, houses or facilities—they rent space for groups to hold meetings and social events in churches or community buildings. Many new AA members have been homeless or living in wet places full of alcohol and illicit drugs —they have no safe sober housing and will not find it in the community. AA members working with them react by helping out and developing housing for their peer alcoholics. The founders probably had multiple motivations for creating such houses in addition to helping their peers in order to stay sober—financial incentives would be strong for some; developing an alternative career of assisting recovering alcoholics for some, and so forth. In the early years the housing for sober alcoholics were called 12 step houses (see Wittman & Polcin's article "The

Evolution of Peer Run Sober Housing as a Recovery Resource for California Communities" in this issue, pp. 157-187).

Relevance to Contemporary "Recovery Oriented Systems of Care"

The original California social model recovery programs have long morphed into professionally-based hybrids or disappeared years ago except for the sober living residences. Today, the substance abuse policy and treatment system in the United States is undergoing extensive reexamination and refocus with a rebirth of mutual help based ideas centered partially through interest in recovery. AA has used the concept of recovery as its central concept since 1935; over the years it has evolved into the alternative to professionalized treatment. Now the federal government, addiction professionals and policy makers are considering "recovery" as the hinge concept for modifying the professionally-centered acute treatment orientation which has shown to be ineffective in comparison with a chronically oriented client-directed system of long-term support.

The federal Center for Substance Abuse Treatment (CSAT) convened a panel of addiction specialists, policy makers, and people in substance abuse recovery who compiled a consensus definition of recovery: "Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life (Center for Substance Abuse Treatment [CSAT], 2007). CSAT's definition emphasized that recovery involves a personal recognition of the need for change and was accompanied by various principles—including that recovery is self-directed by the recovering person, involves various pathways, and exists on a continuum of improved health and wellness.

William L. White (2006, 2007) is a major proponent for the paradigm and system change from the acute oriented professionally-based treatment system to a chronic oriented recovery system of care. He writes extensively about how the new recovery oriented systems of care could unfold. He understands that mutual help groups like Alcoholics Anonymous and others (such as Women for Sobriety or Secular Organizations for Sobriety [S.O.S.]) represent a solid foundation of recovery-oriented networks of people and experiential knowledge and also emphasizes that many other alternatives can be developed to fit individual preferences and cultural traditions.

Many of the ideas and practices of the old California social model of recovery could inform the newly emerging Recovery Oriented Systems of Care including the successes, failures, and limitations of the social model of recovery. Hopefully this issue of the *Journal* will spark some of those connections. At best, the emerging support systems will build on the network of mutual help already available in the communities—this could constitute a rebirth of research interest in studying mutual help within recovery oriented systems of care as they unfold.

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