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ARTICLE

Is Recovery Planning Any Different from Treatment Planning?

THOMASINA J. BORKMAN, PhD

George Mason University, Department of Sociology and Anthropology, Fairfax, VA

Abstract—*Using process evaluation data, this paper compares the "recovery" planning process of the social model programs with the "treatment" planning process in a comparison medical model program. We consider how the planning process is actually conducted, the role of staff versus clients in the planning process, and how the implementation of the planning process is monitored and evaluated at the programs. Results point to major differences in the actual process of treatment planning and recovery planning. Professional staff at medical model programs generally direct and control the planning process and its implementation. In social model programs, clients are directly responsible for developing their own recovery plans, within a context of help from peers and recovering staff; the latter oversee the process. We conclude that both treatment planning and recovery planning are distinct and defining features of medical and social model philosophies. Treatment planning in medical model programs and recovery planning in social model programs serve similar administrative and programmatic functions. However, the impact on patients/residents is likely to be significantly different. Recovery planning becomes a skill acquired by clients, part of the experiential education characterizing social model programs. Future research is needed to assess whether these planning skills actually aid social model clients in structuring a sober lifestyle in aftercare, and whether differences are obtained by the more passive client role in planning taken at the medical model program.* © *1998 Elsevier Science Inc.*

Keywords—social model; treatment planning; client participation; twelve steps; treatment program.

INTRODUCTION

TREATMENT PLANNING IS regarded as an indispensable part of all professionalized treatment programs, whether the approach is medical, psychological, or "Minnesota model." A search of recent publications on treatment planning located 141 records. About half of these publications deal with appropriate instruments to be used in assessing and evaluating patient's problems as the basis of developing an adequate individualized treatment plan (e.g., Allen & Columbus, 1995; Allen & Mattson, 1993; Donovan, 1995). What is striking is that so many publications take for granted the importance of treatment planning, assume the reader understands the planning process, and simply refer to treatment planning in the conclusions (see McCormick & Smith, 1995; Schober & Annis, 1996). Treatment plans are so fundamental to contemporary substances abuse treatment that they are a major means used by third parties, payers, or credentialing agencies (Bois & Graham, 1993) to monitor and evaluate substance abuse treatment programs.

Social model practitioners maintain that they use an alternative paradigm (Borkman, Kaskutas, Barrows, 1996) that is not "treatment," and that consequently they do not utilize "treatment planning" (Dodd, 1986). They argue instead that they engage in the "recovery process," utilizing "recovery planning" and "recovery plans" (see Borkman, 1983; Schonlau, 1990; Wright, Clay & Weir, 1990).

Requests for reprints should be addressed to Thomasina J. Borkman, 3121-7 University Blvd. West, Kensington, MD 20895.

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There has been little systematic research in this area, thus it remains a question whether the processes used in social model programs to develop "recovery plans" for their "residents" are different in principle or in degree, from the processes used by "medical model" programs to develop "treatment plans" for their "patients." This is the subject of the present paper. Using data from a process evaluation, this paper compares the recovery planning process of two social model programs with the treatment planning process in a medical model program we observed. We examine how the planning process is actually conducted that includes the role of staff versus clients in the planning process, and how the planning process is translated into assignments and activities for clients to follow during their course of stay. We also examine what documentation and monitoring of client progress is done in relation to the planning process at the study sites. Finally, we consider what are the functions of treatment planning and recovery planning at the study sites. For this paper, the data used were the observation notes pertaining to group meetings and staff meetings as well as the interviews of directors and staff of each program. References to the process of treatment planning or recovery planning in the observation notes and interviews were selected and analyzed. Written copies of forms used in treatment planning or recovery planning that were collected from each site were examined.

THE PROGRAM CONTEXT OF TREATMENT AND OF RECOVERY

Medical model program (MMP) admits substance abuse patients who have a second diagnosis of physical or mental illness. The hospital detoxifies alcohol- and drug-dependent patients as part of the typical lengths of stay of 7 to 10 days. As a medical facility, the physician, psychiatric, and nursing staff handle the medical concerns of diabetes, gastroenteritis, other alcohol- and drug abuse-related physical conditions, and any comorbid mental illness. The program Medical Director, the only one with authority to admit patients or to discharge patients to the unit, is a physician. The counseling staff, with credentials and professional degrees (a few of whom are also recovering alcoholics or drug addicts), are responsible for the nonmedical aspects of treatment planning, and education involving substance abuse and recovery.

In contrast, residents enter the two social model programs detoxified and without any serious acute medical or psychiatric problems that require constant medical attention; the usual length of stay in 90 days or more. A few stabilized dual diagnosed substance abusers with mental illness as well as clients who are HIV-positive are in residence at each social model site. Both social model programs have the same parent nonprofit organization. The staff there are primarily recovering alcoholics and drug addicts with demonstrated years of abstinence and of a recovery lifestyle. Some of these social model staff also have certification as addiction counselors or other professional degrees, but these credentials are not a job requirement.

THE TREATMENT PLANNING PROCESS AT THE MEDICAL MODEL SITE

Newly admitted clients to MMP undergo a battery of assessments and diagnostic tests based on objective criteria developed by the American Society of Addiction Medicine. Within 72 hours of admission a comprehensive diagnostic battery summary is developed by the counseling staff, who synthesize the separate reports of the physician, psychiatrist, nurse, neuropsychologist, and counseling staff into one document.

At MMP, the staff develop the treatment plans for each patient after deciding what aspects of treatment the patients are lacking knowledge or understanding in based on the results of the diagnostic summary. This information is usually focused on alcohol, drug, medical, and psychiatric health needs and rarely includes job skills development or house searching. At an important treatment planning meeting early each morning, a member of the counseling staff and a nurse meet; they review the status of each patient, assign the day's objectives for each patient, and decide upon tasks that patients should complete to fulfill the objectives and where and how each patient will report on their task accomplishment.

Although discussions of treatment planning in the professional literature often emphasize the important role of patient input into the process (Allen & Columbus, 1995; Hubbard et al., 1989), we did not observe MMP staff asking patients their opinion of the outlined treatment plan or soliciting input from patients about their objectives. Staff–patient interactions about treatment planning there occur primarily in one-on-one sessions, which were not observed for this study (only group sessions and interactions outside of groups were included). We were informed by the program staff that they ask patients whether there is anything specific they would like to work on and whether they have any questions about their treatment plan; patient feedback is included when it is given, and patients are required to sign their treatment plans. While patient involvement in the treatment planning is not *pro forma*, treatment planning is part of the overall paperwork and documentation process that is the domain (and responsibility) of the staff. For the most part, the patient role at MMP appeared to be passive, one of accepting and completing the assignments staff gave them in a timely manner.

In the hospital program, the documentation of patient's treatment plans and the progress notes consumes from 25% to 40% of staff's time according to interviews with staff. In addition to the morning treatment planning meeting and the first meeting with patients at which their treatment plans and assignments for the day are given, counseling staff documents patients' behavior in relation

to their treatment objectives throughout the day (often after each group meeting). The counseling staff are primarily responsible for these progress notes; staff members were often observed, after leading one of the various program activities, to immediately document patient behaviors: "Elbert, who had been leading morning exercise group . . . then took a seat and began writing . . . he volunteered that 'a lot of people participated today,' and that it was 'much better than Wednesday.' He appeared to be writing this down, in more detail" (interviewer notes, October 27, 1995).

At MMP, a weekly meeting is held with all the medical and counseling staff to review each patient and to provide input to the Director about possible discharge dates or other events. In staff meetings, primary sources of information on any given patient are the recollections of staff members who have interacted with that patient as well as the patient treatment plans and progress notes that staff members have recorded in patients' files. "She was able to look up for each patient if they'd attended specific groups, if they'd participated, and what they'd said. This information was obviously recorded by the staff member who had led the group; a typical entry was 'Patient demonstrated knowledge of disease concept,' or 'patient made a commitment to remain sober.' 'Patient did not attend," and "Patient attended but did not participate . . .'" (interviewer notes, October 27, 1995).

At MMP, the demands of assessment, treatment planning, documentation, and discharge planning are so extensive within a short time frame of 7 to 10 days, that a "critical care pathway" strategy has been developed to remind staff as to what assessments, planning, and documentation are due on which day of a typical patient stay (notes from interview, January 17, 1996). This critical care pathway serves as an overarching framework to remind staff of what is needed per patient per day and helps direct their activities so that they are thorough and satisfy all the requirements. The daily treatment planning and the weekly staff meetings along with the critical care pathway provide a structure that serves as a monitoring mechanism to insure that all required planning, implementation, and documentation is done. Although the documentation requirements are a burden on staff time (about which they complained), the documentation requires the staff to become familiar and knowledgeable about the patterns and progress of particular patients.

THE RECOVERY PLANNING PROCESS AT THE SOCIAL MODEL SITES

Since social model programs (SMP) do not believe they are involved in providing "treatment," neither SMP1 nor SMP2 use the term *treatment plan*. Instead, they develop what are referred to as recovery plans, which the residents themselves fill out, rather than the staff. In addition to devising the plan, the residents are responsible for the development, revision, and implementation of their recovery plans each week, month or phase of their stay within a context of staff and peer assistance and support. Although the primary responsibility is placed on the residents to complete and implement their recovery planning process, the staff and peer residents participate in an important guiding and "teaching" role in the planning and monitoring process.

New residents at SMP1 and SMP2 complete several forms about their substance use history and their other problems. They are interviewed by staff (and residents, in the case of SMP1) to ascertain that they meet the criteria for entrance. No diagnostic batteries of standardized instruments are used and staff do not make diagnoses. Consistent with the social model philosophy, newcomers self-identify their own substance abuse problems. As staff are fond of saying, people without substance abuse problems are unlikely to want to be in a recovery program for alcoholics and drug addicts, so elaborate screening devices are unnecessary.

A "master" recovery plan that sets a medium range of objectives (spanning 6 weeks at SMP2 and 3 months at SMP1) is made by a new resident within 30 days of arrival. As the Director of SMP2 put it, the staff helps newcomers develop their master plan, but will not direct residents in its writing. The recovery plan asks residents to assess (a) where they are currently in terms of 10 live domains, (b) where they would like to be, and (c) what they can do to reach their objectives in each life domain. The 10 life domains are: physical, employment, finances, legal, family, social life, drinking, personal, education, and spiritual. The recovery forms used at SMP1 and SMP2 are similar to the typed and photocopied forms found in SMPs observed in the 1980s (Borkman, 1983).

Residents are then expected to make a weekly recovery plan that relates to their "master" recovery plan. In the weekly plan, they describe what appointments they will make (e.g., for medical, dental, job training, or legal needs) and what 12-step activities, reading and writing assignments they will undertake to fulfill the specific objectives that will move them toward reaching their medium level objectives. The resident is expected to maintain a folder that has his or her master recovery plan, weekly recovery plans, and written assignments.

The weekly recovery plan is a concrete list of objectives, actions, and steps that the residents use as a guide of what activities to undertake daily in order to accomplish their objectives for the week. This use of the recovery plan to guide activities and tasks is analogous to the counseling staff deciding what should be each patient's objectives for the day and what tasks the patient should complete in order to fulfill his/her objectives.

How do residents learn how to develop a master recovery plan and the weekly recovery plans? At intervals, guidelines for how to develop recovery plans are discussed at meetings such as the initial morning meeting at SMP1 or Personal Recovery meetings at SMP2. The guidelines explain how to complete a plan, including the

purposes of a recovery plan, the meaning of each domain and its importance to sobriety. Residents have various opportunities to seek assistance from staff and other residents in developing plans. This includes seeing other's recovery plans to use as models, and hearing ideas from staff and other residents regarding the goals they might want to set out and the tasks they might want to accomplish. Recovery plans we have seen at SMP2 have included things as diverse as working on the first step this week, speaking to one's wife about the kids, and being more tolerant over the next week.

The staff role with regard to recovery plans is to assist in "teaching" residents how to develop realistic and concrete plans, to review and sign off on the mastery recovery plan as well as the weekly recovery plan, and to maintain a copy of the plans in the resident's program file. Room's (1997) analysis of the staff role concluded that reviewing recovery plans and assisting residents with them as needed is an important part of the staff role at SMP1 and SMP2. Staff emphasize the importance of preparing for jobs, through completing education or training (see Karp, 1997, Room, 1997) and of developing a sober/clean support network in the community in preparation for leaving the recovery home (see Barrows, 1998).

At weekly staff meetings at the two SMPs, staff discuss individual residents in need of extra help or motivation. In addition, a further monitoring device is in place, the Residents' Council, the self-governing body of residents elected by their peers (see Borkman, 1997). As part of the philosophy of self-management within a context of mutual peer help, residents through their elected Residents' Council decide upon and approve many actions related to the day-to-day operations of the recovery home, including the residents' movement from one phase to another, requests for passes for medical or other outside appointments, and approval of recovery plans. For example, the applicant meets with the Council explaining the purpose of their pass request for a dental, legal, or other appointment, the transportation they intend to use, and when they will return. At SMP1 the Council listens to the request and used Robert's Rules of Order in reaching a decision, with a motion, second, and vote to approve or disapprove a pass request.

The county substance abuse agency that funds most beds at the social model study sites holds a monthly utilization review at each recovery home. The County representative selects, at random, a number of residents' files, reviews them to insure that, among other things, the recovery plans made by the resident are there and are approved with a signature of a staff member and the date.

FUNCTIONS OF TREATMENT PLANNING AND RECOVERY PLANNING

Although the underlying approaches and styles are significantly different, the administrative and programmatic functions of treatment planning in the MMP and recovery planning in the SMPs seem to be similar: providing direction for staff and clients, tailoring the program to fit the individual's needs, providing staff opportunities to know patients/residents, and satisfying the requirements of third-party funders. In both cases, the planning process and documentation constitute a set of objectives and the means for achieving each objective that are tailored for an individual patient/resident during his/her program stay. This process gives a direction and benchmarks for patient/resident performance and progress during their stay. In both treatment and recovery planning, staff who are involved in the planning process and in the monitoring of patient/resident performance in accordance with the plan become familiar and knowledgeable about clients and their response to the program activities.

The written documentation about each patient/resident becomes part of the individual's case file. The staff develop and file the documentation in the staff office at MMP. At SMPs, the residents write their own recovery plans and weekly notes, and the staff review, sign, and date the plans. A copy of the recovery plan and notes is filed by social model staff in resident folders; the residents also have copies of their recovery plan and notes. This documentation is available to satisfy third-party payers about what "treatment" or "recovery" activities and services the individual received in exchange for the reimbursement the third party made to the program.

The substance abuse patients/residents, however, appear to be very differently affected by the treatment planning and case documentation in the medical model versus the social model sites. For patients in the medical treatment program, the plan and its accompanying documentation is controlled and conducted by the professional staff. Patients are involved to some degree in the planning process to the extent that staff decide to include them, but patients have no responsibility for developing their own treatment plans or reflecting upon and thus "evaluating" their own progress in meeting the treatment goals. The researchers saw little indication that patient input was sought by the staff that developed those treatment plans. The staff in the medical program, by going through the treatment planning and documentation of patient activity, learn a lot about the individual patient as noted above, but the process did not appear to be structured to provide the patient with the same learning opportunity. Patients do sign a form that acknowledges their agreement with the treatment plan.

Social model residents, in contrast to patients in treatment, are directly responsible for developing their individual recovery plan, for continually reflecting upon whether or not and to what extent their program activities help them accomplish their objectives and goals, and for modifying their recovery plans as they progress through various phases of the program. The program provides a general framework of life domains to be considered in the recovery plan, but leaves it up to the individual to de-

velop the specific objectives and means of achieving them that are appropriate to their circumstances. The residents use their recovery plan as a guide for what medical and other professional services to seek that week, what spiritual and other 12-step practices to do and what other job, family, or related actions to take that week. Neither the recovery plan or the planning process itself are *pro forma*.

Because of the emphasis placed on personal responsibility for the residents and because of the practice, review, and application aspects of planning in the SMPs, it would seem that residents in the program would be more likely to "internalize" the planning process and lessons, than patients in the MMP. Further, while the treatment planning process in the medical model program focused upon the alcohol, drug, medical, and psychiatric aspects of the patients' lives (befitting the medical focus and the relatively short stay), the recovery planning process appeared to have much broader coverage (about 10 areas of personal and social development), with emphasis upon employment and financial self-sufficiency. Not only were the emphases upon personal responsibility and planning coverage different between the two types of programs, there were distinct differences in the role of staff. While treatment plans appeared to be developed almost exclusively by MMP staff according to "clinical pathways" for particular medical problems, the staff were responsible for communicating these plans to the patients and for monitoring their progress during treatment. In the SMPs, staff appeared to act more as experienced peers and "coaches," providing assistance and ideas to residents while they reviewed and approved the plans.

Our observations suggest that from the beginning of their stay, residents at SMP1 and SMP2 began designing a new way to live, and setting goals they could achieve. Skills as developed in recovery planning are useful for planning for the future, and taking responsibility for that future. For example, an observer reported: "I asked her if she had been in another program. She said yes, she had and that this was the best one because they helped you to figure out your life after you leave the program" (interviewer notes, October 25, 1995). Thus, a direct result of the recovery planning process is that participants should learn how to expect different things from themselves, and for their futures. Such presumed "ownership" of the recovery plan may help participants feel that they "own" their recovery not just the recovery plan as well, and they are the party who is responsible for maintaining it. Future research is needed to test that hypothesis.

CONCLUSIONS

The answer to the originating question: Is recovery planning any different from treatment planning, is definitely yes. Although both recovery planning and treatment planning serve similar administrative and programmatic functions, the role of staff and clients in the planning process is significantly different between the two models. In both cases the planning process is logically related to the philosophy and the model of treatment or recovery. The persons who conduct the planning are viewed in both approaches as the responsible agent that "directs" client change: in one, the staff; in the other, the client. In both models the planning process is an integral part of the entire 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, and it may partially explain confusion about what *does* set them apart. If the similarities in administrative and programmatic functioning are easily apparent, but the differences between them had not been previously shown in detail as we have done here, then the resulting confusion is understandable. Hopefully, this paper will allay some of this confusion.

Treatment planning epitomizes or typifies the medical model and is an integral part of substance abuse treatment at MMP. In exchange for paying for treatment, insurance companies and government health insurance programs require detailed treatment plans and documentation of what clients receive. Funders also want services delivered by licensed professionals. The medical model is thus a system composed of integrated pieces. The expert hierarchical model (Weitz, 1996) is used: professional counselors, nurses, psychologists, and physicians are regarded as having the expert knowledge to identify what their clients need and to develop treatment plans that will fill in their gaps and provide them with what they lack. This system then includes professionals observing, monitoring, and documenting clients' behavior and attitudes in order to evaluate how well they respond to various aspects of the treatment plan.

Recovery planning also epitomizes or typifies the social model of recovery. The mutual peer-based model of experiential learning, the foundation of social model recovery philosophy (see the literature review (Borkman, Kaskutas, Room, Bryan, & Barrows, 1998; Kaskutas, 1998), focuses responsibility on the resident client to make changes in his/her life that will bring sobriety and support it. The self-directed recovery plan that clients are expected to develop and follow is formulated within an extensive network of peer "teaching" and support. Mutual peer help in the SMPs is manifested both through staff serving as senior, more experience, guides and role models, and through resident peers learning recovery *together*. This client-driven approach sets social model recovery apart from other professional therapist-driven treatment models, and is a reflection of the fact that social model recovery was not developed in response to diagnostic criteria.

A national study of the effectiveness of drug abuse treatment programs found that despite federal require-

ments that clients be knowledgeable about their individualized treatment plan, most clients had minimal knowledge and involvement in the development of their treatment plan (Hubbard et al., 1989). Our findings about the lack of client involvement in treatment planning at MMP are similar to those of the national study.

Both treatment and recovery planning processes are valuable in providing clients with individualized assessments, objectives, and the means of accomplishing them. Planning processes, however, are a means to an end, that is, the underlying goal is to assist clients to reach favorable treatment or recovery outcomes. This process evaluation research has descriptively documented similarities and differences in recovery and treatment planning which is an important first step. However, this research needs to be followed up with additional process evaluation research and with outcome effectiveness research on treatment and recovery planning in appropriately compared social and medical model programs.

Additional process evaluation research on other social and medical programs is needed to identify to what extent the results found here are idiosyncratic or generalizable to other programs of their model. Only one MMP was studied that makes it difficult to know how representative it is of MMPs. The two SMPs were basically similar in philosophy and practice, which is not unexpected given that they are part of the same parent nonprofit organization. Other social model programs are likely to vary somewhat in philosophy or in details of daily practice. Our empirical assessment of self-identified social model program (see Kaskutas, 1998) found that while most scored very high (in the top quartile) in social model philosophy, some scored in the third quartile as well, suggesting just such variation.

Although interesting similarities and differences were identified between treatment and recovery planning in the two models, how these findings translate into outcomes for clients cannot be answered by this research. Does the recovery planning process result in clients assuming responsibility for their recovery after they leave the program? Does what clients learn from the recovery planning process impact their recovery outcomes or not? Does the treatment planning process result in patient learning that facilitates favorable outcomes after they leave the program? How does the treatment planning process impact patients' outcomes? Outcome effectiveness research comparing treatment planning in MMPs with recovery planning in SMPs (with comparable lengths of stay and client problems) would be necessary to answer these and related questions.

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