What is a Community Rehab?

Realising Recovery in a Community Setting

South East Alternatives
2007-2012

Prologue

I remember sitting in a meeting with John Goldie and other members of the monitoring group for SEA, and the questions that were to drive me for the next four years just tumbled out, one after another. It was late in 2007.

" I mean, What exactly IS a community rehab? What is it for? And if we work that out, what is the best content and what is the optimum amount of contact time? I mean, can we really get people as abstinent as they do in residential settings? Does anyone know?"

We didn't know the answers. I made a commitment there and then to try and find the answers to our own satisfaction. South East Alternatives was beginning a recovery journey of its own but we didn't know it yet.

Glasgow and Community based rehabilitation

In the late 90's and early y2k's, Glasgow Addiction Service had routinely invested in a set of services ringing the city that came to be known as community rehab to distinguish it from the residential services GAS was also investing in.

By 2007 there were 6 such funded services and later funding was given to another one, bringing the total to 7. Each one of these services was different. They had different approaches, content, ideas about what they were doing and different ways of doing it.

Some focussed on activity based programmes with integral gyms and minibus trips, others focussed on self service, pick and mix programmes built around the participant, some had 12 step focus, others had SMART.

So it was impossible to compare one with the other, it became like trying to compare apples and pears. They were all fruit and all were able to demonstrate they helped people but which of them had the most effective interventions was impossible to identify.

South East Alternatives

SEA was one of the first such community services to be commissioned. Turning Point Scotland was the provider of this service. By 2007 it had a chequered history. Commissioned at the same time as the new Community Addiction Teams, SEA struggled to find and retain its place in the treatment flow. Over its ten years of life it had made some developments, particularly in the creation of an abstinent group within the service, but by 2007 its credit was at an all time low. It seemed that nobody had a good word to say about the project; its funders asked to put the funds on a month by month monitoring basis, the care commission labelled it "at risk", the referrers from CATs thought the service was rubbish (the exact words are not publishable) and the service users and its own staff team were deeply unhappy with it.

But exactly what is a Community Rehabilitation Service?

Evidently a community rehabilitation service could be anything and everything that helps people rehabilitate themselves in a community setting. So maybe the real question I want to answer here is "***What is it that a Community Rehabilitation Service can be?"***

A Community Rehabilitation Service can act as a catalyst for Recovery in a community setting. Community Rehab can increase abstinence in a community and achieve levels of abstinence on a par with residential rehab. A community rehab can speak all languages of recovery equally; can work with 12 step and psycho-social models within the same treatment setting and both models can achieve the same abstinence levels. A community rehab can change the community in which it is sited and can change the treatment system it is part of. A community rehab can positively influence the city and indeed the country in which it inhabits. A community rehab can be a physically beautiful and consistent recovery experience for participants.

A Community Rehab can initiate an excellent recovery journey and help participants achieve consistent, measurable and visible recovery success. People can achieve these recovery outcomes without giving up their tenancies, leaving their home and existing support mechanisms.

From early initiation in a Community Rehabilitation Service participants can act as an example of lived experience of recovery in their own community.

"The shopkeeper asked me the other day, what's going on with me? I haven't been in for my drink for a few weeks now, he was wondering if I was alright? I told him. He was really happy for me and said keep it up. I never realised how many people cared."
Brendan 2009

How do I know all of this is possible? We are doing it. It is a reality right now.

How did we do it?

Organisational Recovery Factor :' leadership stability'
from Wm.L. White's : "Recovery Management and Recovery Orientated systems of care"

The instability of SEA's leadership (it had been through 3 managers and acting up managers in as many years)was a key factor in its previous demise. The project had experienced different management styles, philosophies and levels of support.

The staff team noted that attempts to manage this drug service with a generic care management approach were particularly unsuccessful. Learning Disability services had different needs and approaches to drug services. Also noted was the problem of being managed by one manager who was working across two distinct services albeit both being community rehabs. The arrangement at one time, was that SEA's manager also managed another, equally large, community rehab in the East of the City called " Milestone". This did not help either service in the long term.

In early 2007 Turning Point Scotland took the key decision to appoint a single service manager to each service.

Kim Ross (Milestone, Service Manager) and myself took up post on May 1st 2007. Peer support such as was automatically there for Kim and I was a real boon. We could see that both services settled down really quickly and became increasingly less problematic and more productive by the simple application of regular and consistently available management support in the service and on the floor.

In the five years of operation since then, long term issues that had dogged teams; premises, staffing disputes, poor data quality, were resolved and the services were free to work on the quality, quantity and outcomes of their service delivery.

Organisational Recovery Factor **'Recovery orientation and representation'**
from Wm. L. White's "Recovery Management and Recovery Orientated systems of care"

In November 2007 Turning Point's Recovery Champion knocked on the door of the SEA service and gave us our 'recovery pack'. This new idea that addiction services were now supposed to turn to recovery had been floated at a staff conference earlier that year and I ignored it. My thinking at the time was that I had so much mess on my plate I had no desire to go chasing what I considered to be a pointless "flavour of the month"

Later that day, as I was disemboweling the recovery pack into the recycling bin. I was thunderstruck by this quote.

"Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms.
It is about having control over and input into one's own life. Each individual's recovery, like his or her experience of the mental health problems or illness is a unique and deeply personal process. It is important to be clear that there is no right or wrong way to recover."

I don't know why it struck me that day but it seemed to remind me of something that I had long ago forgotten; that people come to addiction treatment to get better. With nothing more than that simple reminder we began to take a recovery orientation in the service, a little bit at a time.

We began by asking "What does recovery mean to you?" We asked programme participants, we asked our colleagues, we asked our funders.

One day, we asked ourselves ; "**what would the project look like if it was in recovery?**"

Programme participants wanted the project to look better; all bright colours and green leafy plants, good furniture and pictures on the wall.

Staff wanted the project to feel safer; that challenging behaviour would be met consistently and assertively.

Both wanted something better in the way of the organisation and delivery of group-work.

Our chief executive wanted us to celebrate success.

Our referrers wanted a better quality programme that kept the space safe from illicit drug use and moved people on. *It seemed that everyone else wanted that too!*

The Scottish government wanted outcomes; measurable treatment outcomes.

Glasgow Addiction Service wanted greater referrals to be accepted and bigger numbers on programmes with more attention to traditionally hard to engage groups such as women and people from minority ethnic groups.

The most critical point however was, we acknowledged that as a project, we were sick and needed to get better.
The project consciously went into Recovery itself.

So the project itself began to mirror the individuals recovery journey. For the project it means letting down our defensiveness about what we are doing and opening up to feedback. It meant listening to hard to hear criticism.

It meant acknowledging, that even at our best, we are NOT the cure. Indeed no matter how great our programme is, no matter how compliant a person is with our requirements, that still does NOT automatically mean a cure from addiction for the person.

It means though, even at our worst, we do not cause relapse either. Our first realisation of our recovery as a project was this:

We are not responsible for anyone's individual recovery journey. They are.
We are only responsible for our contributions to it.

Organisational Recovery Factor **'Technological Capabilities and Adaptive Capacity'**
Wm L White: IBID.

Some Research about addiction programme content that struck a chord with me is that there is no 'magic bullet' content wise. By 'Magic Bullet' I mean, content that, being applied in a treatment setting, automatically brings about change for the better.

However, what **has** proved to be useful in enhancing recovery outcomes for participants is the boring and predictable stuff. It is the workforce stability, consistency and transparency in the teams service delivery and decision making processes. It lies in the clarity of and belief in the programmes being delivered. Strong and positive relationships with referrers in CATs and positive, active links with lived experience of recovery, increased abstinence outcomes for individuals on programmes immediately.

So we make our content from legitimate well respected sources and offer a consistent recovery based programme that builds a deep understanding of addiction and active practice of tools for recovery.

We incorporated much, but not all, of the feedback we were given, into our programme design and structure. We created a clear three phase day programme, that, from beginning to end, lasts just short of a year. We created clear outcomes for each phase that got incrementally more challenging as the participant moved through the phases. We created clear transition rituals at the end of each Phase. In these rituals we celebrated success, in groups, in reviews and at our quarterly graduation ceremonies in front of families and friends. Then....

We took a leap of faith and created abstinence outcomes for each phase.

To be truthful, I was not sure we could do it. Having set ourselves a collective goal of 7 days abstinence from primary substances of abuse for everyone who passed our 28 day phase 1 programme, we held our breath and went for it.

Obviously we did not just have a wing and a prayer to rely on. We had new support tools to work on in 121 sessions. We set weekly standards for 121 and group attendance. We insisted on 'fitness for work' as a criteria for entering group. Any sleepiness, apparent under the influence symptoms were met with clarity. " Away home and we'll talk tomorrow when you are better"

Our service specific policies were agreed by both staff and programme participants and applied to both groups equally.

These early Time boundaries/ Medication and Drug Use/ Assertive Communication policies have been the basic planks of our recovery together as a project. There were no exceptions to the time boundaries, I have been known to say God himself cannot get you into the group after the 15 minute window has closed. Staff had no such window.

In the beginning everyone tried; care managers, staff, mothers, programme participants. There were really great reasons. But the basic fact is, if you are not there on time, life goes on without you. It is basically rude to enter a group after it has begun its process. Within six months we rarely had anyone late. Within 2 years the culture was on time and it was inconceivable to imagine that you could get in after the group had begun.
These policies have stayed relevant and unchanged for the whole five years.

Daily Dose- Participants
One of the great Glasgow Community Rehab inconsistencies was in the area of programme dose. How much contact time was needed for each individual person to achieve the goals of the Phase? Some rehabs had 6 daily hour contact programmes, others had 2 hours weekly contact.

In choosing to opt for a dose that started at one hour in week one (2 short 121 sessions) and rose to 7 hours weekly (3 groups and 1 hour 121) for the rest of Phase 1, we were looking to create positive consistency but ***NOT*** disable the need for the participant to organise their own life outside of the rehab programme.

In Phase 2 the dose reaches its height with a daily morning group and a weekly 1 hour 121 session (10 hours weekly). This 16 weeks in Phase 2 is the work horse of the SEA recovery programme; a daily morning study of the addiction problem and tools for recovery. The afternoons are free for appointments and other self directed activities. We wanted to encourage, cajole, push individuals into regular use of recovery meetings in the community and generic community resources ***as well as*** the rehab. We wanted to do this at an appropriate pace for the individuals stage of recovery.

In Phase 3 the wave of contact subsides again and we move down to the same pattern of 7 hours weekly that we began with. This six months Phase 3 programme leaves plenty of space for the community volunteering and study that are a key part of the Phase 3 outcomes.

Each participant had to attend 70% minimum of the programme as one of the outcomes, at the beginning this was a challenge, but soon there were 100% attendances in Phase 1, then Phase 2 and there have been several 97% Phase 3 attendance levels.

In addition there is the daily optional acupuncture clinic open to all phases, the weekly blue and green methadone withdrawal group open to all phases, and when it works; the service users forum.

Daily Dose: Content "Something tae dae????

Organisational Recovery Factor **: "An esteemed status of addiction treatment as a cultural and community institution." from Wm L White " Recovery Management and Recovery -orientated systems of care"**

One of the great bug bears of our referral process in the beginning of the recovery change at SEA was an apparent non valuing of the work of community rehab. When asked ; "what it is you are hoping the service user will achieve by coming here?" the most common aspiration of referrers was:

"Give the client something to do" or "something to occupy their time" even " give some structure to their day".

It became clear that not a lot was expected of community rehab, it was the poor relation, not quite good enough in terms of helping people get better, when compared to the high status accorded to residential rehab.

The idea of Community Rehab as a low expectation, engagement focussed, youth club for grown ups was reinforced by community rehabs themselves. The previous SEA leaflet had table tennis bats, pool tables and other games on their cover. Weekly outings and activity based groups were designed to “keep people busy”. We placed a great deal of emphasis on support and person centred planning but very little on outcome planning and exit planning. Now just “keeping people busy” can contribute to recovery but it is an opportunity missed to build conscious and sustainable recovery in the community. “Keeping people busy” can be done by anyone; building conscious recovery takes skill.

It struck us forcibly that you can expect a lot more from your community rehab but it needs to stick to what it is good at and do that excellently. We decided to stop doing “play time”. By that we mean we didn’t use paid staff time to run trips that any grown adult could organise. We handed funds to self organised groups of programme participants who ran football groups, trips to exercise classes, dinner out and took themselves to events . The staff created and delivered, 100% consistently; a recovery group and 121 programme that focussed on the work of addiction recovery. We made a commitment to never miss a day. If it was on the programme, it happened, on time. Our staff compliance rate with this is 100%.

In this we stopped the dependency culture that can arise in addiction projects and began to support a culture of self help activism that is a feature of recovery projects.

Daily dose:Staff
Staff enjoy the predictability in their routine too. They have clear and regular groups to deliver. The programmes are timed, session plans all written up in phase manuals, group rooms are polished and made ready for operation every day, they are given the tools for their job. They know exactly what is expected of them and there is clearly time to do it.

Each full time staff member has 13 programme participants and 2 assessments to meet for hour long 121 sessions to each week. The 3 groups staff deliver each week are attached to a particular phase of the programme. They have the capacity to rise to delivering four but no more than five groups weekly to allow for cover for sickness and holidays in the team. The manager is part of the back up cover for the group programme.

Staff have evolved regular acupuncture clinic and visit presentation rotations and have a working rota of household duties themselves for locking up and tidying up at the end of the day.

It has taken five years of recovery in the project for our collective system to be able to grow a culture of therapeutic duties with programme participants. They have always helped out, but we found it hard to create consistency among us in this. Its still a work in progress along with the participant led forum which goes through boom and bust periods depending on who is on programme at the time.

So in terms of technological capability and adaptive capacity, recovery means the ability to be consistent, to design programmes in which the staff team model stability and where participants can learn it. It means having strong team relationships and the ability to be wrong in public.

There is more of that elusive “magic bullet” in the staff modeling the very behaviour we want the participant to achieve. So for example, if we want them to be on time, we need to be and a bit more. If we want them to be open, them we must also.

Organisational Recovery Factor **“ Increase client choice of treatment goals, methods, recovery maintenance frameworks and strategies” Wm L White “ Recovery Management and Recovery -orientated systems of care”**

Recovery by any path.
The adaptive capacity was also shown in being the first of the community rehabs in Glasgow to actively speak all languages of recovery equally. We adopted the ‘ by any path’ approach. A previous attempt at an abstinence only group in SEA made a critical error which only became clear after the first enormously successful wave of participants had concluded their work in the service.

The ‘abstinence only’ group created a two tier recovery and one was considered to be ‘better’. It meant the other group was automatically the ‘non-abstinence’ group or harm reduction group. Though they were both, when I arrived, Phase 2 programmes. The harm reduction group had much lower expectations of themselves in terms of coming off their substitute prescriptions and not using illicit drugs on top of the prescribed medication.

We decided to really promote choice in recovery models. We declared that whatever path participants chose, their choice would lead to the same outcomes. So our Phase 2 now has a clearly 12 step centred sequence of groups and a clearly Psycho-Social centred sequence of groups at the same time. Now both treatment pathways lead to abstinence and the same recovery outcomes. Participants can move from one to the other on a daily basis if they choose.

‘You have achieved 8 weeks consecutive abstinence from your primary substances of abuse and are clear about your goals and approaches to any secondary substances and behaviours that may threaten your long term recovery.’
SEA outcomes Phase 2 , 2011.

After a year or two our staff team requested that we add more languages of recovery, so we looked at positive psychology, CBT and Solution Focused groups. We created 4 group programmes from them to sandwich the week with positively directed groups and the core of week would be 12 step/ psychosocial. This creates a culture of recovery path choice and respect of difference in path. The shared goal is:

‘ You have a working knowledge of your addiction model of choice and can tell us how you came to have an addiction problem from that perspective.
You can give concrete examples of having applied any learning from the group programme in Phase 2 to your ongoing recovery challenges. ‘
SEA outcomes Phase 2 , 2011.

The greatest technological and adaptive challenge: Creating a Phase 3!

It took three years to create a sufficiently challenging and engaging Phase 3 programme. It was road tested and refined over another 18 months.

Long after our Phase 2 programme was 'motoring' as we say in Glasgow, we were still toiling with what this Phase 3 should and could be.

One of the salient problems was that after a five month programme of solid addiction work, participants had all the key tools to get and stay abstinent in the community while they were ***on programme.*** They were bored rigid with addiction models. But they were early in recovery still and there was still a whole 'road less travelled' of maturing recovery to be developed in them. How Phase 2 participants would sustain their recovery in the community after the programme completed we were not so sure.

So we faced the challenge; how do we create a six month recovery programme that built on maturing recovery and didn't go backwards into basic triggers and relapse prevention?

On the other hand staff hired, trained and experienced in an acute treatment model only are not routinely equipped to deal with the challenges brought by people in maturing recovery. Its not enough anymore for staff to know their triggers, their basic 12 step work,etc. I mean what do you offer to someone who is already abstinent and attending recovery meetings in the community? Do they need anything more?

In many respects, perhaps not. Many community rehabilitation programmes such as LEAP in Edinburgh and Second Chance (prior to 2012) were 90 day programmes and after completion; aftercare meetings were what was on offer.

They both report strong continuing abstinence outcomes after closure of treatment, attributed to ongoing involvement in both aftercare and attendance at community recovery meetings.

We could have stopped there and sat on our hands and pointed to these examples and said job done but it did not feel right. There was a whole level of preparedness to return to the world that was still not apparent at the end of Phase 2.

Our Failures/ Experiments

We tried working with these twin limitations; the unknown need of the participant in ongoing and maturing recovery at the 6 month to first recovery birthday stage and the undeveloped staff trying to meet it. Our first attempt was made by buying whole ranges of self help manuals and working through them together.

This faltered on the rocks of group members lack of comprehension of some of the materials and staff lack of familiarity with advanced group work practices. It left the programme very cognitively based for a group of people whose naturally learning styles tend more to the kinesthetic and visual. It was too much and what we had done in Phase 2 was now too little for them.

A colleague; Billy, grappling right now with the Phase 3 programme creation problem put it succinctly;

“ We have to offer something pretty spectacular to get them back to the project base in this part of town after they are linked into fellowships”

We then rooted round in our experience and asked what are the key areas that cause relapse in people after treatment completion? Romantic Relationships, Family Relationships, Self Awareness came out top. We created courses from our widest human knowledge banks and the most experienced staff (including the manager) taught them. We bought in outside teachers where we had no experience and while we were developing the skills ourselves.

The whole team developed their group work skills to advanced level. They deepened their levels of feedback to each other and worked on their co-working and interpersonal issues very strongly. A culture of taking personal responsibility for our actions, feelings and relationships with each other in the team began to take root. This is significant in our ability as a team to deliver the Phase 3 material because..

What we are essentially grappling with, at this stage of maturing recovery, is the individuals need to take their spiritual and human development to a greater level than the one on which their addiction arose. To facilitate this process, the team member needs to be a bigger personality themselves; to have explored something further in human psychological and spiritual experience than the minimum required to get an SVQ 3.

Now this kind of human development can happen naturally in the course of the 12 step programme and personal recovery journey’s after completion of treatment. It rarely happens naturally as result of being in the workplace though! I thought about my own recovery journey and that of my friends. We had the benefit of long term self financed personal therapy, I could attend workshops on therapeutic issues like trauma and was well involved in spiritual practice before I got into recovery.

But we had the manpower in SEA, the funding and the willingness to create a new kind of treatment contribution in community rehab. One that would make a significant contribution to sustainable recovery in the community. Might there be something emerging from the new recovery research and practice that might help us to make that contribution effectively? Might the effort to make that contribution not also raise the bar for staff as well and help them develop as humans too?

Enter the BIG IDEA..... '*FIVE YEARS OF RECOVERY'*

"addiction treatment has become detached from the larger and more enduring process of long term recovery'
from Wm. L. White " Recovery Management and Recovery Orientated systems of Care"

The Connecticut Recovery work showed us two key ideas : The idea of the 5 Years of Recovery and the outline of the 9 dimensions that sustain long term recovery in the community.

The significance of the Five Years of recovery is that when individuals reach that milestone in their recovery, they have the lowest rate of relapse from then on. They report themselves to be happier, better adjusted citizens than ***people who never had an addiction*** at all. The 9 dimensions of Recovery are the parts of one's personal behaviour and social organisation that support the achievement of that magical five years of recovery.

These helped us find the answer to the question "why bother do a Phase 3 at all?" They gave us the purpose and theoretical underpinnings for our new phase 3 programme and some ideas of how we might contribute to recovery journeys beyond treatment.

Phase 3 exists as a six month therapeutic and educational programme to build the factors that sustain five years of recovery in the community.

We are building lifetime resilience to relapse by developing the human adaptive capacity. We are developing the future citizens of Scotland, adapted, sophisticated, psychologically developed. The 9 dimensions are explored in depth over a six month programme. We used everything we have ever learned and some more to create the content around six themes. We added strong community action outcomes to Phase 3 and Phase 2 as a result of our work with these dimensions.

At the beginning of the programme; the participant co-creates a care plan that focusses on building their practice of the 9 factors that sustain long term recovery

During the programme participants undertake a clearly planned community project whose focus is giving something back to the community. Their report of this forms part of their claim for Phase 3 graduation.

At the end of the programme: The participant makes a report on how they have maintained their recovery so far and how they plan to sustain their recovery for five years using the 9 factors as a framework.

from Phase 3 Outcomes 2011.

This Phase 3 has now been written up in manuals and the whole programme has been run through three times. We are now confident enough in it to make graduation from Phase 3 contingent on completing all six of the themes as well as the 90 days abstinence and other recovery capital outcomes.

Our Recovery programmes are now well attached to the larger and more enduring process of long term recovery.

We are seeing our graduates leading on community activism in recovery, making up the front row in city recovery events and often organising them behind the scenes too! Our graduates are the largest group in the volunteer training and now are among the community rehab graduates who are beginning to find work in the treatment system they graduated from. There are 255 of these SEA graduates now.

Putting The Community back into Community Rehab

Recovery Factor "availability of funding streams for sustained recovery support"
Wm L White " Recovery Management and Recovery -orientated systems of care"

Community Rehab is now creating greater numbers of people in recovery. Abstinent, active individuals who are keen to offer "something back" to the rehab in their community. We began to get urgent requests from our graduates to let them help in our third year of recovery as a project. After a winter of dialoguing and a graduate recovery conversation cafe, we developed the recovery and beyond team (RAB). Our first experiments with recovery volunteers began 2009/10.

This experiment has been funded from our own basic funding sources; the local health and social care partnership for treatment and the city wide community planning funds for employability.
In 2010 we made a deliberate shift in how we used the City Wide funds and started to allocate some of that resource to creating recovery tools and processes for community rehab and to experiment with what sustained recovery support might look like. This fund paid for both the first recovery volunteer training programme and the evening SUSTAIN programme facilitators.

There is a separate report about the outcomes of this work " The Final Report- FSF/ Community Planning," Our next steps on the Road to Recovery" published Dec 2011.

First funding stream- zero sum

All of our initial recovery work was done within existing budgets. We could see no point asking for " mo' money" when we had not fully used the money that was available to us.

This was incredibly helpful in the first instance because we did not need to ask permission to spend some of our available funds to develop recovery tools and processes. It meant our conversation cafe experiments were able to develop unfettered by expectations or need for any great outcome. It meant we operated below the institutional committees and conference circuits radar. It meant we could move quickly, make mistakes, learn and move on. It felt a tad subversive! And it has worked amazingly well in the areas where we applied it. Glasgow South sector is leading the recovery transformation in Glasgow from just this zero sum position.

Second Funding Stream- seed funds, with a little help from your friends.

None of the early experiments were funded from any fund labelled 'Recovery Fund'.
The Second All City Conversation cafe was funded by the Alcohol Initiatives Fund to the tune of 4k. It was given £ 200 from the main budgets of each participating community rehab.

The scottish government paid for the BIG WELCOME from a fund set aside for service user involvement. It also gave seed funds to pay for the adaptations to Wired In to allow it to create and launch a scottish forum within the online community.

SERAG was funded by Glasgow Community Planning and then spent a good part of its funding from this source on the set up and first half of the year running costs of RAFT. SEA supported this RAFT initiative by offering its rooms, its technical support and photocopier!
Now RAFT is funded by the AIF, the ADP and the service user involvement fund and is supporting the extension of the SUSTAIN programme in its event.

The Second Stories experiment, currently in production at the Citizens Theatre is funded by AIF, the Scottish Book Trust and the Turning Point Scotland Innovations Fund.

This type of mutual co-sponsoring and helping out each others ideas comes from a strong commitment to networks, relationship building and arises naturally from conversation cafe based development approaches. It makes solid and creative use of existing resources.

Third Funding stream- every service plans for five year contributions
With the Glasgow Abstinence Service bid, Turning Point Scotland went into partnership with Second Chance. Our collaboration helped create the " Glasgow Model" for community rehab. An important part of that service design was taking a bit of the 150k annual budget and setting aside funds to make service contributions to year 2 - 5 of Recovery.

This new Glasgow Abstinence Partnership took up the mantel of funding the first city wide Recovery Volunteer Training and the second. Extra places were made available to community rehabs outside of the GAP. The SUSTAIN programme was entirely funded by GAP this year and made its leap out of SEA and into RAFT as a result of RAFT offering to fund rooms for it. This programme was open to all, not just GAP projects.

The GAP also ran the first Steps to Excellence training course jointly for staff and volunteers. This spring(2012) it trains a cohort of staff and volunteers as Steps To Excellence facilitators. It also contributed Acupuncture training to the working volunteers. The GAP made 'a lived experience of recovery' one of its desirable qualities in its staff recruitment.

This shift in direction may seem small but it creates the habits and the intention to fund more than just the early stages of recovery. It allows for low key, low risk experimentation to work out the wrinkles in our evolving practices in these new areas of service and treatment contribution to maturing recovery.

The Community addiction team in the south has begun to look at how it can offer small bits of commissioned recovery work to people in year 2 -3 of recovery who are moving back towards work or self employment.

SEA is now using its Community Planning funds to set up a recovery volunteer support unit and placement bureau for the city. This unit will take the GAP funds and organise the second all city recovery volunteer training programme and ensure that the SUSTAIN programme happens in all 3 sectors of the city not just the south. This very small team will also begin to organise the post treatment completion recovery check-ups that are suggested in Wm L White's Recovery research.

Fourth funding Stream- re-tendering of the entire community rehabilitation system to commission for recovery/ main stream funding sources.
This has not happened yet in Glasgow, but interestingly this is where many treatment based recovery actions have begun in the UK. When it comes to Glasgow, as surely it must, this re-tendering will be strongly influenced by the recovery work that has gone on already. We know so much more from these experiments about how to work the various levels of recovery contributions and are creating the language and the habits that mean that recovery is already alive and well in the City. Each main funding area, addiction or not, can contribute to recovery.

The Second Stories experiment will be the foundation for an application to Creative Scotland to establish an arts in Recovery project for Glasgow. The project will hire artists in recovery to bring an arts and creative element to years 1-5 of Recovery. Glasgow Works, the employment creation group, has been asked to support a drug worker trainee scheme that can offer paid training posts to people in recovery and give them a years work experience in Community Rehab. These are attempts to bring funds other than those labelled addiction to the work of recovery.

Community Rehab can and does have an active role to play in recovery in the physical community in which it sits as well as the system in which it treats. It has a responsibility to plant the flag for Recovery; for people getting better and exiting service land. We find when one part of system, like a community rehab, gets the Recovery bug, the whole system gets affected positively.

To do this we need a little help from our friends and colleagues. No service, no agency and no organisation can do recovery alone. By combining in natural affinity groups to promote and develop recovery, we can use our collective leverage to pack a much bigger punch than our numbers, status and resources would normally merit. Community rehab can be the key stone in treatments response to Recovery.

Dharmacarini Kuladharini
February 2012.

'If I have been able to see further, it is because I am standing on the shoulders of giants' Sir Isaac Newton

dedicated to the Giants of SEA, South CAT and my friends in Recovery.