Recovery Community Centre

Business Case

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September 6, 2019

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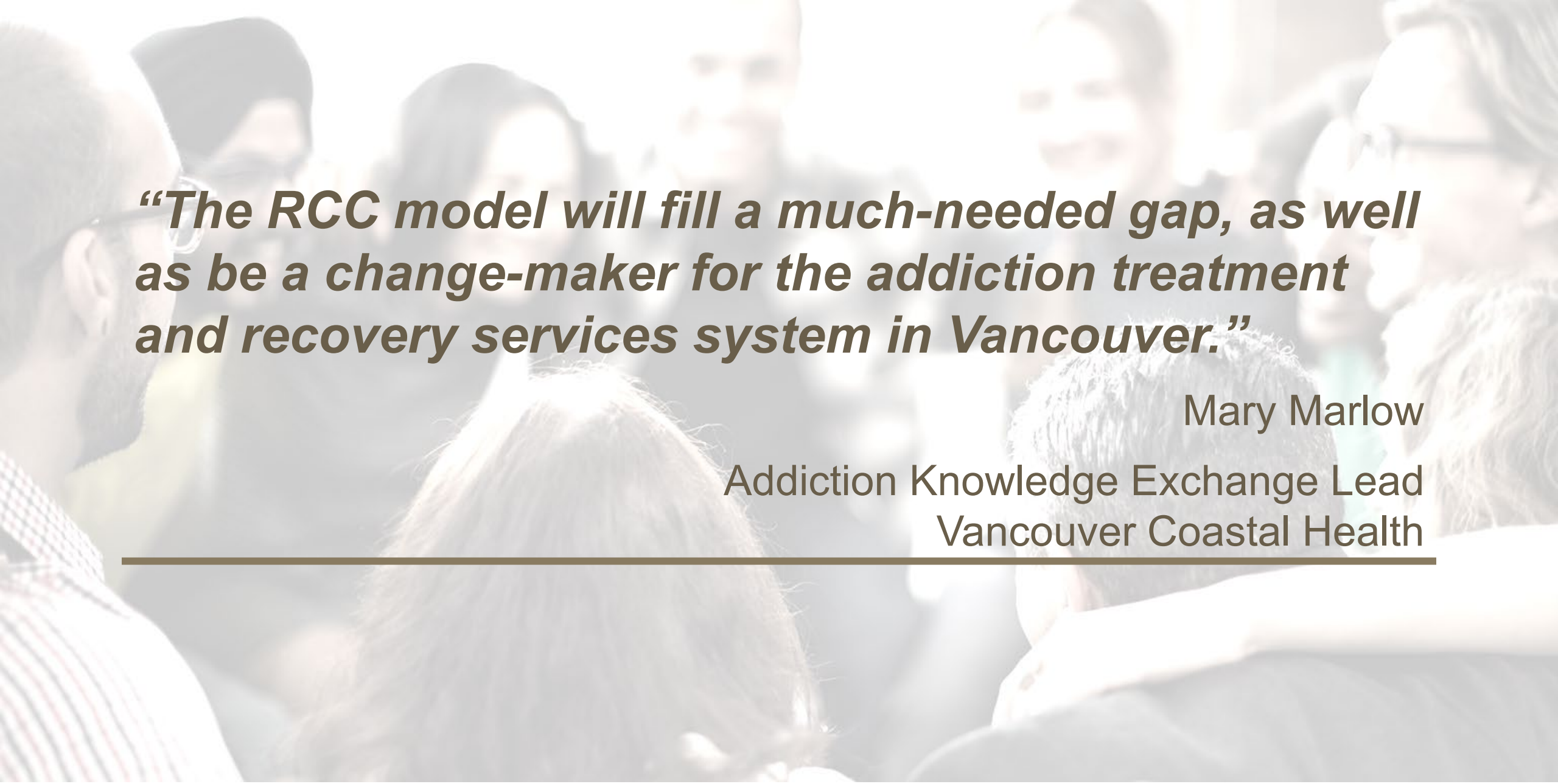

"The RCC model will fill a much-needed gap, as well as be a change-maker for the addiction treatment and recovery services system in Vancouver."

Mary Marlow

Addiction Knowledge Exchange Lead
Vancouver Coastal Health

1 Understanding the Challenge

2 RCC as a concept

3 Components of an RCC

4 Cost and Funding

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Executive Summary

Streetohome is a charitable organization committed to the development of thriving citizens by addressing gaps in the homelessness services system with innovative evidence-based or promising practices that enhance safety and belonging, housing, health, employment and education for this vulnerable population. Streetohome is exploring opportunities to broker and leverage an adaptation of the Recovery Community Center model, that has propagated coast to coast across the United States, to prevent homelessness and provide additional pathways out of homelessness.

A Recovery Community Centre (RCC) is a peer-operated, community-based recovery support centre. RCCs deliver peer-to-peer recovery services targeting individuals who are advancing their recovery journey. RCCs offer a place for mutual aid group meetings, workshops, training, and community-building among peers helping to change social networks and enhance recovery outcomes.

This business case provides an analysis and evaluation of a preferred adaptation of the RCC model in Vancouver. To support this analysis, the business case first outlines the current state of addiction, key risk factors related to addiction recovery, and an introduction to the recovery journey. Next, the RCC model is further defined, with consideration of successful models in Seattle and Portland. To arrive at the 'best fit' adaptation, this business case identifies critical components. This exercise considered findings from a literature review, ongoing RCC studies, qualitative feedback from case studies of the U.S. models, as well as insights shared by the RCC Advisory Committee.

Streetohome identified seven RCC-like sites currently operating in the Greater Vancouver Area. A comparative analysis of these seven local sites and the two successful U.S. sites was completed. The nine sites were assigned a score from 1 (little to no alignment) to 5 (full alignment) to indicate how closely each site aligned with each critical component. This review is not a reflection of the quality or services provided by these seven sites, but instead of how closely their existing operations aligns with a best practice RCC model (i.e., reflecting all critical components).

Four different scenarios are considered in the business case. Based on the analysis put forth in the business case, a Recovery Café model offers a significant benefit in risk mitigation, ease of implementation, and is closely aligned with Streetohome's goal to broker and leverage homelessness services system enhancements that prevent homelessness and provide additional pathways out of homelessness in Vancouver.

A primary recommendation is to adapt the Recovery Café model for Vancouver. A preliminary cost and funding considerations as well as other implementation and design considerations for this recommended scenario have also been provided for reference.

A secondary recommendation is to run parallel initiatives: both the Recovery Café model, and work with existing RCC-like site(s) to enhance individual site operations and connections with the addiction recovery system in the Greater Vancouver Area.

Contributors

Thank you to the Promising Approaches Committee of the Streetohome Foundation Board, Rob Turnbull (President & CEO) and Tracey Harvey (Addiction Recovery Lead) for their inspiring vision in support of people seeking and in recovery.

This business case reflects the expertise, passion and courage of the following individuals who have contributed time and energy to Streetohome's Recovery Community Centre Advisory Committee:

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- **Amanda Butler**, MA (Criminology), PhD Candidate, Faculty of Health Sciences, SFU, Research Assistant, Psychiatry, UBC
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- **Mary Marlow**, Addiction Knowledge Exchange Lead, Vancouver Coastal Health
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Thank you to **Adler University** for their support through the following Social Justice Practicum Students:

- **Caitlin Zalm**, Master in Counselling Student, Adler University
- **Jue Wang**, Master in Counselling Student, Adler University

All documentation created over the course of this initiative was shared with Dr. Seonaid Nolan, Clinician Researcher, BC Centre on Substance Use; Assistant Professor in the Department of Medicine, UBC; Physician Program Director, Interdisciplinary Substance Use Program, Providence Health Care.

The Terms of Reference for the Recovery Community Centre Advisory Committee are located in the Appendix C.

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What is the state of addiction today?

Addiction and Recovery in Vancouver

69% of the homeless surveyed in the 2019 City of Vancouver Homeless Count reported an addiction issue as a health concern.[3)]

1 in 5 Canadians personally experience a mental illness or addiction problem[4)]

"British Columbia is in the midst of the worst public health emergency in decades. Before the end of this day, three to four people...will die, each of them leaving behind family, friends, loved ones and communities that are devastated by their loss."
– Judy Darcy,
BC Minister of Mental Health and Addictions[1)]

Many individuals living in shelters and supportive housing are aware that their drug use is problematic and that they need to make a personal change. Recovery is a priority for most, yet accessible and effective addiction treatment and recovery pathways that meet individual needs are often unavailable or inaccessible.[2)]

Recognizing that addiction is a chronic disease, and that relapse is common for some, it would be useful to find a support mechanism that improves outcomes for individuals exiting recovery programs, while demonstrating an improved return on public investment and the freeing up of limited resources for others in need.

In the City of Vancouver Homeless Count 2019 survey, there were 2,223 sheltered and unsheltered homeless people identified, of which 69% had an addiction to at least one substance.[3)]

What is Streetohome's vision?

This business case delivers on Streetohome's objective of "Thriving Citizens"

Streetohome is committed to the development of thriving citizens by fostering enhancements to the homelessness service system that contributes to a robust array of support options to meet the safety and belonging, housing, health and wellness, skills and training, employment and legal goals of a vulnerable population.

Our role: Streetohome's overarching goal is to leverage and broker a comprehensive system response to homelessness to ensure that homelessness in Vancouver is prevented whenever possible and, when homelessness can't be prevented, to ensure the experience is least harmful, brief and non-recurring.

Our goals:

1) Provide stable housing with appropriate support services
2) Prevent people who are most vulnerable from becoming homeless
3) Build broad public support and commitment for permanent solutions to homelessness

Our focus area: After broad consultation with the community and partners, and a review of what's working in other jurisdictions, Streetohome is exploring opportunities to broker and leverage innovative promising models that prevent homelessness and/or provide additional pathways out of homelessness in Vancouver. Addiction recovery is one of the significant areas of focus emerging from Streetohome's work.

Streetohome supports evidence-informed and outcome-focused addiction recovery pathways that can be adapted in Vancouver to fill gaps in the addiction recovery service system. Further, initiatives that encompass the Streetohome stool and help to solve the myriad of goals individuals have to move forward with their lives will be favoured.

$31.5M In donations raised for housing and homeless prevention programs since 2008

2669 Vulnerable individuals helped, who will not be included in future homeless counts

34 Supportive housing and homelessness prevention initiatives that filled system gaps

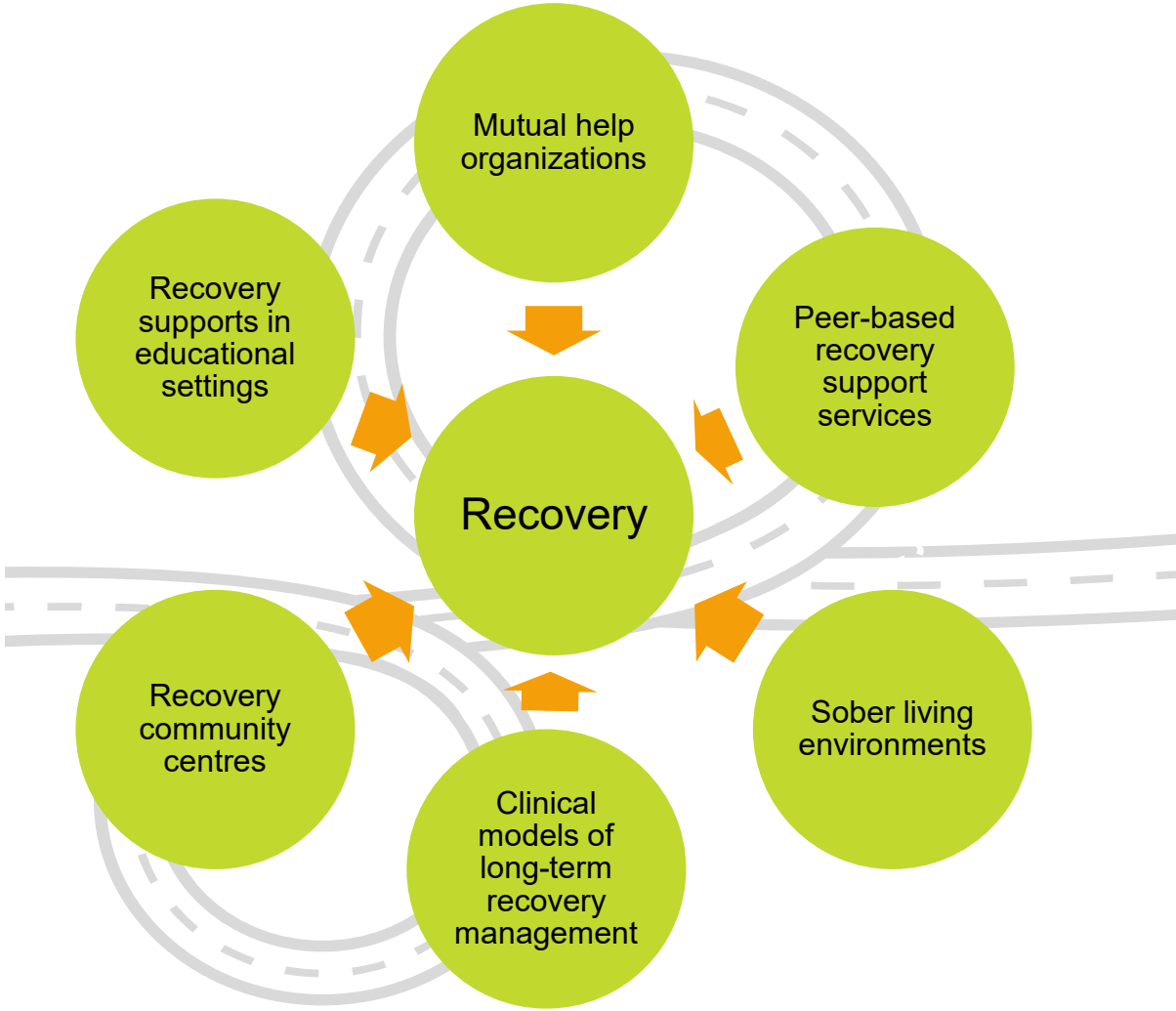
There is no single pathway to addiction recovery

Addiction is a disorder with complex interactions between biological and social variables.[5)]

The last decade has seen new forms of peer support emerge from a “new addiction recovery advocacy movement.” One structure for organizing peer support is the Recovery Community Centre (RCC), which combines social fellowship with the service mission of a community centre, while offering system navigation, assessment, referral and new services like recovery coaching. The backbone of the RCC is its volunteers from the recovery community, who instill hope, role model recovery, and dispel stigma. This movement took root in the USA in 2001 and since the implementation of the first RCC, there are now more than 100 coast to coast. To date, there are no true Recovery Community Centres in Canada, however, there are programs with elements of an RCC model.

The relationship between substance use and experiences of homelessness is complex. While rates of substance use are disproportionately high among those experiencing homelessness, homelessness cannot be explained by substance use alone. Once on the streets, an individual with substance use issues will face many hurdles to access housing as they face significant barriers to obtaining health care, including substance use treatment services and recovery supports. The longer people live on the streets, the poorer their health status becomes.

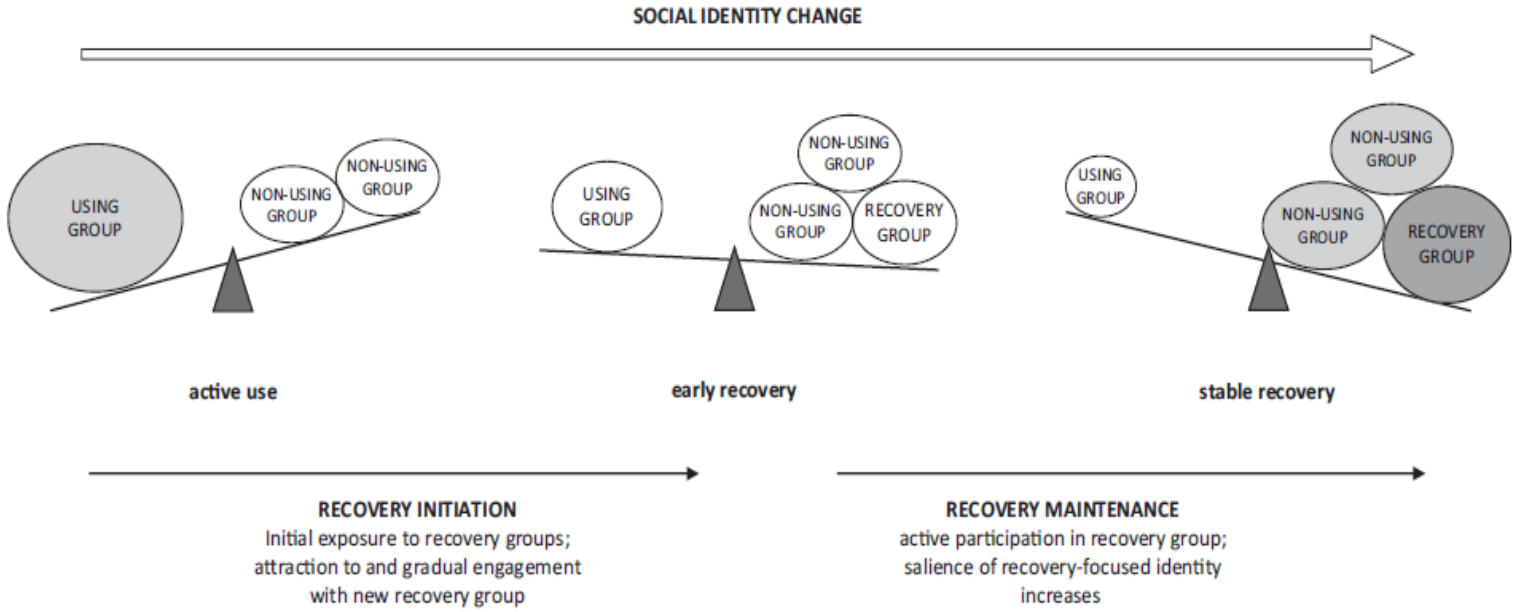
The Recovery Community Centre (RCC) is a model of delivering services to interrupt and break the cycle of entrenched structural barriers and create a new sense of identity associated with recovery. It also provides people with a stable and welcoming place to go during times of transition through institutions - **Ultimately, building capability and reducing risk of homelessness**.[6)]



What is the greatest motivating factor to addiction recovery?

Social identity is a leading factor for addiction recovery

"…In order to achieve recovery, addicts must fashion new identities, perspectives and social world involvements wherein the addict identity is excluded or dramatically depreciated".



50-60%

Individuals with an addiction will achieve full sustained remission (White, 2013).[5)]

A review of evidence supports claims that simply belonging to one or more social groups or networks is supportive for recovery (Best et al., 2010). This emphasis is consistent with related observations that groups and their associated norms influence a range of substance-related outcomes including the initiation and maintenance of substance use (Hawkins, Catalano, & Miller, 1992), attrition from treatment (Dobkin, Civita, Paraherakis, & Gill, 2002), as well as risk of relapse following Alcohol and Other Drugs treatment (Hser, Grella, Hsieh, Anglin, & Brown, 1999).

Social identity model of recovery (SIMOR) builds on two complementary theories – Social Identity Theory (SIT) and Self-Categorisation Theory (SCT). SIT proposes that, in a range of social contexts, people's sense of self is derived from their membership of various social groups. The resulting social identities serve to structure (and restructure) a person's perception and behaviour – their values, norms and goals; their orientations, relationships and interactions; what they think, what they do, and what they want to achieve (Tajfel & Turner, 1979; see also Haslam, 2014).

Factors that maintain recovery are primarily social; recovery involves moving away from the using social network and actively engaging with an alternative social network that includes other people in recovery.[7)]

How can we address the risk factors related to addiction recovery?

The addiction recovery pathway should address the "whole person."

Stress is one of the major precursors of relapse, along with cues, such as people, places, things, and moods, and priming doses of the substance. The road to relapse may have signs that appear in all areas of one's life.[5)]

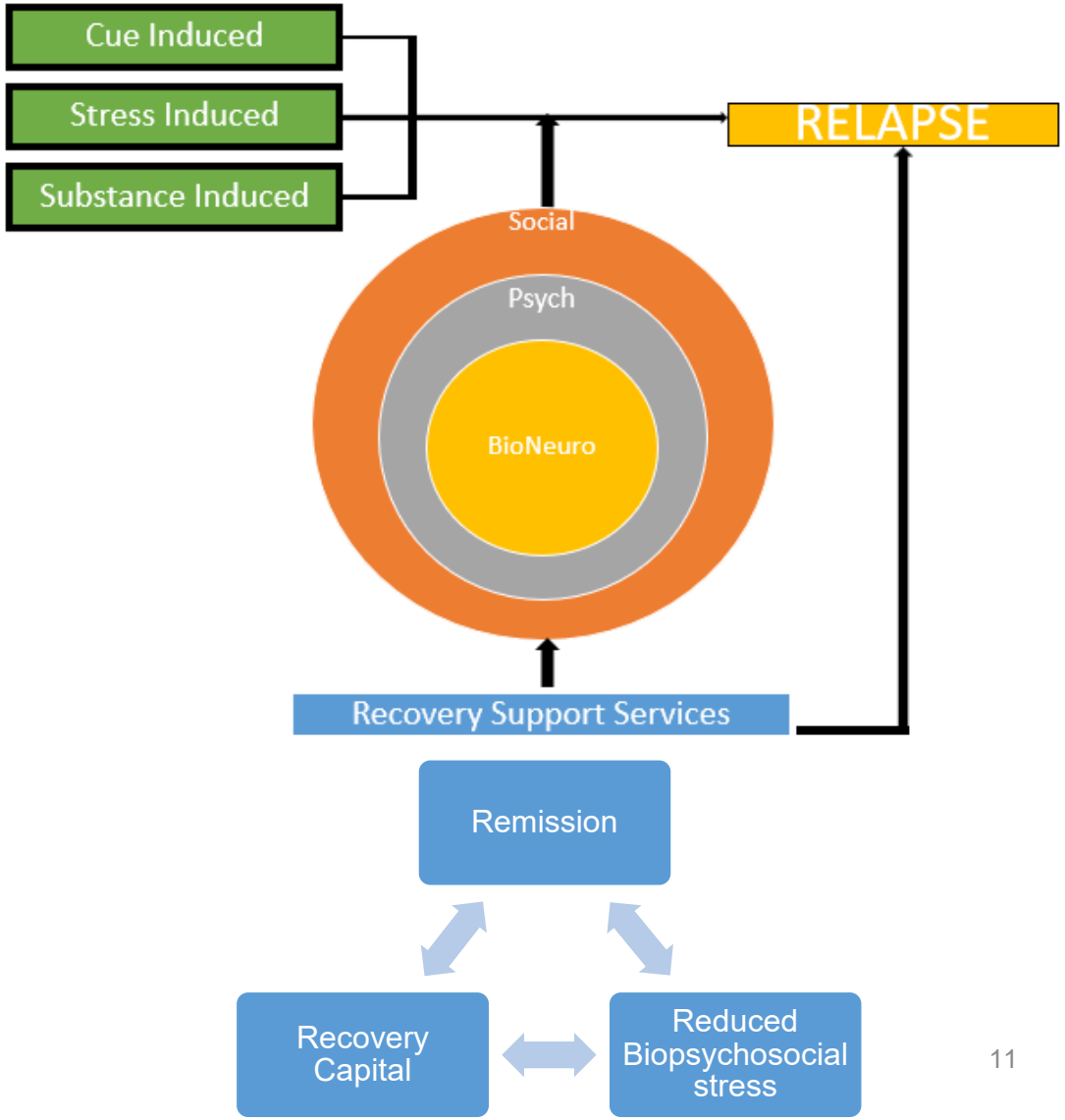
Recovery Capital is "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery" (Best and Laudet, 2010).

Longer remission results in greater accrual of recovery capital; in turn, greater recovery capital increases the chances of longer remission because it reduces biological, psychological, and social stress – a major pathway to relapse.

Recovery capital is stable recovery best predicted on the basis of recovery assets not pathologies. Recovery capital helps reduce the burden of biopsychosocial stress.

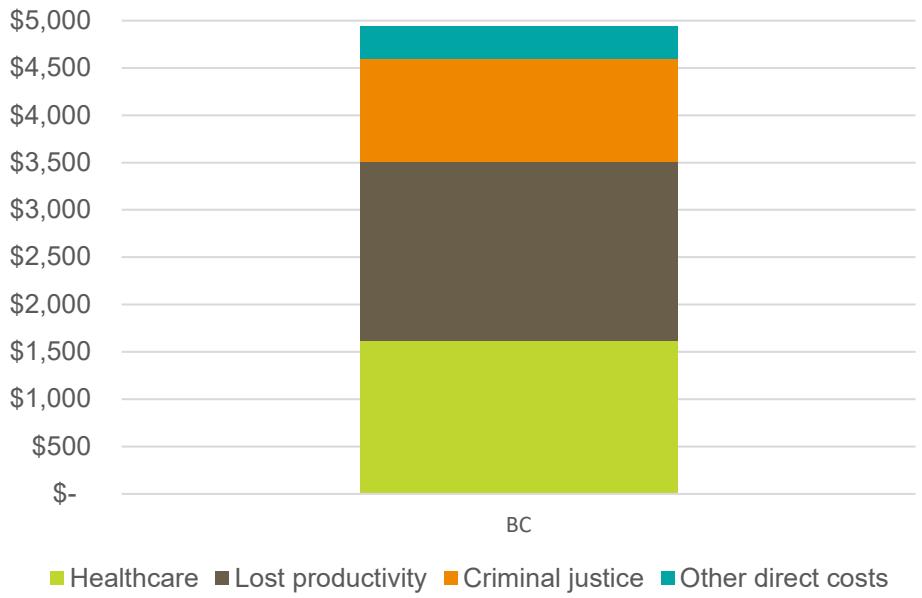
An individual's access to resources that constitute their recovery capital can greatly contribute to long-term recovery. These resources include social, physical, human and cultural factors that have been shown to mediate and moderate the effectiveness of treatments and the associated outcomes.

For a more extensive discussion on recovery capital, please refer to the Addendum to the Recovery Community Centre Advisory Committee Terms of Reference in Appendix C.



There is a high prevalence of substance use among homeless

Figure 1: Direct costs of substance use in BC in millions of dollars (2014)



> ***In 2014, substance use costs in Canada were $38.4 billion a year – or approximately $1,100 spent for every Canadian regardless of age.***
>
> *Canadian Substance Use Costs and Harms (2007-2014)*

$4.9 billion

Was the estimated direct cost of substance use in British Columbia in 2014 according to the Canadian Centre on Substance Use and Addiction study *Canadian Substance Use Costs and Harms: 2007-2014.*

The year of focus, 2014, is at the very beginning of the current alarming rise in opioid overdose events in Canada. It can be expected that the associated economic costs of opioid use will increase — probably quite substantially. Canadian jurisdictions such as British Columbia and Ontario have substantially loosened restrictions on the sale of alcohol since 2014, which suggests there could be increasing alcohol-attributable harms in future estimates. (Baggio, Chong, & Kwon, 2017).

538

Illicit overdose deaths in BC during the first six months of 2019.

BC Coroners Service,
Illicit Drug Toxicity Deaths in BC

According to the latest report from the B.C. Office of Chief Coroner, alcohol and drugs accounted for 49% of all reported deaths of homeless individuals in 2015. Given the prevalent rates of problematic substance use, the homeless population becomes particularly susceptible to the opioid crisis; the first public health emergency in B.C. history.

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There is no single definition of an RCC but the 100 plus locations in the US share common characteristics

What is an RCC?

Recovery Community Centres are locatable sources of community-based recovery support beyond the clinical setting, helping members achieve sustained recovery by building and successfully mobilizing personal, social, environmental, and cultural resources. An RCC delivers peer-to-peer recovery support services using its volunteer force as the deliverers of these services. In addition to the one-on-one recovery coaching, skill-building workshops, targeted support groups, socials, motivational enhancement, resume development and special topic discussion groups form part of the various programs delivered at an RCC.

An RCC will:

- Focus on people in recovery, family members and friends to serve as volunteers, who in turn help those coming up behind them;
- Act as a place where a person with long-term recovery can give back;
- Act as a place to find workshops, training and educational sessions to enhance one's own recovery;
- Help change social networks towards those that model and support recovery in the communities in which people live; and
- Provide formal peer support which can help facilitate the acquisition of coping skills, increases in abstinence self-efficacy, maintenance of recovery motivation, serve as a healthy recovery role model and social contact, provide community service and linkages, and emotional support.[8)]

What RCCs are not

Recovery Community Centres are NOT Residential centres, Sober living environments, Treatment centres (No clinical services on-site), 12-step clubhouses or Drop-in centres. An RCC is not a place for people to simply hang out, watch TV, play cards or pool and attend a daily meeting. An RCC is not a drop-in centre whose primary purpose is to refer and help people get into treatment. Obviously, people in need of help will enter the RCC and everything in its power will be done to assist them.

Principles of RCCs[9)]

Source of recovery capital at the community level

- Provide complementary services to formal treatment
- Offer formal and tangible linkages to social services, employment, training and educational agencies

There are many pathways to recovery

- RCCs are not allied with any specific recovery philosophy or model

Services Offered

Mutual Aid Meetings	Telephone Support	Peer Recovery Coaching
Social Gatherings/ Recreation Opportunities	Navigation of Recovery Resources	Life Skills Development

Where are RCCs operating successfully?

Gold Standard Model - Recovery Café - Seattle

Recovery Café is a supportive community for individuals in recovery from homelessness, addiction, and/or other mental health challenges.
Delivers a community of belonging for its Members through a set of core interventions:

- 'Recovery Circles' – Small groups offering peer-to-peer support,
- 'School of Recovery' – activities, classes,
- Nutritious lunch and dinner service 5 days/week, and
- Navigation to needed services and resources.

The Space:

- Located in a neighborhood that used to be downtrodden but now has been gentrified – however, homeless are present
- Good signage on all sides of the building
- Inside - Bright, airy, open, colourful and inviting.
- Single floor with multiple rooms surrounding large gathering place
- Computer and phone access for Members
- Recovery Café (Long Term Recovery Community) forms the third leg of the Recovery Stool alongside Prevention and Treatment
- It is not a drop-in centre or a fellowship hall. While it is free, there are three commitments. Member's commitment is meant to foster a sense of community and accountability:
  1. 24 hours drug and alcohol free to enter.
  2. Attends weekly Recovery Circle meeting or calls in to be excused.
  3. Contribute to the community by helping run the Café and nurturing the recovery of others.

What makes Recovery Café Special?

- 140 people use the centre daily; serves 300-350 unique individuals per month
- Core Team has three hats – HR & Finance, Fundraising, Program
- RC has one Red Seal Certified cook and works with members to do food preparation (Food Safe Training provided)
- Community & Government Support
  - Brooks provides running shoes
  - Coffee roastery donates coffee
  - Second Harvest provides food (90% donated)
  - Job Training is optional – RC partners with Fare Start for Barista, Culinary and Food Service training
  - Café Companions (community volunteers with and without ties to homelessness, addiction or mental health) contribute 2 FTE to organization

Recovery Café Seattle

Start-up Cost:
Estimated costs are $300k annually but average 'start-up' costs are closer to $150k. Recovery Café Network training and support costs $5000/year for the first two years and $1k for an evaluation visit is at the end of the second year. Teaches Front Door Management, Recovery Circles and fundraising best practices (10-15% government; the rest is private donors). Recovery Cafés don't ask for money from members.

Where are RCCs operating successfully?

Gold Standard Model– Alano Club Portland

The Model:

Alano Club Portland's four goals (Strategic Plan):

1. Diversify funding sources (regional foundations, corporate sponsorships, major gifts, public mental health and addiction funding, planned giving)
   a) Create a national fundraising toolkit with landscape analysis for funders
2. Become the primary hub in Portland
   a) Create an Arts and Recovery Series (visual, literary, film, multimedia)
   b) State credentialing of staff as Certified Recovery Mentors
   c) Recovery Speaker Series (sponsored experts by Hazelden Betty Ford)
   d) Develop a recovery-based nutrition and cooking series
   e) Offer parenting and life skills classes (basic financial planning; resume/job search training)
3. Transform the policy landscape
   a) Hire a paid lobbyist and develop a state-wide recovery advocacy network (Oregon Recovers) to increase funding across prevention/treatment/recovery continuum
   b) Create an annual Recovery Day in Portland
4. Develop stronger linkages to become an integral part of the substance use disorders continuum
   a) Secure ongoing funding from the Health Authority
   b) Strengthen ties to substance use disorder providers and awareness of complementary services (clinicians, treatment providers, for-profit providers, and Oregon Health & Science University)

The Space:	**Values:**
• A heritage mansion located in a high-end neighborhood • Alano generates $175-$200k annually on room rentals • There is a rent schedule for any given space and time (e.g. $875/month for loft) • Basement hall hosts 110 people meetings • Practice of offering free meeting space for two years in order to build up each new mutual aid community (e.g., Smart Recovery; Refuge Recovery) and then start charging for space • 10,000 visits per month (125 meetings per week)	• Family members must have access to support and resources too. • We have a right to advocate for sensible policies that support and sustain recovery. • Believes that it is not necessary to promote 'community' or belongingness in the Alano Club - Folks will find different pathways on their own. (contrasts with Alano Club's sponsorship of the Recovery Gym where creating a sense of community is key to engagement). • Alano Club is more like a drop in centre

Alano Club Portland

Key points:

- Does not serve the homeless. "Central City Concern handles that population locally."
- Open 7 days per week, 365 days per year from 10:00 a.m. – 9:30 p.m.
- Variety in services offered – major flow in and out of building
- No one-on-one recovery planning nor monitoring and surveillance participant outcome data although there is targeted research using consumer surveys.

Comparison of “Gold Standard” Models

S.No.		Recovery Café	Alano Club
1	Serves homelessness population	✓	×
2	Supports friends and families	×	✓
3	Creates sense of belonging	✓	×
4	Incorporates recovery plans	✓	×
5	Provides multi-functional digital recovery support app (goal setting, actions, text, reminders, progress reporting)	×	✓
6	Contains the Core Elements of an RCC (Valentine, 2014)	✓	×
7	Collects data and evaluates efficacy	?	?
8	Governs and operates by peers	×	×
9	Facilitates generic recovery - homelessness, mental health issues, substance use challenges	✓	×
10	Offers life-long or as-needed supports	×	✓

What does the research tell us?

Environmental Scan, Literature Review, Exemplary Models & Connecting with Experts

Streetohome became aware of the Recovery Community Center model proliferating across the United States from Dr. John Kelly who presented the model at the Recovery Capital Conference of Canada in 2017. Dr. Kelly is an Associate Professor of Psychiatry in Addiction Medicine at Harvard Medical School and the founder and Director of the Recovery Research Institute at Massachusetts General Hospital. Dr. Kelly has been awarded a National Institutes of Health grant to characterize and evaluate Recovery Community Centers in New England and New York. John explains that "Recovery Community Centers have existed, grown and persisted," and intends to demonstrate the efficacy of the model.

Streetohome Projects: Streetohome consulted with Dr. Kelly who provided a Recovery Community Centers systematic review and a summary of the findings from his participation in a Substance Abuse and Mental Health Services Administration Summit in August 2017. Streetohome subsequently commissioned two projects through Adler University's student Social Justice Practicum:

1. A Current State Analysis of seven Recovery Community Center-like sites in the Lower Mainland (i.e., environmental scan) involved surveying the following sites: Vancouver Recovery Club, Vancouver Alano Club, Avalon Women's Centre (Vancouver), North Shore Alano Club, Avalon Women's Centre (North Shore), Little House Alcohol & Drug Addiction Recovery Society (Tsawwassen) and Avalon Women's Centre (White Rock).

   Each site completed an electronic survey about their overarching philosophies, organizational structure, operational practices, clientele, service offerings, staffing, volunteer engagement, revenues & expenses, and governance. This was followed up by site visits to complete and corroborate survey information. Data collected was then shared with the sites for validation.

2. A literature review of evidence-based and promising practices found limited published research on the Recovery Community Center model (i.e., three studies). Subsequently, research was reviewed on typical components of Recovery Community Centers to assess the evidence base for each component practiced in isolation (e.g., mutual aid groups, peer support, etc.).

The literature review provided useful background information to inform a study tour of 'gold standard' Recovery Community Center models on the west coast (Recovery Café in Seattle and Alano Club in Portland). A debrief followed the study tour and 'critical components' for a made-in-Vancouver Recovery Community Centre model were identified. The same 'critical components' were used by the initial surveyors of the seven local Recovery Community Center-like sites to determine how each site aligned as well as to identify common challenges across sites that could benefit from collaborative assistance.

Summary: There are key components that contribute to abstinence and program satisfaction. For greater success, the best practices on the following page should be incorporated into a made-in-Vancouver Recovery Community Centre. The business case also relied on core elements of a Recovery Community Center that Valentine (2014) identifies in *Stay in Your Lane: Distinguishing between a Drop-In Center, 12-Step Clubhouse, Recovery Community Center and Addiction Treatment Agency* (http://www.williamwhitepapers.com/pr/Recovery%20Community%20Center%20Role%20Clarity%20Valentine%202014.pdf).

Practices to Incorporate in an RCC

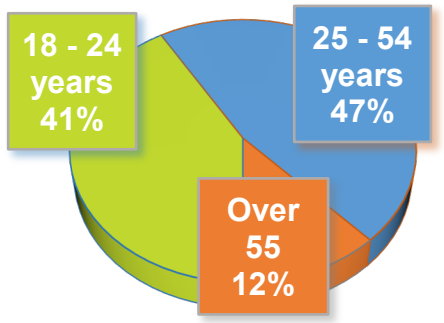
Theory - Social Identity of Recovery	Social identity change Social identity in the course of recovery
Peer Support (In Person)	Peer intervention increases the abstinence rate (especially with heroin use)
Social Gatherings	Social network changes with the stages of recovery Social identity helps achieve long-term abstinence
Mutual Aid Groups	Peer volunteer engagement
Assertive Linkages	Assertive Continuing Care should supplement the usual clinical pathways Significant increase in abstinence
Life Skills Development	Includes: Classes, Workshops, Leadership Training, etc.
Fitness, Sport and Recreation	Develops healthy lifestyles Feel better physically and psychologically
Serving and Involving Family/Friends	(A sense of) unconditional acceptance with families Better communication with loved ones

Are any RCC's currently operating in the GVA?

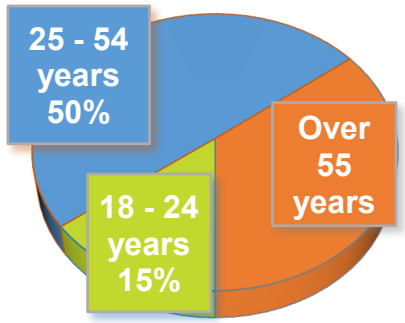
There are seven RCC-like sites operating in the GVA

- Streetohome identified seven RCC-like sites operating in the Greater Vancouver Area.
- Streetohome completed a current state survey and visited each site to gather information on each of the location's operating and program model.
- The seven sites have been in operation between 15 - 71 years.
- Top referral points are through self-referrals or word of mouth. Members within the RCC community promote the organization to others looking for support. This aligns with the peer-to-peer aspect of the RCC model.
- Each site has capacity and is looking to grow their community.
- A few connections are being made through BC211, corrections and faith-based organizations.
- Most members stay engaged with the sites between three months and up to one year.

Demographic - Age



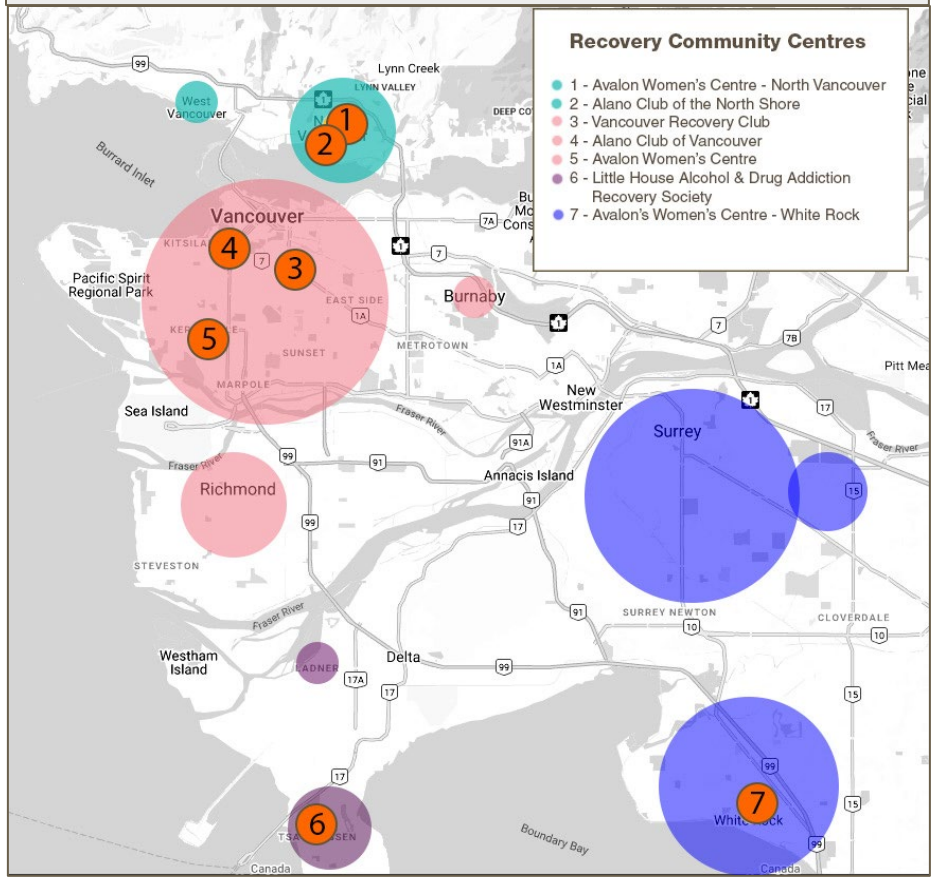
Three sites serve 18 – 54 years demographic



Four sites serve a 25 – 55+ years demographic

The map shows the location of each site and what areas they serve.

Underserved Vancouver Coastal Health Service Areas include: *Coast-Garibaldi, West Vancouver and Richmond*



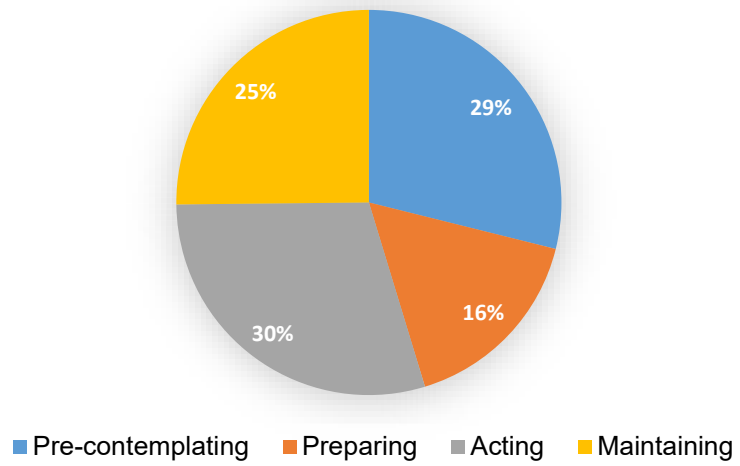
Approach to Recovery

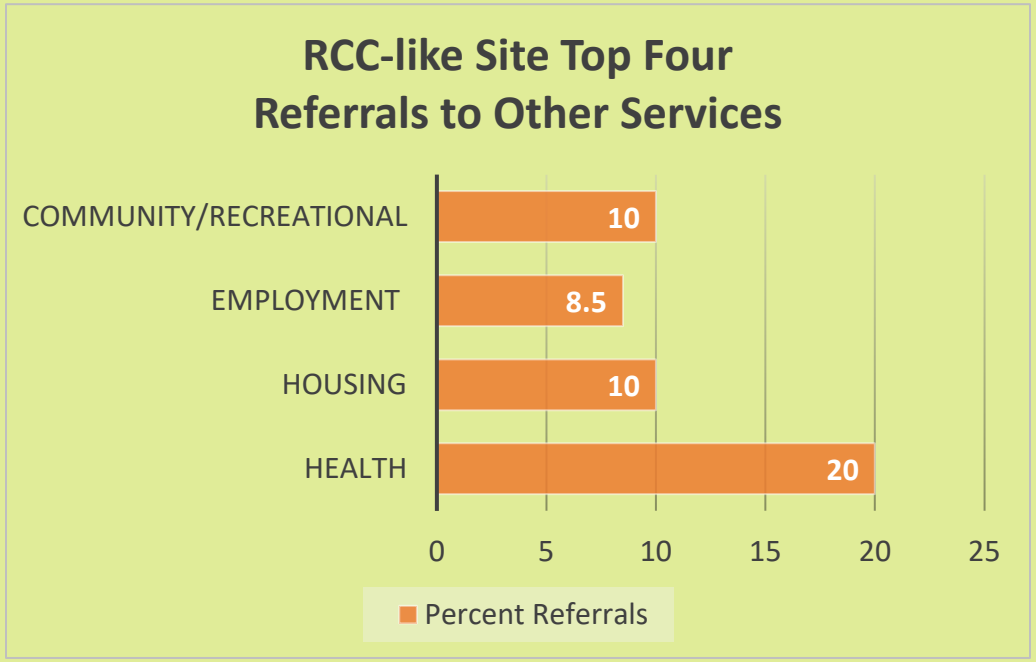
The overarching philosophy is that recovery is the expectation. Sites are AA-focused as a foundation but one site had clinical supports in place. Sites offer support and choice to choose services according to their needs - free of coercion, resulting in a self-directed recovery.

In addition, “lived experience”, which describes people in recovery having knowledge and understanding available to those seeking support is regarded positively.

Success is defined as providing a safe and accepting space for those struggling with addictions. An RCC’s success relies on encouraging and empowering a community to offer hope, compassion, resources and connections to build recovery.

States of Change Experienced at the RCC-like Sites





Comparison of services referred out by the sites.

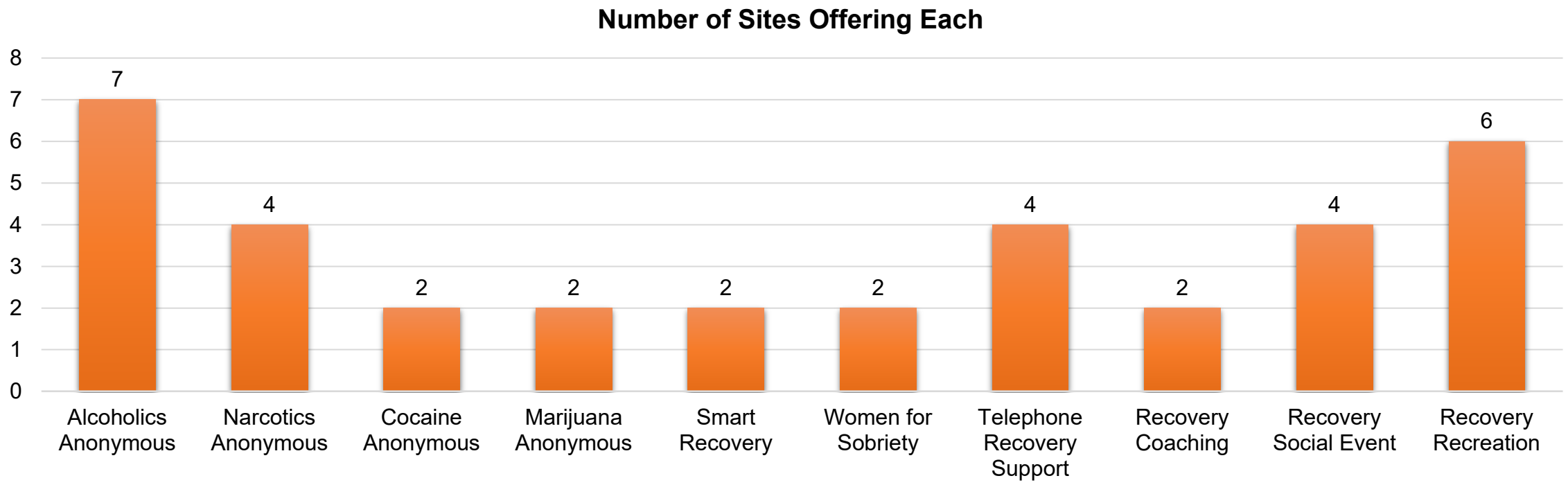
Traditionally, the RCC model focuses on supporting people in the Action and Maintenance stages (grey and yellow). However, the 7 sites are a point of contact for those seeking help (blue - Pre-contemplating and orange - Preparing). The majority of referrals were to health-related services (detox and treatment centres). Housing, Community & Recreational and Employment were also areas where the sites assisted with connections.

Common Services of the RCC-like Sites

Of the seven RCC-like sites, the most common services offered were Alcoholics Anonymous and Recovery Recreation.

All seven sites host Alcoholics Anonymous and Narcotics Anonymous meetings and a number of other services. Diverse programming including telephone recovery support, coaching, social and recreational events are needed to attract a diverse membership.

Some of the seven sites struggled with a lack of space and/or a lack of volunteers to host the variety of services and programming they desire, such as hosting multiple meetings at the same time. It was noted that those individuals in the “maintaining” stage are often the source of volunteers for each site, and each site would benefit from developing a volunteer engagement strategy.

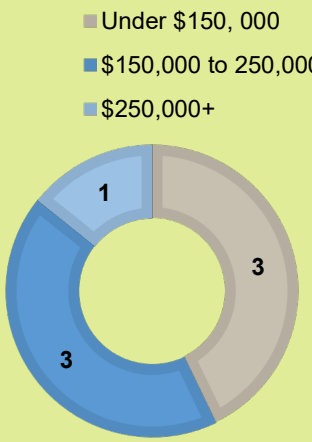


Staffing and Financing of the RCC-like Sites

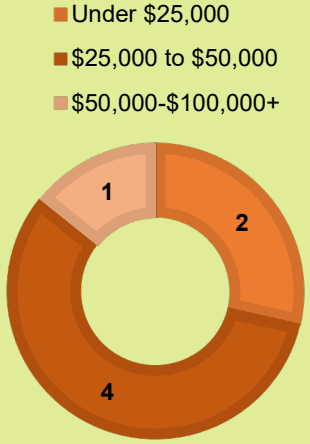
Operations and Staffing

- Three sites operate with an annual budget under $150k, three sites between $150-$250k, and one over $250k.
- For annual lease costs, two sites are under $25k, four sites are between $25k and $50k and one is over $100k.
- Six sites have at least one paid Full Time Employee (FTE) site manager, and one site pays their FTE site manger an honorarium. One site also provides outreach services with paid staff.

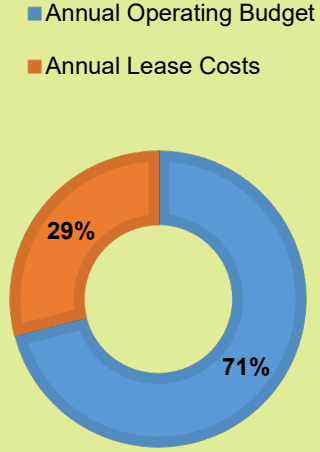
Annual Operating Budget



Annual Lease Costs

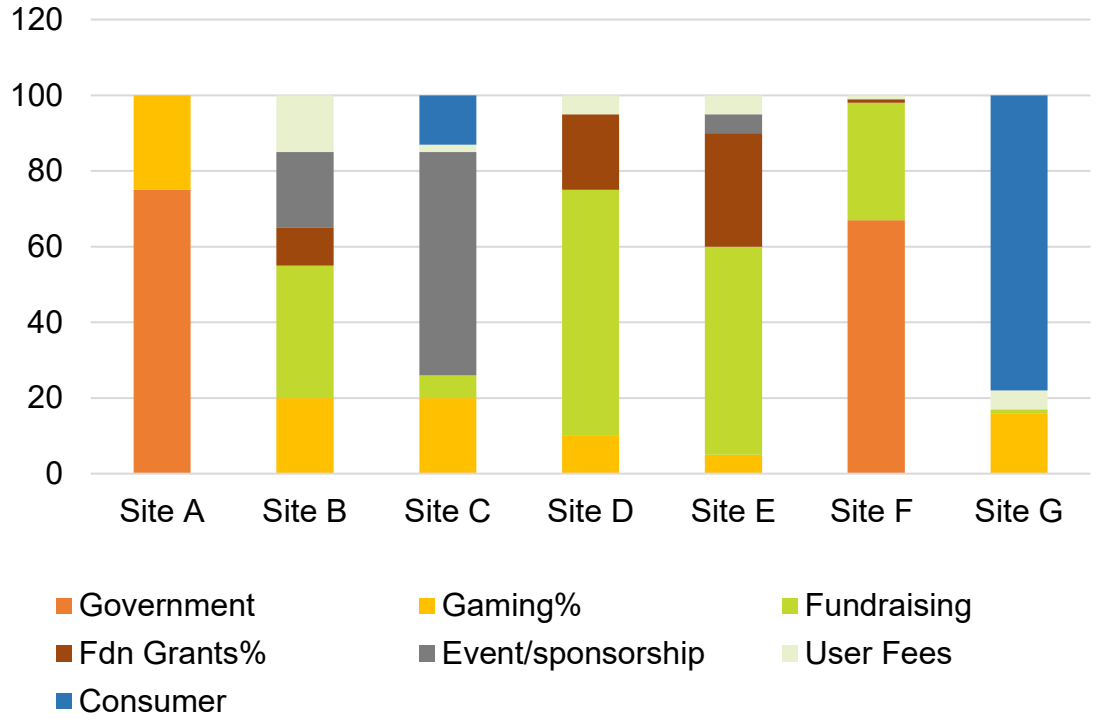


Average Percentage Lease Costs/Operating Budget



Funding sources vary from site to site. Site managers are responsible for fundraising and grant writing efforts. Volunteers are key in helping each site achieve their fundraising goals**.** Some sites are able to use volunteers creatively, as they may have skills in book-keeping, site upkeep, or other services skills.

Funding Sources



Physical space and safety of the RCC-like sites

These RCC-like sites serve various components of the recovery journey and overlap with some components of the RCC model. The RCC is not a drop-in centre, and as such, does not provide shelter, beds, showers, meal-service, etc.

As part of our Current State Analysis, Streetohome conducted site visits and looked at specific criteria including:

Location

- Each site was centrally located within the community they served.

Accessibility

- Each site was accessible by transit. Some sites took in disability accessibility into account, including ensuring that their spaces had elevator access or street access. One site installed a sound system for those with hearing challenges.

Welcoming *(Therapeutic Informed Designed Space)*

- Five sites have a warm and cozy feel. Walking into these five sites, it felt as if you were walking into a friend's home. One site had a welcome desk for people to be greeted and provided with a warm introduction into the site.

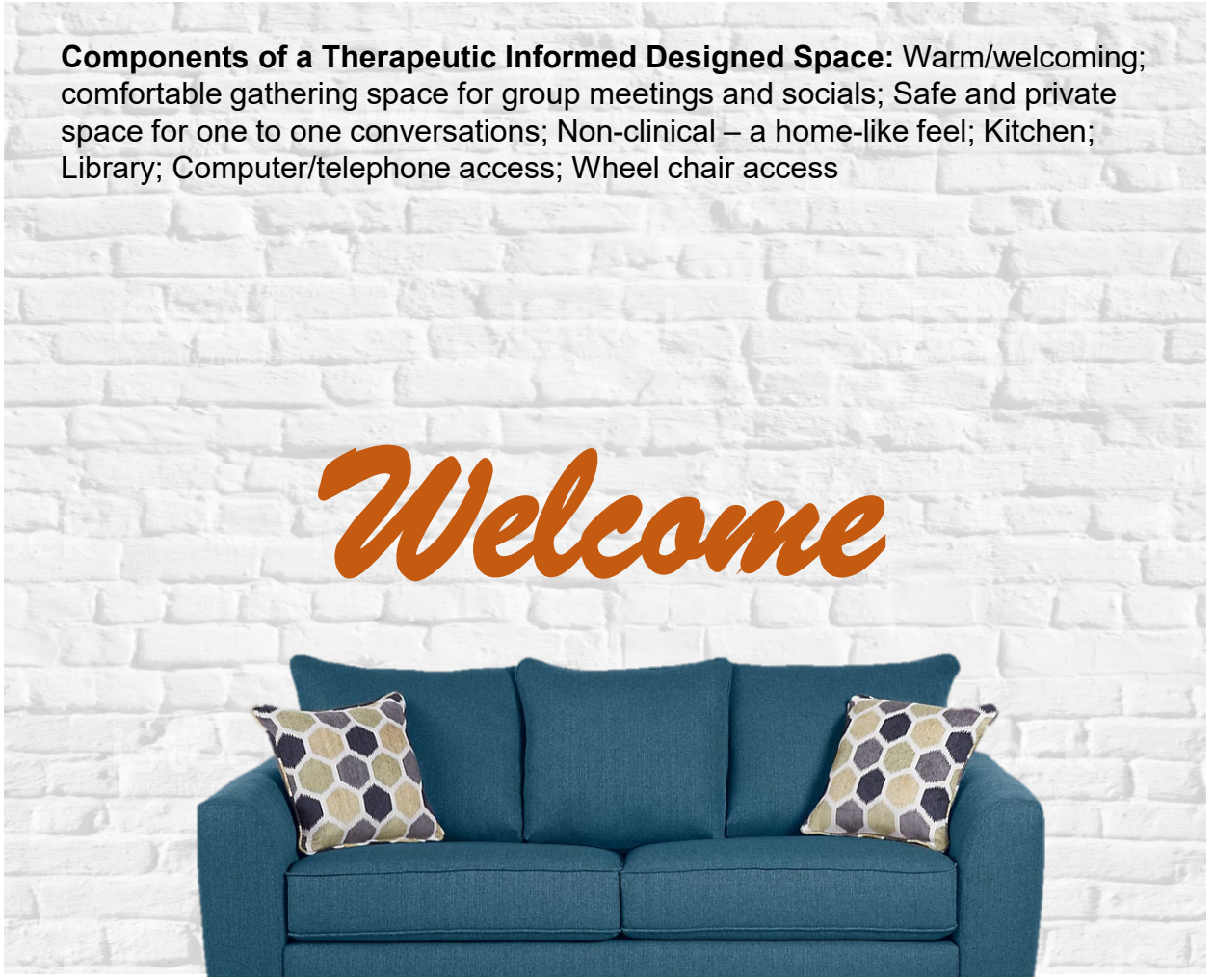
Multi-purpose spaces

- Two sites had multiple rooms to host one-on-one meetings, diverse programming and multiple mutual aid group meetings. The other sites had the ability to host a large meeting alongside a small meeting. Each site had a kitchen to make coffee or host potlucks.

Safety

- Sites offered a safe and inclusive environment. Each site had a code of conduct and strategies in place to deal with conflicts.

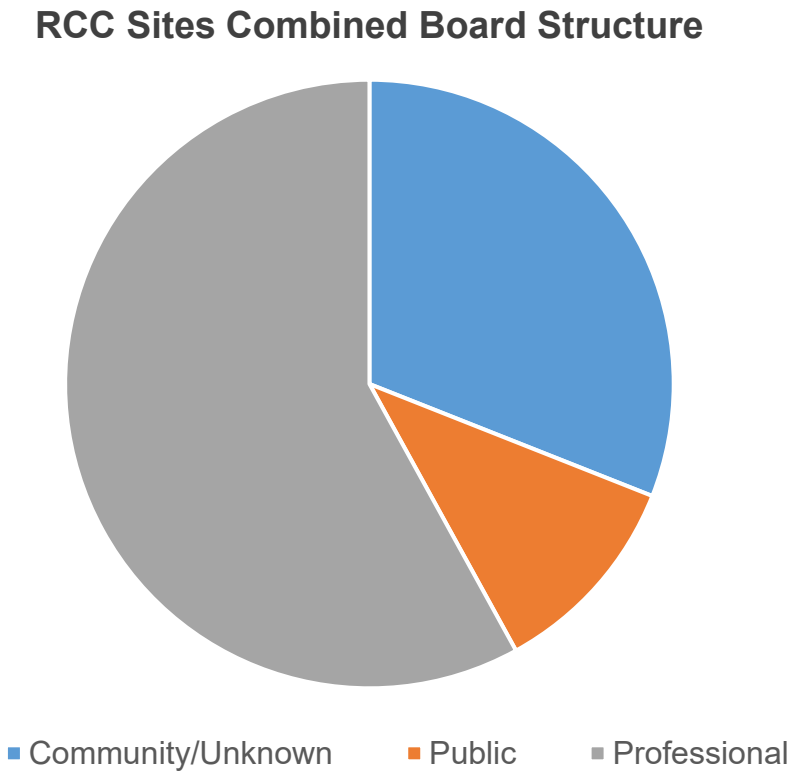
Components of a Therapeutic Informed Designed Space: Warm/welcoming; comfortable gathering space for group meetings and socials; Safe and private space for one to one conversations; Non-clinical – a home-like feel; Kitchen; Library; Computer/telephone access; Wheel chair access



Governance and Oversight of the RCC-like sites

Governance/Oversight Structures

- Common to all seven RCC-like sites, there is a paid Site Manager and a Board of Directors.
- Board members include members of the community (with and with-out lived experience), professionals, and the public sector.
- While all sites included community members and professionals on their board, only two included public sector members.
- While most sites have opportunities for the community to submit suggestions and feedback, there was no evidence that there were any evaluation surveys being used to gage satisfaction or determine programming
- Four sites have a strategic plan in place.



Enhancement Opportunities for Common RCC Needs

Address common RCC needs:

a) Create a board development & governance handbook.

b) Develop a diversified fundraising toolkit with templates.

c) Design a marketing & communications plan to promote the best practice RCC model and the newly assembled 'RCC sector'.

d) Facilitate proactive referrals of potential members from social services, faith-based organizations, corrections, treatment centres, hospitals, family physicians, self and the homelessness service system.

e) Promote the retention of members by encouraging a 'sense of belonging' to each centre and multiple service use through standardizing a recovery plan used by each member.
"These are my peeps and my recovery capital development pathway options" – RCC Participant

f) Implement a best practice volunteer engagement strategy, building on the success of Café Companions, and invite congregation participation from local churches similar to 'Out of the Cold'.

g) Explore feasibility of sustainable real estate options including: Co-location with treatment centre redevelopments; social purpose real estate and municipal notional leases.

Recruit Adler University Social Justice Practicum students or SFU and UVic Master in Public Policy students to address these needs project-by-project. Streetohome has engaged these students in the past.

Opportunity: Create an RCC network across the Lower Mainland.

The network would help to develop and build a supportive recovery community. Agreed core components would help define a set of standards as well as provide the opportunity to share learnings and best practices.

RCC Network Core Components for consideration:

1. Diverse mutual aid meetings
2. Activities: social, educational, recreational
3. System navigation support
4. Peer driven
5. Compliments other approaches (e.g. Indigenous, medical & cultural approaches)
6. Do what you do best (*Stay in your lane*)

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Critical Components of an RCC

Defining critical components

- Critical Components of an RCC are those essential for consideration when designing a recovery-oriented sanctuary for the community.
- Critical components generated were under the following high-level categories with the assistance of the Advisory Committee:
  - Physical – related to the physical space of the RCC
  - Services – services offered by the RCC to participants
  - Approach – the approach taken by the RCC to focus on recovery and to build recovery capital
  - Operations – logistics related to the day-to-day operations of the RCC
  - Policy – policies around access and membership to the RCC to ensure it remains a sanctuary for recovery
  - Safety – considerations to ensure the safety of participants

Assigning ratings to the sites (seven RCC-like sites, the Recovery Café and the Alano Club)

- Components have been assigned a subjective rating from 1-5 with the assistance of Streetohome surveyors to describe how well the site aligns with the criteria (1 indicating little to no alignment and 5 reflecting full alignment).

What are the critical components of an RCC?

Critical Components of an RCC

	Category	Components	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Recovery Café	Alano Club
Critical Components	Physical	Physical location	3	4	3	4	5	3	5	5	3
		Accessibility / Access to Transit	3	3	3	1	3	3	3	5	1
		Therapeutically Informed Design	1	3	3	3	3	1	1	5	3
		Multi purpose space	3	3	3	1	3	3	5	5	5
	Services	Information access (linkages to other services)	2	3	2	3	3	2	1	5	1
		Navigation of System Resources	3	3	3	3	3	3	1	5	3
		Website	2	5	1	5	5	2	1	3	5
		Access to computer and phone	5	5	5	5	5	5	5	5	5
		Calendar of Events	2	5	1	5	5	3	1	5	5
		Onsite/Offsite programming	1	3	1	3	3	1	3	3	5
	Approach	Not a treatment centre	5	5	5	5	5	5	5	5	5
		Standardized / evidence based	1	1	1	1	1	1	1	3	3
		Sense of safety / wellbeing	1	5	3	5	5	3	3	5	3
		Complement the current offerings	1	3	1	3	3	1	1	3	5
		Interfaces with services	3	3	3	3	3	2	1	5	3
		Peer mentorship	1	3	1	3	3	1	2	5	1
		All stages and forms of active recovery	5	5	5	5	5	1	5	5	5
		Free/affordable to clients	5	5	5	5	5	2	3	5	5
		Opportunity for mentee to mentor progression	1	4	3	4	4	1	3	5	3
		Self-assessment/ goal planning	1	3	1	3	3	2	1	5	1

What are the critical components of an RCC?

Critical Components of an RCC

	Category	Components	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Recovery Café	Alano Club
Critical Components	Operations	Largely volunteer run including Peer leadership	1	3	3	3	3	1	5	5	3
		Evaluation/data collection/Monitoring/Surveillance	1	1	1	1	1	1	1	3	1
		Privacy of managing personal information	3	3	3	3	3	3	3	3	3
		Fiscally sustainable	1	3	3	3	3	1	3	5	5
	Policy	24-hour sobriety request	1	1	1	1	1	1	1	5	1
	Safety	Privacy	1	5	3	5	5	3	3	3	3
		Diversity / Inclusivity	3	1	3	1	1	1	1	5	3

What are the critical components of an RCC?

Critical Components of an RCC (Aggregated by Category)

	Category	Components	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Recovery Café	Alano Club
Critical Components	Physical	Physical location	3	3	3	2	4	2	4	5	3
		Accessibility / Access to Transit									
		Therapeutically Informed Design									
		Multi purpose space									
	Services	Information access (linkages to other services)	4	4	3	4	4	2	2	4	4
		Navigation of System Resources									
		Website									
		Access to computer and phone									
		Calendar of Events									
		Onsite/Offsite programming									
	Approach	Not a treatment centre	2	4	3	4	4	2	3	5	3
		Standardized / evidence based									
		Sense of safety / wellbeing									
		Complement the current offerings									
		Interfaces with services									
		Peer mentorship									
		All stages and forms of active recovery									
		Free/affordable to clients									
		Opportunity for mentee to mentor progression									
		Self-assessment/ goal planning									

What are the critical components of an RCC?

Critical Components of an RCC (Aggregated by Category)

	Category	Components	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Recovery Café	Alano Club
Critical Components	Operations	Largely volunteer run including Peer leadership	2	3	3	3	3	2	3	4	3
		Evaluation/data collection/Monitoring/Surveillance									
		Privacy of managing personal information									
		Fiscally sustainable									
	Policy	24-hour sobriety request	1	1	1	1	1	1	1	5	1
	Safety	Privacy	2	3	3	3	3	1	3	4	4
		Diversity / Inclusivity									

Critical Components of an RCC (Aggregated Total)

Total component aggregation is determined by summing the total (before rounding) of the component category aggregation and then rounding this to the nearest integer. The maximum score available is 30.

		Site A	Site B	Site C	Site D	Site E	Site F	Site G	Recovery Café	Alano Club
Critical	All Categories Aggregated	13	17	16	16	18	9	15	27	18

Potential Scenarios

		Pros	Cons
1	Work with existing RCC-like site(s) to change operations to better meet critical components of an RCC	• Facilities and staff already in place	• Changing long established/entrenched operating philosophy is challenging • Difficult to change perception of site in minds of consumers
2	Adopt Recovery Café model for Vancouver	• Recovery Cafe history of successfully developing sites in new cities • Recovery Café Network training and support	• One or more RCC-like sites and their consumers view model as competing • Costs associated with development (site, building and operations)
3	Build an evidence based “best practice” RCC model	• Develop prototype model • Potential to develop a grass-roots community within the framework of critical components	• Most effort • Costs associated with development (site, building and operations)
4	Do not develop an RCC model for Vancouver	• Least expensive up front	• Missed opportunities • Does not address the needs identified • Cost to society is high

Important note:
These scenarios are not considered mutually exclusive; a further potential scenario is a combination of two or more of the above scenarios.

Scenario Evaluation

		Greatest Impact on Homeless Population	Greatest Impact on Recovery Community	Cost efficiency	Time efficiency	Feasibility/ Ease of Imp.	Streetohome Partner Capacity to Support	Overall
1	Work with existing RCC-like site(s) to change operations to better meet critical components of an RCC	L	M	M	M	M	M	M
2	Adopt Recovery Café model for GVA	H	L	H	H	H	H	H
3	Build an evidence based “best practice” RCC model	L	L	L	L	L	L	L
4	Do not develop an RCC model for Vancouver			*High Lost Opportunity Cost*				

Primary Recommendation

1. Work with existing RCC-like site(s) to change operations to better meet critical components of an RCC
2. **Adopt Recovery Café model for GVA**
3. Build an evidence based "best practice" RCC model
4. Do not develop an RCC model for Vancouver

Scenario 1

- Streetohome could host and facilitate a quality improvement collaborative with the ultimate goal of establishing system connections for the existing RCC-like sites. This would entail ensuring minimum standards for consistency; safety through common policy and behaviour signage; and commitment to complement and support medical, cultural, and alternative approaches.
- There are common enhancement opportunities across the RCC-like sites. Many of the consumers are not homeless or at risk of homelessness, however, site enhancements would benefit all consumers.

Scenario 2

- Requires significant effort in the siting, development, and implementation of a new facility. The development of a Recovery Café model offers the benefit of a road map and institutional experience. Based on our analysis, a Recovery Café model offers significant benefit in risk mitigation, ease of implementation, and Streetohome's ability to broker and leverage with partners to successfully deliver this model.
- **Based on these considerations, scenario 2 is the recommended option.**

Scenario 3

- Offers many of the benefits of Scenario 2, however; it also incurs significant risk associated with the implementation and management of an entirely new RCC model in Vancouver where an established plan and replication history will need to be developed.

Scenario 4

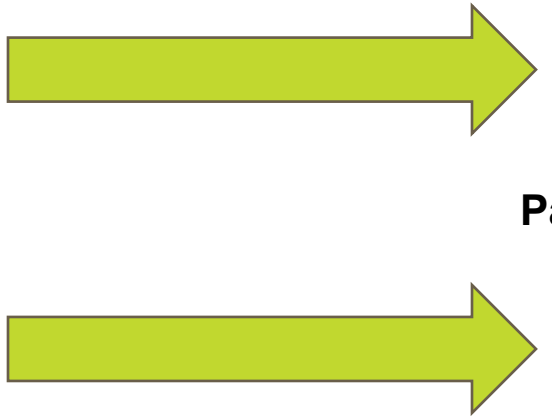
- There is compelling evidence against scenario 4, hence, a high lost opportunity cost.

Summary:

The Recovery Café model is the closest model to meet the needs of the homeless population including people living in shelters, SROs and supportive housing for consideration in this business case. The model provides time-limited support (up to 2-years) and a warm transition to best practice RCCs would provide an opportunity to remain tethered to support if needed.

Parallel Opportunities

1	Work with existing RCC-like site(s) to change operations to better meet critical components of an RCC
2	Adopt Recovery Café model for GVA
3	Build an evidence based “best practice” RCC model
4	Do not develop an RCC model for Vancouver



Parallel Opportunities

Primary and Secondary Opportunities

Although scenario 2 is the recommended option, Streetohome should consider parallel options to improve delivery of services across the GVA.

We recommend scenario 1 be investigated further. Working with the existing sites to improve their standards and operations and further develop the RCC network in the GVA will provide additional benefits to those in recovery in the GVA. Further, the development of RCC standards of practices and knowledge sharing will likely create benefits that will add resiliency to the entire system.

A Recovery Café and Recovery Community Center-like sites can coexist and are likely to become symbiotic. In terms of consumers, Recovery Café members will have an option to transition to a Recovery Community Center-like site when they are ready or have completed their two-year membership. There will likely be mutually beneficial relationships between the two distinct models in terms of sector networking to collectively address challenges (e.g., fundraising) and share best practices (e.g., Recovery Circles and Recovery Plans).

Measures of Successful Implementation and Impact

Implementation Measures (These are promising elements of a Recovery Café believed to positively impact one or more outcome measures and are key to improvement efforts.)

1. Diversity of incoming referral partners (e.g., social services, emergency responders, hospitals, family physicians, recovery counsellors, corrections, treatment centres, outreach teams, shelters, supportive housing, faith-based organizations, self and other providers in the homelessness service system)
2. Volume of incoming referrals by referring partner
3. Number of unique regular consumers (weekly contact) – 'consumer roster'
4. Consumer inclusiveness (i.e., age, gender, minorities, disabilities)
5. Consumer engagement in terms of: visit frequency, recency, multiple services accessed and community contribution (i.e., helping run the café or nurturing the recovery of others)
6. Comprehensiveness and volume of outgoing referrals to homelessness service system partners (e.g., food, shelter, healthcare, social assistance, employment, etc.)

Measures of Successful Implementation and Impact

Outcomes Measures (These are the quality of life and cost targets that we intend to improve with a Recovery Café)

1. Improve the recovery journey consumer experience – **housing, health & wellness (including recovery and social), skills & training, employment and legal goals pursued/achieved**
2. Improve the health of recovery journey consumer populations (e.g., individuals living on the streets, in shelters, SROs or supportive housing; youth, adult, senior; gender diversity) – **percent of each subpopulation of RCC consumers who achieved 'managed substance use'**
3. Promote warm transitions to Recovery Community Centres (RCC) that are designed to provide life-long or as-needed supports upon graduation from a typical two-year Recovery Café engagement – **percent of Recovery Café graduates that remain local and transition to an RCC**
4. Reduce the public per capita cost of recovery journeys – **measured reduction in: contact with emergency responders, emergency department visits and associated hospital admissions, crime and interface with police and justice systems; and measured increase in: employment and taxable income, transition from social assistance, community volunteering and self-sufficiency**
5. Reduce clinician, staff, emergency responder burnout by distributing recovery support – **volume of referrals to the Recovery Café and surveyed impact of Recovery Café on reducing respective workloads**
6. Provide hope for an enhanced addiction recovery housing system with better outcomes for consumers and families – **documented in consumer and family satisfaction surveys**

Challenges

The main challenge of measuring a successful implementation and impact of a Recovery Café is tracking individuals while keeping their safety and privacy in mind. A combination of electronic card access to the building and individual program offerings (room access) with the implementation of a goal setting and tracking app (e.g., Smart Cities Life Intentions) may provide sufficient anonymized back-end analytics to demonstrate efficacy of the model and direction for ongoing quality improvement. Some process and outcome measures will not be captured by the above-mentioned electronic surveillance and activity monitoring system and will require external evaluation.

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Recovery Café Vancouver: Start-up Costs

Start-up Costs and Implementation Next Steps

Anticipated implementation costs items include: space, employees, equipment and supplies. The full cost of operations is estimated $300,000 in early years but the average cost of site replications to date has been closer to $150,000, due to in-kind contributions such as space and food donations. Streetohome will broker and leverage space, construction or renovation funding and operations funding with partners (e.g. Vancouver Coastal Health, City of Vancouver and BC Housing). A Recovery Café Start-Up Budget Template and Recovery Café Capital Expenditures Template follow on page 42 and 43.

Additional costs include group participation in the 6th Cohort of the Recovery Café Cohort Learning Model. The $10,000 cost will be funded by Streetohome. Streetohome, Vancouver Coastal Health, City of Vancouver and BC Housing will be asked to designate one staff member to participate in a Recovery Café Vancouver Implementation Committee (RCVIC) and attend a two-day training at Recovery Café in Seattle on October 14 & 15 as well as cover their respective staff's travel and lodging expenses.

Over the two years, there will be three personalized one to two-day immersion visits with the RCVIC at Recovery Café Seattle. There will also be a biennial Recovery Café Network Summit (April 2020 in San Jose, California) that brings together Recovery Cafés from across United States (and now North America with the addition of Recovery Café Vancouver) for two days of learning, information sharing, and inspiration. Travel and accommodation costs associated with the above events will be the responsibility of the sponsoring partners.

The Recovery Café will be operational within the two years. It is assumed that Recovery Café Vancouver will receive health authority operating grant funding, which is why ongoing operational oversight ought to be provided by Vancouver Coastal Health (VCH). VCH may opt to issue a request for proposals from organizations interested in operating Recovery Café Vancouver. Over time, governance would transition from the Implementation Committee to the Board of Directors of the charity operating Recovery Café Vancouver.

Streetohome will also fund the Recovery Café Network evaluation visit to Vancouver at the end of the second year – $1000 flat fee.

Recovery Café Cost Breakdown: Start-Up Template

Space	Sq. ft.
Café/Dining Room	1000
Kitchen	350
Multi-purpose Room 1	300
Two bathrooms	150
Office	200
Total Space	**2000**
Rent/Sq. ft.	$15
Total Rent per Month	**$2,500**
Total Rent - Year 1	**$30,000**

Program Operations	Year 1
Meals: • Meals per Day (Lunch and Dinner) • # Plates per Meal • Total Plates per Day • Cost per Meal • % Excess Inventory • Inventory Cost per Day	 2 50 100 $2.50 10% $275
Food Cost per Year:	**$71,500**
Expresso Bar/Coffee Cart: Cups per Day Cost per Cup	 200 $0.25
Coffee Cost per Year:	**$13,000**
Other Operations Costs: Misc. Supplies Utilities & Related Services Insurance Capital Equipment/Repairs Fundraising	 $833.33 $5,000 $2,291.67 $1,500 $10,000
Total Program Operations:	**$19,625**

Staff	Year 1
Salaries Executive Director Program Staff 1 Program Staff 2	 $58,333.33 $31,325.00 $31,325.00
Total Salaries	$120,983
Benefits & Taxes Executive Director Program Staff 1 Program Staff 2	 $16,333 $8,771 $8,771
Total Benefits & Taxes	$33,875
Total Salaries, Benefits & Taxes Executive Director Program Staff 1 Program Staff 2	 $74,667 $40,096 $40,096
Total Salaries, Benefits & Taxes	$154,859
Grand Total – Year 1	**$288,984**

Note: Figures in USD, based on 18 Recovery Cafe developments. Assumes 5 days per week open.
Adapted by Streetohome

Recovery Café Cost Breakdown: Capital Expenditures Template

A) Kitchen Upgrade	Cost
Equipment	
• Dishwasher	$7,500
• Stove	$3,500
• Refrigerator	$3,000
• Freezer	$1,500
• Cabinets	$30,000
• Installation	$10,000
Subtotal Equipment	**$55,000**
Remodel	
Floor	$3,500
Paint	$1,750
Permit	$10,000
Subtotal Décor	$15,250
Total Kitchen Upgrade	**$150,750**

B) Café Dinning Room	Cost
Construction	
• Floor	$15,000
• Paint	$3,750
• Décor	$5,000
• Construction Costs	$10,000
• Permits	$5,000
Subtotal Construction	**$38,750**
Furniture & Equip.	
• Café Tables & Chairs	$6,600
• Furniture & Décor	$7,850
• Espresso Cart	$17,000
• Portable Buffet Cart	$2,000
• Smallwares	$2,250
• Fixtures	$3,000
Subtotal Dining Room	**$38,700**
Total Café Build Out	**$84,450**

C) Multipurpose Room	Cost
Paint/Décor/Renovation	$2,500
Furniture	
• Conference table	$1,000
• Chairs	$3,000
Subtotal	**$6,500**
Total Multipurpose Room Reno	**$6,500**

D) Two Restrooms	Cost
Paint/Décor/Renovation	$750
Plumbing upgrade	$1,000
Subtotal	**$1,750**
Total Restroom Reno	**$1,750**

E) Office/Private Counseling Room	Cost
Paint/Décor/Renovation	$1,000
Furniture	
• Table	$900
• Chairs	$600
• Computer Terminals	$2,500
Subtotal Equipment	**$5,000**
Total Office Reno	**$5,000**

A – E Expenditures plus contingency	Cost
Combined: Construction & Furniture Expenditures	$248,450
Contingency Fund	$51,550
Total Capital Expenditures	**$300,000**

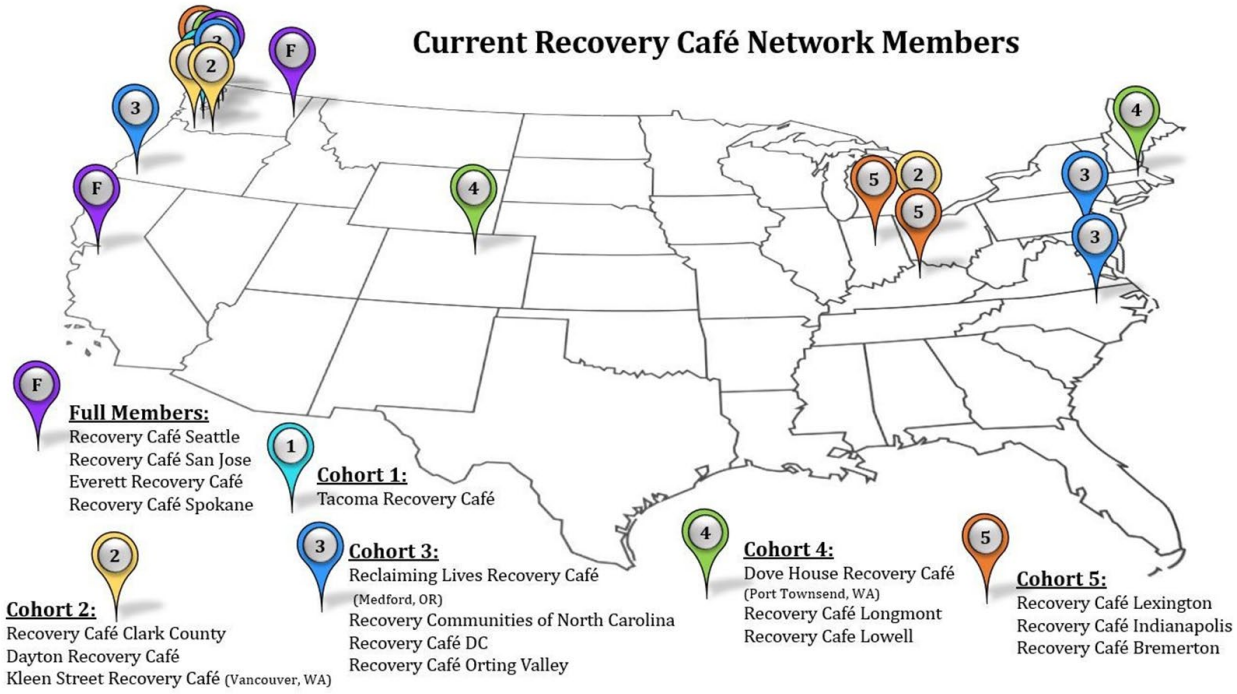
Note: Figures in USD, based on 18 Recovery Cafe developments. Capital amounts for the contingency include an amount designated for additional rooms from the original figures.
Adapted by Streetohome

Recovery Café Network

Recovery Café Network (RCN) is comprised of Member organizations committed to serving people suffering from homelessness, addiction and other mental health challenges using the Recovery Café model. Recovery Café Network members are dedicated to five Core Commitments:

1. Creating a community space that is drug and alcohol free, embracing and healing
2. Supporting Recovery Circles as a structure of loving accountability
3. Nurturing a Café culture in which everyone is a contributor
4. Raising up Member leaders
5. Ensuring responsible stewardship

The Recovery Café Network was launched in 2016 as a cohort learning model that provides mentorship, materials, expertise and facilitated learning experiences to create recovery communities in desired areas. The Network is committed to helping those who join the Network as an Emerging Member to be successful in starting their program, building recovery capital in their communities and becoming certified as Full Members of the Network.



Recovery Café Network is built upon a foundation that incorporates best practices informed by lived experience and the latest academic research. The Network creates a structure for members to teach each other about what does and does not work. It also creates a platform to generate and share resources. Members receive a license to use Recovery Café manuals and other supporting materials to implement the model.

Recovery Café seeks to partner with groups of 3-4 people that endorse their Core Commitments, support multiple pathways to recovery, have lived experience in recovery and have time and resources necessary to bring a Recovery Café to life. There have been five cohorts to date with four Full Members who have been certified in successfully replicated that Recovery Café model and fourteen Emerging Members with developments underway.

Recovery Café Network

Recovery Café Vancouver would be the first Canadian replication. The 6th Cohort launches October 14-15 with an initial two-day training in Seattle. New Recovery Network groups will learn the basis of the Recovery Café's longer-term recovery community model including:

- How to create a welcoming and healing setting for all people to thrive
- Raising up individuals to become leaders in the Café using their gifts and talents
- Peer facilitated support groups called Recovery Circles
- Providing activities as pathways to deepen recovery including classes, physical fitness opportunities and community events
- Monitoring and evaluation or programming to demonstrate impact

The Cohort fee per group is $5,000/year for the two-year training and support initiative. Additional costs include travel and lodging for attendees and an evaluation visit at the end of the second year. At the end of the two years, each Emerging Member will be evaluated on how the model has been implemented and adherence to the Core Commitments with the hope of being certified as a Full Member and granted a Recovery Café Network License (to be re-evaluated every three years) that entitles each Full Member to continued support and use of the Recovery Café Network brand.

Refer to Appendix D for: Recovery Café Network – Emerging Member Application, Emerging Member Benefits and the Cohort 6 Launch Agenda.

Recovery Café Seattle is implementing a second location in Seattle – with tentative opening in January 2020.

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Siting Considerations – accessibility to current AA meetings

In order to pinpoint where addiction is best catered for in the GVA, the location of Alcoholics Anonymous (AA) meetings was used as a proxy for addiction density. Alcohol does not capture the full spectrum of addiction, but it is a useful proxy because the data on AA locations is open-source, and AA is a core service offered in recovery centres.

The yellow areas in the maps below show hotspots of where it is possible to access the highest number of AA meeting locations in the region within 30 minutes, when travelling by either public transit or car. 30 minutes was chosen as a reasonable time residents should expect to travel to reach an AA meeting. Areas with no colour do not contain any routing within the time threshold.

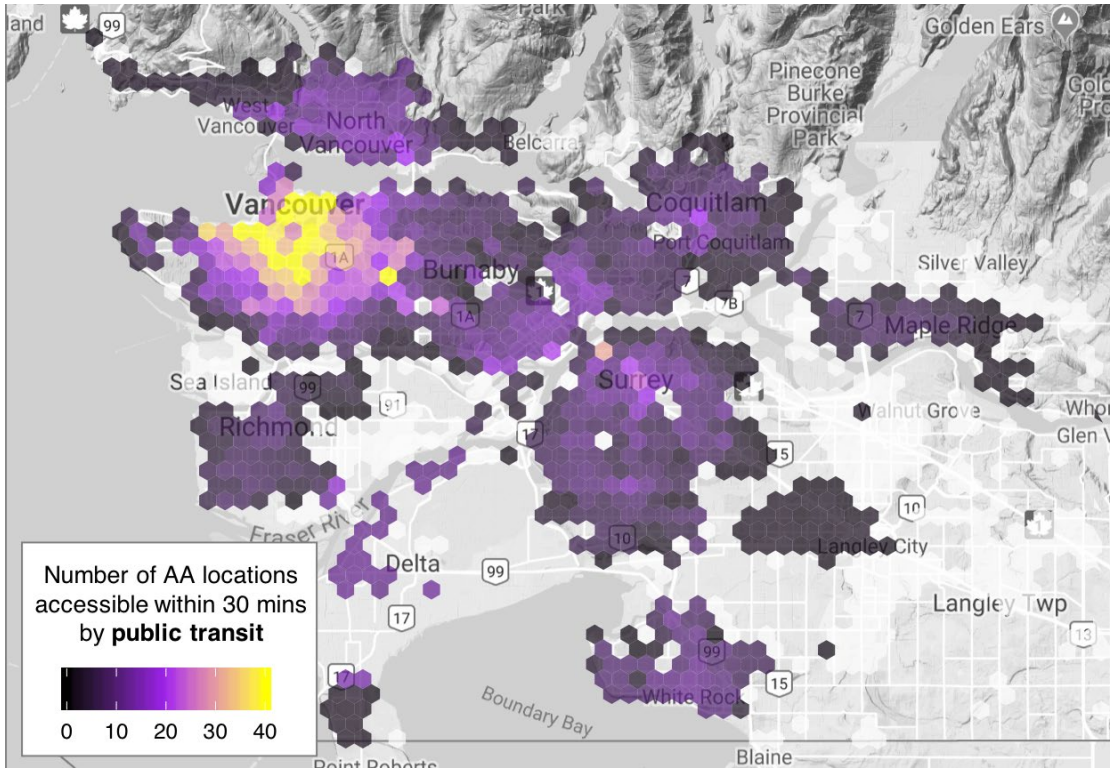


Figure 1: Total number of AA locations reachable within 30 minutes by public transit.

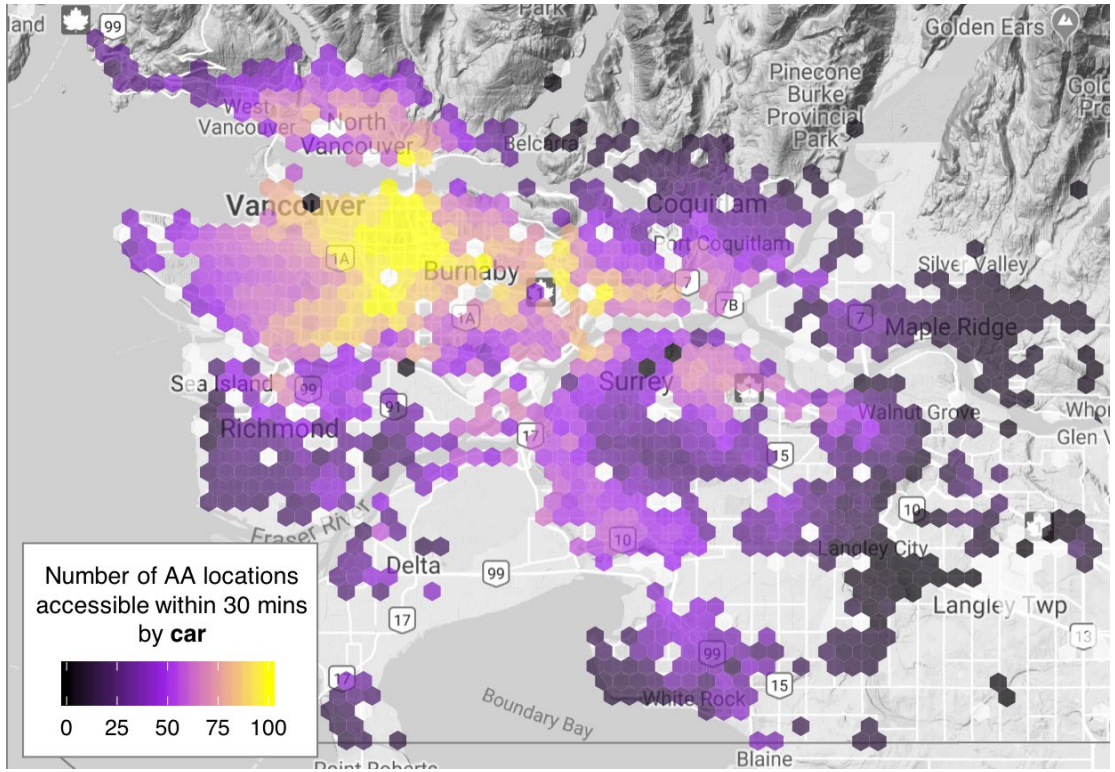


Figure 2: Total number of AA locations reachable within 30 minutes by car.

Analysis and figures prepared by Jerome Mayaud

Siting Considerations – best and worst combined access to AA meetings

To understand overall accessibility across the region using all available transport modes, accessibility scores by car and transit were weighted and then combined. Transit was assumed to be twice as important as cars in the weighting, because many vulnerable populations accessing AA services are likely to do so by transit.

The map below highlights the neighborhoods with the best (coloured in green) and worst (coloured in red) combined accessibility to AA meetings. The locations with best accessibility are concentrated in East Vancouver and Burnaby. There are a number of locations with little access to AA meetings, notably around Langley.

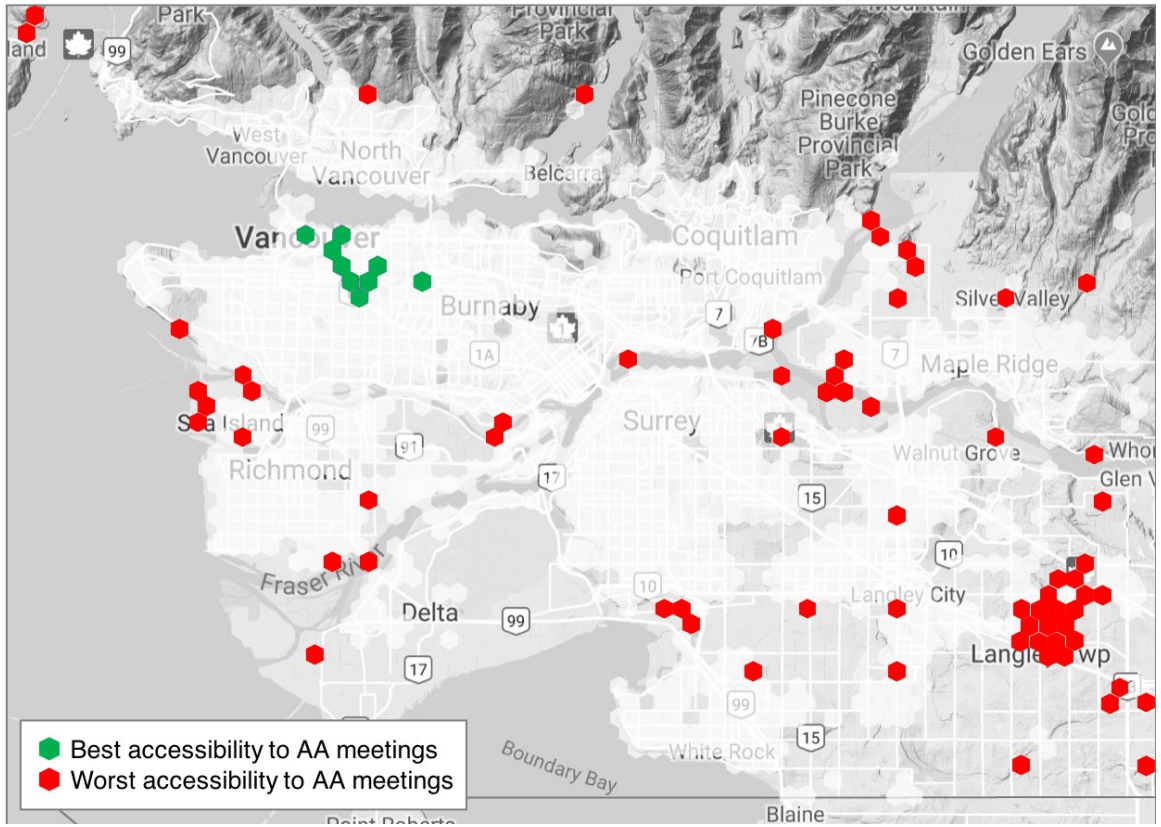


Figure 3: Locations with the best and worst combined (car and transit) accessibility to AA locations.

Analysis and figures prepared by Jerome Mayaud

Siting and Design Considerations

The following should be considered as the facility siting and design is being developed:

Location	What is the physical context in which the RCC is being proposed (e.g. bustling downtown, quiet residential, industrial, etc.)? Consider what type of environment would be most supportive for recovery.
Service Area	Define the service area, consider who is captured within it—residents, workers, patients, etc. What is the demographic profile captured within the service area? How might that impact programming and built needs (e.g. accessibility, finishings, spaces, etc.).
Zoning & Amenities	Is the property zoned for uses compatible with an RCC? What are the adjacent or nearby uses zoned for (e.g. are there incompatible uses such as liquor stores)? Are there positive nearby uses (e.g. park, grocery store, library, etc.)?
Access	How accessible is the location for different transportation modes and abilities? Are there nearby bus routes or rapid transit, parking, a good pedestrian environment? What is the typical travel time within the service area? Is the location accessible to people of ranging abilities, if not consider what upgrades are necessary (e.g. elevators, automatic doors).
Interior	How do you want patrons of the space to feel? Does the interior reflect the RCC's mission—is the space inviting, welcoming, and safe? Does the space functionally meet the needs of the RCC—are there adequate and various types of meeting spaces, public and private spaces?

Communications Planning

The following should be considered as a Communications Plan is developed and implemented.

Goals and Objectives	What do we aim to achieve in communicating? What objectives do we have for each stakeholder group?
Performance Metrics	How do we know we're successful?
Stakeholder Mapping	How do we understand our stakeholder needs and motivations?
Program Image	What image are we conveying? How do we make this meaningful and memorable?
Key Messages	What do we want people to hear and remember? How does this differ by stakeholder group?
Channels, Resources, Controls	How do we reach our stakeholders?
Tactics	What are the specific activities we will undertake?

Communications Goals and Considerations

Communication Goals

Ensure the stakeholders have a common understanding of the Recovery Café goals, mandate, and role/ function within the GVA recovery ecosystem, and are engaged at the right time, in the right way.

Objectives

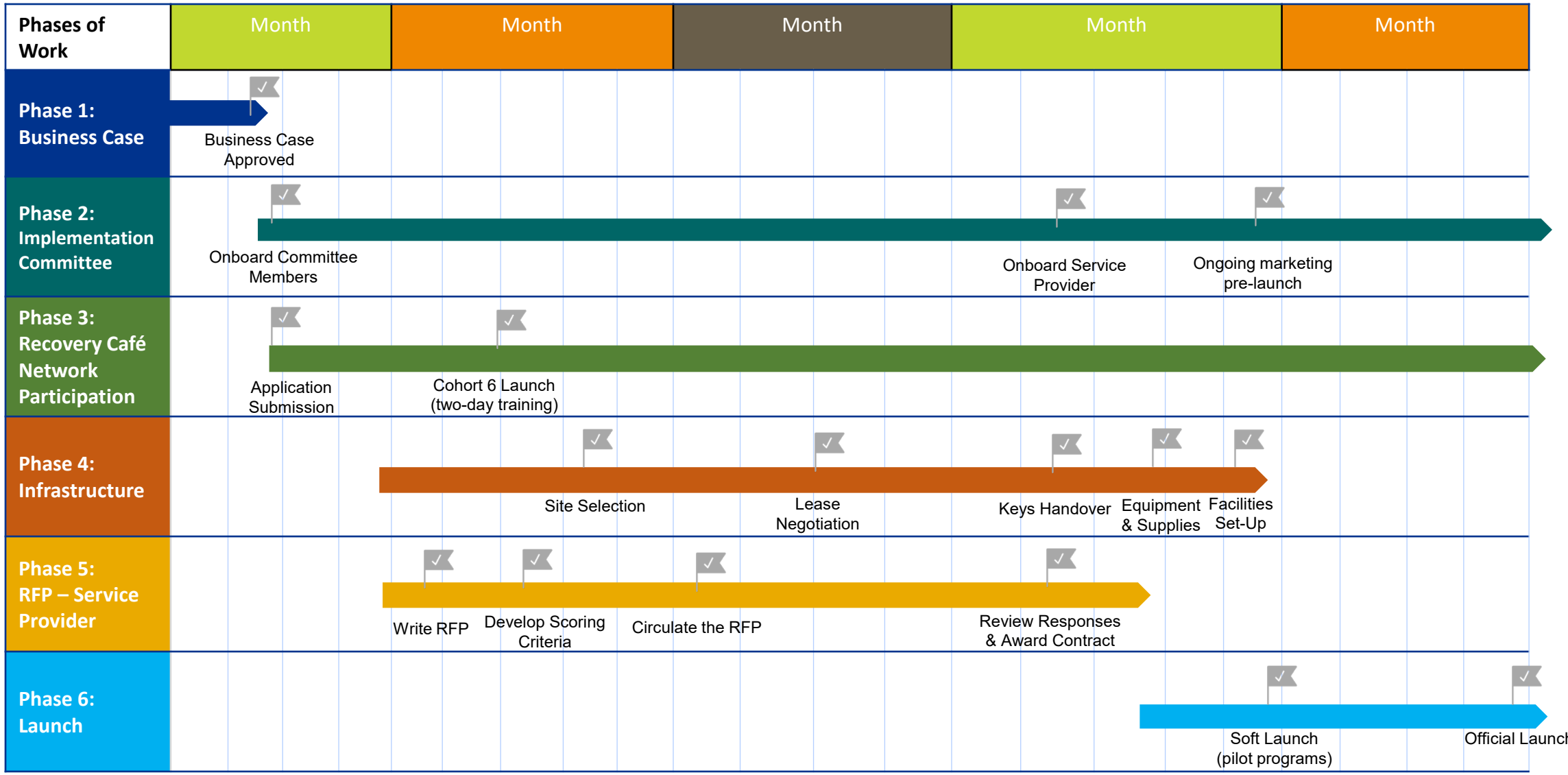
Create general audience awareness and understanding of the RCC:

a) What is the RCC
b) Who is it intended to serve
c) Why this benefits them and the community
d) Where and when it can be accessed
e) How the program is being run

Engage internal and external stakeholders effectively.

Motivate teams and participants to achieve the vision and progress the organization's maturity in meeting the RCC objectives.

Decision Roadmap



Note: The Roadmap assumes that an external RCC impact evaluation will be scheduled and undertaken ~1 year after launch.

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Appendix A | Methodology for Siting Considerations

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Methodology for Siting Considerations

1. Locations of all AA meetings were acquired ('scraped') from the AA Metro Vancouver website.
2. The Metro Vancouver area was divided into 1-km sized hexagons.
3. A routing algorithm (described in full detail in this paper) was used to route the centroid of every hexagon to every other centroid in the region, using actual transportation routes (based the open-source OpenStreetMaps platform). This essentially is the same as running thousands of 'A-to-B' trips on GoogleMaps.
4. The algorithm was run assuming transportation by car and then transportation by public transit.
5. The total number of AA meeting locations that are reachable within 30 minutes of transport were then summed up. 30 minutes is taken as a rough ballpark of how long someone would realistically want to travel to get to a meeting.
6. The accessibility scores for transportation by both car and transit were then *weighted*: transit is considered twice as important as car in the weighting, on the assumption that public transit is used more often by the vulnerable populations we are talking about when using RCCs. The combined, weighted score was converted to an 'accessibility index' between 0 and 1 (where 0 = worst, 1 = best).
7. To account for competing demand for AA resources, the population of each catchment (determined from Dissemination Area data from the 2018 Canadian census) was combined with the accessibility measure described above. This effectively represents a 'per capita' measure of accessibility, and is unitless.
8. Combining number of accessible AA locations with the number of people living in each location's catchment.
9. The various 'AA accessibility' measures were then plotted spatially on a map of the region. Six maps were produced:
    a. **Figure 1:** Total number of AA locations reachable within 30 mins by public transit.
    b. **Figure 2:** Total number of AA locations reachable within 30 mins by car.
    c. **Figure 3:** Locations with best combined accessibility to AA locations.
    d. **Figure 4:** Locations with worst combined accessibility to AA locations.
    e. **Figure 5**: Combined, weighted accessibility to AA locations within 30 mins by car and transit.
    f. **Figure 6:** Competition-based accessibility (combining number of accessible AA locations with potential demand from surrounding population) to AA locations within 30 mins by car and transit.

Additional Figures for Siting Considerations

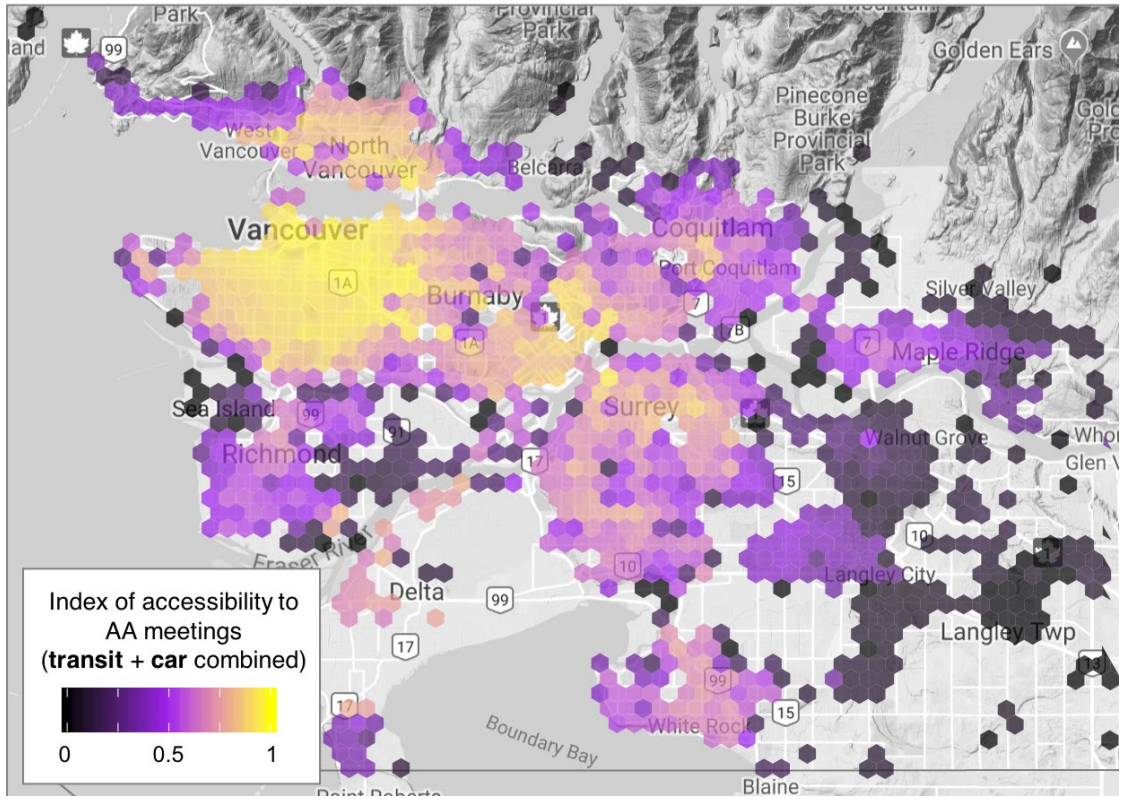

Figure 4: Combined, weighted accessibility to AA locations within 30 mins by car and transit.

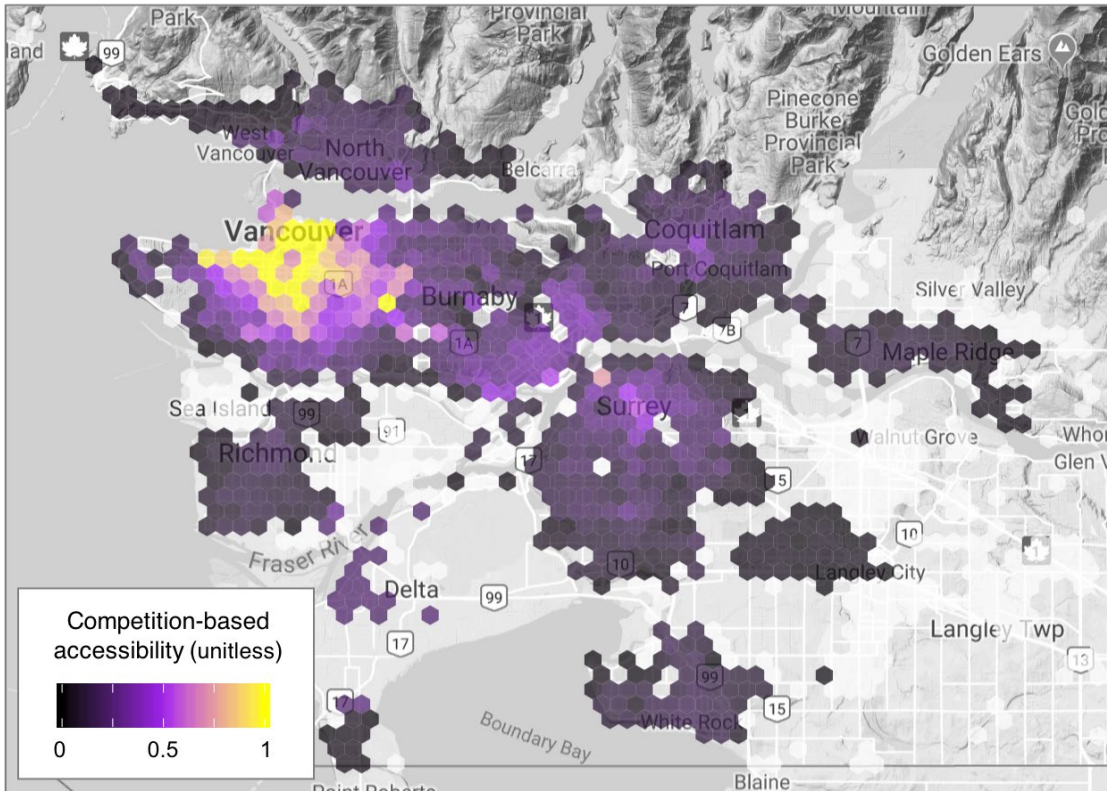

Figure 5: Competition-based accessibility (combining number of accessible AA locations with potential demand from surrounding population) to AA locations within 30 mins by car and transit.

Analysis and figures prepared by Jerome Mayaud

Appendix B | Methodology for critical component analysis

Methodology for critical component analysis

1. Components are assigned a subjective rating from 1-5 to describe how well the site meets or is able to meet the criteria (1 being the least and 5 being the most).
2. Component results are aggregated by category by determining the average rating for the category and rounding to the nearest integer.
3. Total component aggregation is determined by summing the total (before rounding) of the component category aggregation and then rounding this to the nearest integer. The maximum score available is 30.
4. Total aggregation is done to provide a better sense of relative score versus each component.
5. Note: Total aggregation may not match the sum of the rounded category results because the sum occurs using the raw category value and is rounded to the nearest integer after summation.

Appendix C	1. Advisory Committee - Terms of Reference 2. Addendum - The Potential of Recovery Capital (2010) by David Best and Alexandre Laudet

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Recovery Community Centre Model – Advisory Committee
TERMS OF REFERENCE

1. Context

Many Vancouverites go from participating in intensive and expensive outpatient or live-in recovery programs, where they have access to a multitude of program supports and 24-7 peer support, to the opposite extreme of fully detaching from these supports and becoming relatively isolated in the community. Some will have follow-up appointments with a physician, while others may attend a self-help group or two. Many individuals struggle and are often discouraged when neither a good or immediate fit, nor a sense of belonging, are experienced in their community. Compounding feelings of disconnection is a challenge in finding opportunities to replace the usual people, places and things that act as triggers – problematic cues that lead to cravings and a desire to obtain and use a preferred substance of abuse.

Surprisingly, there is no assurance of outcomes, nor a sound return on investment, for the public funding exchange covering addiction treatment and recovery services. Often, the same individuals revolve in and out of a variety of programs, posing an opportunity cost for those on long wait lists, conflicting with the brief window of time these latter individuals are willing to address their addiction.

Recognizing that relapse is a common experience, it would be useful to find an array of low cost and high potential supports that:

1) Improve outcomes for individuals exiting: withdrawal management; treatment or supportive recovery programs; recovery housing; hospital and corrections;
2) Demonstrate an improved return on public investment;
3) Free-up limited resources for others in need; and
4) Lead to cost savings and improved public safety in terms of reduced addiction related crimes, incarceration and emergency services use (e.g., police, ambulance, fire, emergency department).

A Recovery Community Centre Model promises such impacts and outcomes. The following brief paper is provided as an addendum to these Terms of Reference to ensure a common understanding of terms including ‘recovery’ and ‘recovery capital’: *The Potential of Recovery Capital* (2010) by David Best and Alexandre Laudet – also available for download at https://www.thersa.org/globalassets/pdfs/blogs/a4-recovery-capital-230710-v5.pdf .

1. RCC Background

Ideally, a Recovery Community Centre (RCC) model will fill a void in the recovery services and support continuum in Vancouver. RCCs are largely peer-operated centres that serve as locatable resources of community-based recovery support. These resources can help individuals build recovery capital at the community level through: support groups (e.g., Alcoholics Anonymous, SMART Recovery, Life Ring); social engagement opportunities (communal outings, book clubs, lunch gatherings, movies, coffee get-togethers, cooking classes); recreational activities on and off-site (e.g., yoga, meditation, walking, cycling, hiking); and supportive relationships developed among individuals in recovery. The increased recovery capital helps some individuals begin their recovery journey and others to sustain their recovery over time.

RCC participation is open to individuals on the recovery continuum from those who have yet to begin their recovery to those in long-term recovery. RCCs provide a meaningful sense of belonging to a positive peer group as well as an accountability to help those coming up behind them. '*I feel at home…these are my peeps…this is my tribe'* are examples of sentiments from people who access RCCs. There is a definite sense of connection. There are also benefits for collective responsibility – the belief that '*I help someone else and I feel better and stronger in my own recovery'* is a common experience.

The services and supports available through the Recovery Centres are non-clinical, peer-driven and peer-delivered. They are fueled by the energy of volunteers who freely share their experience, knowledge and support with others in efforts to prevent relapse and sustain recovery. RCCs can cater to different cohorts in addiction (i.e., any group that would prefer to be among similar individuals while pursuing recovery) such as professional athletes, business executives or the general population as well as high-risk industries (health care; law; accommodations & food services; arts, entertainment & recreation; mining; construction; waste management & remediation services). Membership in meetings, social activities and relationships can be intentional and closed. Additional groups can be added to serve unmet population segment needs.

RCCs are both a physical location and virtual space (without walls) where there is a choice to access support opportunities and participate in programs, social events and recreational activities on the premises or off-site and elsewhere is the community. In some RCCs, telephone support and outreach recovery coaching are available options for those unable or not willing to step through the door. In other RCCs, peer volunteers provide in-reach into schools, prisons and/or hospitals. RCCs maintain an up-to-date digital calendar of mutual-aid, individual supports, social, recreational and connection opportunities offered in-house, by phone and around town.

1. Recovery Community Centre Model AC Purpose

The Recovery Community Centre Model Advisory Committee (AC) will provide a sounding board for the group of individuals who have been moving this initiative forward including:

1) Tracey Harvey, Streetohome Project Lead;
2) Caitlin Zalm, Master in Counselling Student, Adler University – completing a Social Justice Practicum Project that involves conducting a 'current state analysis' of seven RCC-like organizations currently operating in the Lower Mainland (Vancouver Recovery Club; Alano Club (Vancouver, North Shore); Avalon Recovery Society (North Shore, Vancouver, White Rock) and Little House Society (Delta) – process involves: a survey completed by each organization; individual site visits to corroborate data; and facilitating face-to-face meetings and a digital community of practice to promote sharing and collaboration among the seven sites;
3) Jue Wang, Master in Counselling Student, Adler University – completing a Social Justice Practicum Project that involves conducting a literature review of evidence-based and promising practices as well as documenting a Streetohome-hosted study tour of two highly recommended 'gold standard' Recovery Community Center models operating on the West Coast (Recovery Café in Seattle and Alano Club in Portland) – process involves: sharing guidance from the literature review back with the seven sites; and hosting a debrief following the study tour that focuses on observations and practical steps in any local adoption/adaptation of significant practices;
4) Rob Turnbull, President & CEO, Streetohome Foundation, and
5) KPMG Team (Laura Evans - Lead Consultant, Robyn Budd, Madeleine Pullen and Kyle Schmick) – providing in-kind support to develop a business case for Streetohome; and
6) Jerome Mayaud (Postdoctoral Research Fellow, School of Community and Regional Planning, Faculty of Applied Science, University of British Columbia) providing in-kind data support.

1. AC Membership

The Advisory Committee will be comprised of the following individuals:

1) Lisa Bayne, A/Associate District Director, BC / Yukon Parole District, Correctional Service of Canada
2) Amanda Butler, MA (Criminology), PhD Candidate, Faculty of Health Sciences, SFU, Research Assistant, Psychiatry, UBC
3) Dr. Bill MacEwan, Addictions Psychiatrist, Clinical Professor, Department of Psychiatry, Faculty of Medicine, UBC
4) Mary Marlow, Addiction Knowledge Exchange Lead, Vancouver Coastal Health
5) Annie McCullough, Co-Founder and Executive Director, Faces and Voices of Recovery Canada
6) Dave Nelson, Graduate of San Patrignano in Italy (2016), Subject Matter Consultant
7) Devika Ramkhelawan MSW, Manager, Vancouver Addictions Services, Pacific Community Resources Society

Administration Support will be provided by Tracey Harvey, Project Lead, Streetohome. Information will be shared with Dr. Seonaid Nolan, Clinician Researcher, BC Centre on Substance Use; Assistant Professor in the Department of Medicine, UBC; Physician Program Director, Interdisciplinary Substance Use Program, Providence Health Care.

1. Mandate

The AC will be tasked with the oversight of the business case development. This includes identifying key information to be included in the business case to ensure there is sufficient support for recommendations that are ultimately made to the Streetohome Board. *Examples of information that may be requested by the AC include:*

a) An identification of the components of an RCC model;
b) Thoughts on the costing and funding of an RCC model;
c) Thoughts on the design considerations of an RCC model;
d) A plan on how best to spread and promote an RCC; and
e) What a new self-sustaining evidence-based RCC model development looks like.

The following information will be shared with the AC and KPMG: a current state analysis of seven RCC-like sites across the Lower Mainland; a literature review of evidence-based and promising practices of the RCC model in the U.S.; a study tour debrief of 'gold standard' RCC sites in Seattle and Portland; and a consideration of best practices in terms of metrics, minimal data set and data gathering processes that could inform the efficacy of the RCC model in Canada in terms of its contribution to improved outcomes for individuals accessing its recovery pathways as well as the RCC model's contribution to addiction recovery services system efficiencies.

KPMG will collate the information, guidance and feedback into a robust business case intended to provide clarity for the AC, so that they may make fulsome recommendations to the Streetohome Board on a preferred 'made in Vancouver' RCC model and Streetohome's involvement moving forward.

The AC will:

a) Establish Committee Co-Chairs
b) Be expected to meet at three points during the project timeline from April to September:
    1) At the first meeting, the AC will meet the KPMG Team and be asked to provide feedback on the business case Table of Contents and Development Timeline.
    2) At the interim meeting, the AC will be asked to: review an early draft of the business case; confirm interpretation of the information as presented; discuss early pivotal takeaways for adapting the model in Vancouver; identify additions/deletions that strengthen the business case; and suggest key messages that should be highlighted in the final version.
    3) At the final meeting, the AC will proof-read the completed business plan and provide any last-minute additions, deletions and revisions prior to publication for the Streetohome Board.
c) Review the completed business case and, based on the information provided, make recommendations to the Streetohome Board on opportunities for Streetohome's involvement in brokering and leveraging the proposed RCC model in Vancouver.

1. Governance

Co-chair responsibilities include:

- Guiding the meeting according to the agenda and time available
- Ensuring all agenda items requiring direction or decision are discussed with a definite outcome and/or assigned action
- Confirming that directions and decisions of the Committee are made by consensus
- Providing Committee recommendations to the Streetohome Board in September

Committee member responsibilities include:

- Reviewing the agenda, minutes and supporting documentation prior to each meeting
- Identifying revisions and accepting revised minutes as a true and accurate record
- Asking questions, offering perspective and suggesting alternative approaches to opportunities and challenges
- Supporting fellow Committee members and Committee decisions

Streetohome Foundation responsibilities include:

- Scheduling meetings and notifying Committee members
- Distributing the agenda and supporting documentation with sufficient time to review
- Inviting Committee members to participate in a visit to one or more local RCC-like organizations and study tour of ‘gold standard’ Recovery Community Center models operating on the West Coast
- Distributing the minutes to all Committee members within two weeks of the meeting

1. Endorsement of Terms of Reference

Originally prepared by Streetohome staff – May 2, 2019

Endorsed by the Recovery Community Centre Model Advisory Committee – *May 14, 2019*

Reviewed and/or Revised and Approved by Streetohome Board – *June 6, 2019*

The Potential of Recovery Capital

This paper

This short paper outlines the concept of recovery capital and discusses the impact that the accumulation of individual success has on groups and communities. It seeks to define recovery capital, to capture its flavour and principles, and to look at the intrinsically social forces that are at play in shaping change and in growing communities of recovery. It also outlines how we will be taking forward these ideas in our action research.
Forthcoming RSA papers will discuss how the ideas in this report are being operationalized, and what the lessons are to date in trying to embed recovery-oriented practice and behaviour; and will report on our recent work in West Sussex.

About the authors

David Best is Chair of the UK Recovery Academy, Chair of the Scottish Drugs Recovery Consortium and a researcher at the University of the West of Scotland. He is currently involved in researching recovery pathways and in developing training manuals in recovery approaches to treatment.

Alexandre B. Laudet, Ph.D, is an expert in addiction recovery from the US. Her federally funded research in the past 15 years has focused on elucidating what helps people with drugs and/or alcohol problems quit drinking or getting high and how they stay in recovery. A social psychologist, her main goals are to build and help translate the science of recovery into services and policy that create opportunities for long-term recovery and improved quality of life for people with substance problems.

"voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society"

— UK Drug Policy Commission, defining recovery capital

Introduction

The addictions field is now overflowing with references to 'recovery' with service providers and workers increasingly designated as 'recovery-focused', although in many areas there is confusion as to what this means in practice and what needs to change. There is an increasing awareness that people do recover, but we have limited knowledge or science of what enables recovery or at what point in the journey recovery is sparked and made sustainable.

There is also the recognition that recovery is something that is grounded in the community and that it is a transition that can occur without professional input, and where professional input is involved, the extent of its role is far from clear. We are also increasingly confident that recovery is contagious and that it is a powerful force not only in transforming the lives of individuals blighted by addiction but in impacting on their families and communities as well.

What do we mean by recovery and recovery capital?

Researchers and clinicians have devised the construct of 'recovery capital' to refer to the sum of resources necessary to initiate and sustain recovery from substance misuse. Before discussing this construct in more detail, it is first necessary to explain what we mean by recovery.

In the US, the Betty Ford Institute Consensus Panel (2007, p. 222) defined recovery as "a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship".[1] Subsequently, the UK Drug Policy Commission (2008, p.6) followed up this statement with a definition of recovery as "voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society". Both of these definitions involve three primary component parts – wellbeing and quality of life, some measure of community engagement or citizenship, and some measure of sobriety. [2]

In contrast, the definition from mental health recovery is typically more focused on the quality of life component regardless of the others. Deegan (1988) has argued that "recovery refers to the lived experience of people as they accept and overcome the challenge of disability... they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability". [3]

What is clear, however, is that the essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings. Recovery is a process rather than an end state, with the goal being an ongoing quest for a better life.

"the essence of recovery is a lived experience of improved life quality and a sense of empowerment; ... the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration"

— Best and Laudet

1 Betty Ford Institute Consensus Panel (2007) **'What is Recovery? A Working Definition from The Betty Ford Institute', Journal of Substance Abuse Treatment**, Vol. 33, pp221-228

2 UK Drug Policy Commission, (2008) **Recovery Consensus Statement,** www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml

3 Deegan, P. E. (1988) **Recovery: the lived experience of rehabilitation. Psychosocial Rehabilitation Journal**, 11, 11-19.

"Those who possess larger amounts of social capital, perhaps even independently of the intensity of use, will be likely candidates for less intrusive forms of treatment"

— Granfield and Cloud

".... the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems"

— Granfield and Cloud, defining recovery capital

Table 1: Recovery capital / Problem Severity matrix
(re-produced with permission from **White and cloud**, 2008)[8]

High Recovery Capital	High Problem Severity/ Complexity
Low Problem Severity/ Complexity	Low Recovery Capital

With recovery conceptualized as a process in this way, recovery capital refers to the sum of resources that may facilitate the process. The notion of social capital initially developed in the field of sociology, where **Pierre Bourdieu** (1980) described it as one of three resource forms along with economic and cultural capital as the basic resources for power.[4] When this concept was applied to the addictions field, **Granfield and Cloud** (2001) suggested that "Those who possess larger amounts of social capital, perhaps even independently of the intensity of use, will be likely candidates for less intrusive forms of treatment".[5]

However, social capital in this sense does not mean only the social resources that an individual can draw upon – their parents and families, partners, friends and neighbours when times are tough. It also implies the person's engagement and commitment to the community and their willingness to participate in its values.

Further, **Granfield and Cloud** (1999) defined recovery capital as " the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD [alcohol and other drug] problems".[6] In the same paper, they summarize early evidence among naturally recovering individuals (people who did not seek professional treatment or participate in mutual aid support groups) suggesting that both the quality and the quantity of recovery capital play a major role in predicting recovery success both in and out of treatment, and crucially that the growth of recovery capital can signal a 'turning point' in addiction careers.

White and Cloud (2008) assert that the type of interventions that will be appropriate will depend in part on the balance of recovery capital and problem severity/complexity.[7] They represent this in a 'quadrant model' as shown in Table 1 below, where people can be allocated to one of four cells (although this is a shorthand for people's overall ratings of recovery capital and problem profile). Thus, people with high recovery capital and low problem severity may be appropriate for brief interventions of various types. People with high recovery capital but also high problem severity may be appropriate for out-patient detoxification with intense community support. White and Cloud argue that people with low problem severity and low recovery capital may be appropriate for residential rehabilitation with appropriate follow-up and people with low recovery capital and high problem severity may need a combination of intensive interventions.

4 Bourdieu, P. (1980) **The logic of practice.** Polity: London

5 Granfield, R. and Cloud, W. (2001) **'Social Context and "Natural Recovery": The Role of Social Capital in the Resolution of Drug-Associated Problems', Substance Use and Misuse,** Vol. 36, pp1543-1570

6 Granfield, R. and Cloud, W. (1999) **Coming clean: Overcoming addiction without treatment.** New York: New York University Press

7 White, W. and Cloud, W. (2008) **'Recovery Capital: A Primer for Addiction Professionals',** Counselor, Vol. 9, No. 5, pp22-27

8 Ibid.

Consistent with Deegan's definition of recovery in the mental health field, this model makes no assumption that those high in addiction severity/complexity will be low in recovery capital. However, the influence of change in recovery capital (increases or decreases) on subsequent patterns of substance use and related problems remains an unanswered question.

What are the key components of recovery capital?

Cloud and Granfield (2009) recently revisited their initial concept and have argued that there are four components to recovery capital:[9]

1. **Social capital** is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to groups to which they belong; thus, family membership provides supports but will also entail commitments and obligations to the other family members.
2. **Physical capital** is defined in terms of tangible assets such as property and money that may increase recovery options (e.g. being able to move away from existing friends/networks or to afford an expensive detox service).
3. **Human capital** includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem solving that is required on a recovery journey.
4. **Cultural capital** includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours.

Although the focus here is primarily on individual factors, it is the meshing of three of these components – social, human and cultural capital – that may be particularly important in assessing recovery capital at a group or social level.

What does recovery capital mean at a community level?

In social epidemiology, **Christakis and Cowler** (2007) reported on the increased risk rates for obesity in up to three degrees of separation from a target individual such that a person's odds of becoming obese increased by 57% if they had a friend who became obese, with a lower risk rate for friends of friends, lower again at three degrees of separation, and with no discernible effect at further levels of remove.[10] Moreover, if the friend is perceived to be a close friend then the risk rate is increased. Repeating this social network analysis for smoking, **Christakis and Fowler** (2008) found that smoking cessation by a spouse decreased a person's chances of smoking by 67%, while smoking cessation by a friend decreased the chances by 36%. The average risk of smoking at one degree of separation (i.e. smoking by a friend) was 61% higher, 29% higher at two degrees of separation and 11% higher at three degrees of separation.[11]

9 Cloud, W. and Granfield, W. (2009) **Conceptualising recovery capital: Expansion of a theoretical construct, Substance Use and Misuse,** 42, 12/13, 1971-1986

10 Christakis, N. A. and Fowler, J. H. (2007) **"The Spread of Obesity in a Large Social Network Over 32 Years" New England Journal of Medicine 357** (4): 370–379

11 Christakis, N. A. and Fowler, J. H. (2008) **"The Collective Dynamics of Smoking in a Large Social Network" New England Journal of Medicine** 358 (21): 2249–2258

In “Connected”, Christakis and Fowler (2010) assessed the effect of social contagion in emotions and the extent to which this reaches beyond immediate social networks, which they refer to as hyperdyadic spread.[12] Using happiness as the topic for investigation, they reported that, if a person’s friend is happy, there is a 15% increase in the chances that the target will be happy, but that even at a further degree of separation there is an increase of around 10% and at three degrees of separation, the increased likelihood of happiness is 6%. This is a critical issue in the development of interventions and policies that attempt to promote recovery as it would suggest that focusing exclusively on individuals underestimates the impact of key icons of recovery and of recovery communities. Thus, there is evidence for the social transmission of some of the key elements of recovery capital, and we do not have to conceptualise it exclusively as the property of an individual.

The development of recovery ‘champions’ as charismatic and connected community figures who are visible examples of success provides not only the opportunity for ‘social learning’ for those who claim that recovery is not possible, but also increases the waves of impact within local communities for recovery spread. Similarly, the growth of vibrant recovery groups and recovery-oriented systems of care may well provide ready-made social supports for individuals starting out on their recovery journeys (as has often been attributed to mutual aid groups, particularly Alcoholics Anonymous) while also providing the scaffolding for the development of the human and physical capital that are likely to be part of the developmental journey of recovery. In other words, recovery champions may be the key contagion that allows the ‘viral spread’ of recovery capital.

Within the addictions field, Best and Gilman (2010) have argued that the growth of recovery has a ripple effect that confers benefits on families but also serves to generate ‘collective recovery capital’ that provides support and hope for those in recovery and that engages people in a range of activities in the local community.[13] This process translates into active participation in community life and ‘giving something back’ by creating a collective commitment in recovery groups to community engagement and immersion. In other words, the recovery community acts and is seen as a positive force in the local community and a resource for that community that goes beyond managing substance misuse issues.

12 Christakis, N. A. and Fowler, J. H. (2010) **Connected: The Amazing Power of Social Networks and How They Shape Our Lives**, Harper Press: London

13 Best, D. and Gilman, M. (2010) **Recovering Happiness, Drink and Drugs News**, 15 February 2010

14 Laub, J.H. and Sampson. R.J. (2003) **Shared Beginnings, Divergent Lives: Delinquent Boys to Age 70**. Cambridge, MA: Harvard University Press

What does this mean for professionals and addiction agencies?

As **Laub and Sampson** (2003) have reported with respect to the predictors of long-term desistance from crime, it is not direct treatment effects that will trigger the growth of recovery capital; rather, it is likely to be a range of life events and personal and interpersonal transitions:[14]

- attachment to a conventional person (spouse);
- stable employment;
- transformation of personal identity;
- ageing;
- inter-personal skills; and
- Life and coping skills.

However, this does not mean that treatment providers or commissioners have nothing to offer – they are often best placed to act as guides to recovery communities, and they are essential in activating the basic health supports that are needed. In "Getting back into the world", the mental health recovery group, Rethink (2010), argued that the starting point for a recovery journey requires three components – a safe place to live, effective control over symptoms and general health problems, and basic human rights supports.[15] While not all clients are looking for recovery guides, the *sine qua non* of treatment services and workers should be to enable their clients to get to the starting blocks of the recovery journey and to enable and support recovery activities that will be community-based and socially grounded.

Recovery capital as community engagement

This overview of recovery capital has focused on recovery from addictions and the increasing recognition that recovery is not only possible, it is the reported experience of many people who have (had) addiction problems. Recovery unfolds in the lived, physical community as well as in the substance misusing communities and it has significant ramifications for those wider communities. The growth of recovery capital as a collective, community concept will involve mutual empowerment, support and recovery contagion in substance misusing groups, but it will manifest itself in improved functioning for the family and the wider community. The growth of recovery capital is, as far as we currently know, idiosyncratic and personal, but its manifestation is inherently social and community-based and its impact can be measured in terms of those lived communities.

What this means is that at a systems level – the Drug Action Team in England or the Alcohol and Drug Partnership in Scotland – it is meaningful to conceptualize and measure recovery capital as the sum of resources and supports available to people starting recovery journeys. This will include the range and dynamism of recovery support groups, the local champions of recovery and the services that provide continued and ongoing care. This resource is the community asset that we should aim for as the foundation stone of recovery-oriented systems of care.

15 Ajayi, S., Billsborough, J., Bowyer, T., Brown, P., Hicks, A., Larsen, J., Mailey, P., Sayers, R., and Smith, R. (2010) **Getting Back into the world: Reflections on lived experiences of recovery**. Rethink recovery series: volume 2 www.rethink.org/intotheworld

The RSA

RSA Projects put enlightened thinking to work in practical ways. We aim to discover and release untapped human potential for the common good. By researching, designing and testing new social models, we encourage a more inventive, resourceful and fulfilled society.

The RSA Commission on Illegal Drugs, Communities and Public Policy published its report, Drugs – facing facts, in 2007, which argued, inter alia, for a more tailored and expansive approach to drug services.

Following this report, and with our modern mission to extend our thought leadership into practical action on the ground, we are working with West Sussex Drug and Alcohol Action Team and partners to develop and test a user-centred approach to personalized recovery.

Building on this work, we have launched a new project to explore how to develop a broad recovery community

RSA Peterborough Recovery Capital Project

The RSA is working with Peterborough City Council and partners to put the ideas in this paper into practice as part of the broader **Citizen Power Programme** of work which sets out a vision for active citizenship across the City and seeks to realize it with local stakeholders.

There are strong overlaps between the notion of recovery capital and its domains, and the RSA's account of individual and collective civic health. Broadly, the latter includes being engaged in civic life; acting in an other-regarding, pro-social manner; being resilient in the face of change and shocks; having sufficient self-reliance to make change and to participate in civic life; and being resourceful and creative in problem-solving and in the face of scarcer resources.

The RSA's **Recovery Capital** project will work with current and former substance misusers to map and understand their recovery capital. We will then work with substance misusers, service providers and a wide range of other stakeholders to re-design services for recovery, foster recovery capital, and mobilize community assets to support recovery journeys and the active participation in civic life.

Appendix D	Recovery Café Network Emerging Member Application, Emerging Member Benefits & Cohort 6 Launch Agenda

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RECOVERY CAFÉ NETWORK: EMERGING MEMBER APPLICATION

Thank you for your interest in joining the Recovery Café Network (RCN) as an Emerging Member. As you know, Recovery Café is a recovery community supporting men and women who have suffered trauma, homelessness, addiction and other mental health challenges. We are excited you are exploring the possibility of creating a recovery community in your town or city. Recognizing the increasing, critical need for supportive recovery communities, we would like to support you as best as we can.

Our primary goal is supporting your success in building a recovery community. Laying the groundwork is key to a successful community. This business plan is the first step in a larger discovery process. It is important that before you expand your organization you have a solid grasp of your current situation, including the need and potential community partners. Please take your time to thoughtfully work through each question with your team. Most teams will need to meet together several times in order to complete all the questions, within the word limits provided.

Recovery Café Network

Recovery Café Network is committed to nurturing organizations seeking to start recovery centers based on the Recovery Café model. The Recovery Café model delivers a community of belonging for its Members (most closely held clients) through a set of core intervention elements such as small groups offering peer-to-peer support, activities, classes, nutritious meal service, and access to needed services and resources. All Members contribute to running the café facility and to nurturing the recovery of other Members.

What makes Recovery Café special?

- **Radical Hospitality**: We are a community of belonging where everyone is met, valued and loved wherever they are on their journey.
- **Membership Based**: Members make commitments, share responsibilities, enjoy benefits of membership and experience a sense of ownership.
- **Loving Accountability**: There is accountability that comes from being both deeply known and loved that transforms us.
- **Everyone Contributes**: We do not just receive services; everyone is expected to contribute to the running of the Café and to the healing of others.
- **Raising Up Leaders**: Everyone is expected to develop their gifts, to lead at the point of their gifts and to follow at the point of another's gifts.
- **Mutually Liberating Relationships**: We form relationships that cross socio-economic, racial, religious, gender, and other barriers that exist in our larger culture.

RECOVERY CAFÉ NETWORK

1. INTRODUCTORY INFORMATION

Please provide the following information on your organization and team.

Q1 *Please provide basic details for the lead organization interested in joining the Recovery Café Network.*	
Organization/Group:	
Mailing Address:	
County, City, or State in which you anticipate opening your recovery community:	
Your current status: *(please check only one box)*	☐ an independent nonprofit ☐ group with a fiscal sponsor ☐ a program of a nonprofit
Legal name of entity (fiscal sponsor if applicable)	
EIN of entity (fiscal sponsor if applicable)	
501c3 determination letter (fiscal sponsor if applicable)	*(please attach a copy of this to your application)*
Are you currently operating?	

Q2 *Please list the contact information of all people who have contributed to and are submitting this plan. Please also note who the primary contact person is for communication regarding your plan.*	
1) Main Contact Name:	
Email:	
Phone:	
1) Name:	
Email:	
Phone:	
1) Name:	
Email:	
Phone:	
1) Name:	
Email:	
Phone:	

RECOVERY CAFÉ NETWORK

2. VISION, MISSION, AND IMPACT ALIGNMENT

RCN's Values

Our vision is a world where everyone thrives in a community of love and belonging. To work toward this vision, our mission is to nurture a life-transforming community of people committed to recovery from homelessness, addiction, and other mental health challenges.

Through the Recovery Café model, our flagship Café in Seattle, WA helps over 900 individuals (our Members) annually experience the benefits of community, recovery support, loving accountability, nutritious meals, daily encouragement, and more.

Our approach is explicitly value-led. We are looking for partners who reflect our values: those with a demonstrated commitment to nurturing recovery in community. We want to partner with organizations who are drawn to this approach, and who will treat Members of the Café with respect and dignity.

RCN's Core Commitments that we ask every Recovery Café to live out are:

- Creating a community space that is drug and alcohol free, embracing, and healing
- Nurturing structures of loving accountability called Recovery Circles
- Empowering every Member to be a contributor
- Raising up Member Leaders
- Ensuring responsible stewardship

RECOVERY CAFÉ NETWORK

Q3
What draws you to the Recovery Café model? Why are you interested in running a Recovery Café? What experience does your team have with recovery support services?

(Max. 250words)

Please type response here:

Q4
What is your Recovery Café's working mission and vision statement?

(Max. 100 words)

Please type response here:

Q5
Please provide a review of how your organization's mission, impact, and values fit with RCN's mission, impact, and values.

(Max. 250 words)

Please type response here:

Q6
How would you describe your recovery philosophy (i.e. 12 Step, All Pathways, Holistic, Faith Based, etc).

(Max. 250 words)

Please type response here:

3. CORE TEAM

Team Requirements

The following sections are designed for you to provide further information about the staff team who will be responsible for delivering the Café model in your local area, including the Leadership, Administrative, Programmatic, and Fundraising roles required to open and run a café.

A Recovery Café requires a minimum of 2-3 core individuals who can execute the Leadership, Administrative, Programmatic, and Fundraising functions required to successfully operate.

The team functions listed below are necessary for ensuring that Recovery Café can be run with quality and fidelity to impact.

1. **Leadership:** Leadership responsibilities include holding the whole team accountable to your mission and vision as a Café. This function area coordinates (and delegates) the many pieces of starting a Café and moves the process along by identifying goals, barriers, and next steps.

2. **Administrative:** Administrative responsibilities include implementing responsible financial stewardship and abiding by related policies. Local governance and strategic planning decisions and tasks also fall under this function area, as does ongoing communication with the Seattle location and others in the network. Additional responsibilities include managing human resources, payroll, and related policies and systems.

3. **Programmatic:** Programmatic responsibilities encompass all aspects of implementing the Café model in order to ensure impactful delivery and that quality standards are met on an ongoing basis. These include but are not limited to: overseeing front door management, the formation and maintenance of local partnerships, activities relating to meal service and kitchen operations, and building maintenance. The program function also manages monitoring and evaluation activities.

4. **Fundraising:** Fundraising responsibilities include grant writing and management, as well as relationship management for major donors. In addition, this function encompasses event planning, planning and executing external communications, and regular maintenance of your website.

Additionally, successful implementation requires that the organization has some technological savvy (at minimum, proficiency in Microsoft Office and email).

RECOVERY CAFÉ NETWORK

Executive Director (or authorized signer)

Q7.a
Please provide details for the individual authorized to sign the licensing agreement. This individual will have overall responsibility for ensuring the terms of the social licensing arrangement are upheld, processes documented in the Operations Manual are followed, and that quality is maintained.

NOTE: If you have a fiscal sponsor, please list that fiscal sponsor contact here.

Name:	
Email:	
Phone:	
Current time availability per week to devote to Café start-up and operations:	
Team function (check all that apply)	☐Programmatic ☐Administrative ☐Fundraising ☐Leadership

Q7.b
Please provide further details regarding applicable experience and expertise for the Executive Director.
- *Include a brief bio and/or resume.*

(Max. 500 words)

Please type your response here

Main Contact

Q8.a
Please provide details for the individual who will be the main contact with RCN. This will be the point person for the majority of communications.

Check if same as Executive Director ☐

Name:	
Relationship to Organization:	
Email:	
Phone:	
Current time availability per week to devote to Café start-up and operations:	
Team function (check all that apply)	☐Programmatic ☐Administrative ☐Fundraising ☐Leadership

Q8.b
Please provide further details regarding applicable experience and expertise for the Main Contact.
- *Include a brief bio and/or resume.*

(Max. 500 words)

Please type your response here

RECOVERY CAFÉ NETWORK

Additional Core Team Members

Tell us about your team. Please provide information on the additional members of the team who will be running the Café, and how much time each is able to give. If these people have yet to be recruited, please indicate that below.

Q9.a *Please provide basic details for each individual involved in operating the Café.*	
Name:	
Current role with the Café:	
Current time availability per week to devote to Café start-up and operations:	
Please provide further details regarding applicable experience and expertise. • *Include a brief bio and/or resume.* *(max 250 words)*	
Team function *(check all that apply)*	☐Programmatic ☐Administrative ☐Fundraising ☐Leadership

Q9.b *Please provide basic details for each individual involved in operating the Café.*	
Name:	
Current role with the Café:	
Current time availability per week to devote to Café start-up and operations:	
Please provide further details regarding applicable experience and expertise. • *Include a brief bio and/or resume.* *(max 250 words)*	
Team function *(check all that apply)*	☐Programmatic ☐Administrative ☐Fundraising ☐Leadership

Q9.c *Please provide basic details for each individual involved in operating the Café.*	
Name:	
Current role with the Café:	
Current time availability per week to devote to Café start-up and operations:	
Please provide further details regarding applicable experience and expertise. • *Include a brief bio and/or resume.* *(max 250 words)*	
Team Function (Check all that apply)	☐Programmatic ☐Administrative ☐Fundraising ☐Leadership

Q10

What staff do you anticipate needing during your time as an Emerging Member?

- *Does your organization have the staff structure that could be dedicated to the roles as outlined above?*

(Max. 250 words)

Please type response here

Q11

If applicable, please detail which roles you still need to recruit in order to run your Café.

(Max. 200 words)

Please type response here

4. COMMUNITY NEED

Recovery Café would like to understand more about where your organization is interested in implementing the Café model, and what existing relationships you may already hold to support your work.

4.1 Community Demographics

Q12
Please describe your community area in which you hope to establish a recovery community. *a. What is the overall population?* *b. Is it rural, urban, or suburban?* *(Max. 250 words)*
Please type response here

Q13
Please describe the population that you currently serve, or intend to serve (e.g. individuals experiencing homelessness, substance use disorders, mental health challenges, co-occurring disorders; justice involved individuals, veterans, etc.) • *Please include any additional insights and/or research about why there is a need for this program in your local area, including relevant statistics.* *(Max 500 words)*
Please type response here

4.2 Community Need

Q14

If you are an existing organization tell us about your work.

a. What programs and/or services is your organization currently providing to the community where it is based?

b. What new or additional services do you anticipate providing in your community?

(Max. 250 words)

Please type response here

Q15

Describe the current services available to this population in your community and who the providers in your area are.

(Max. 500 words)

Please type response here

Q16

Describe the unmet needs you see in your community.

- *What essential services (stable housing, transportation, health care, etc.) will your target population need? (Max. 500 words)*

Please type response here

4.3 Community Support

Q17

What level of support do you currently have from community partners?

- *Please include details of any existing partner relationships (i.e. service providers, government agencies, donors, facilities, etc.)*

(Max. 300 words)

Please type response here

Q18

Please include details of recovery centers or similar interventions in your local area and how you believe Recovery Café will fit into this landscape.

- *Please include details of any existing relationships or previous work with these organizations.*

(Max. 500 words)

Please type response here

5. STRENGTHS, WEAKNESSES, OPPORTUNITIES, AND THREATS

The following section is intended to help you consider your organizational strengths and weaknesses—as they relate to the delivery of the Café model—in addition to any external opportunities and threats that may arise and which may affect the success of implementation. (For more information: en.wikipedia.org/wiki/SWOT analysis)

Q19

Please provide an outline of your strengths and opportunities in delivering the Café model, as well as an outline of the weaknesses and possible threats and how you would mitigate these.

In your response please include reference to:

i) People
ii) Resources
iii) Innovation and ideas
iv) Marketing
v) Operations
vi) Finance and fundraising
vii) Partners
viii) Relevant experience
ix) Track record with similar projects

(This response may be given through diagrams, text or a combination but must not exceed one side of 8.5"x11" page)

Strengths *What about your organization prepares you to deliver the Café model well?* *Please include response here*	**Weaknesses** *What about your organization will you need to strengthen in order to deliver the Café model well? How do you plan to address these areas?* *Please include response here*
Opportunities *What external opportunities have you gauged that may help ensure the success of the Café model in your community?* *Please include response here*	**Threats** *What external threats have you gauged that might hinder the success of implementing the Café model? How do you plan to mitigate these?* *Please include response here*

6. MARKETING AND BRANDING

Tell us how you plan to market and brand your Café, as well as your projected participation in the Recovery Café Network.

Q20 *Does your organization operate under an established brand?*	*Yes*	
	No	
If yes, please use this section to provide information on your current brand and brand awareness in your community. • *Include any photos, logos, brand guidelines, or other supporting documentation available.* *(Max. 250 words)*		
Please type response here		

Q21 *Please use this section to tell us how you currently market, or plan to market, your recovery center in your local area and what channels you will use to do this – for example, social media, local media, local events or networks.* • *Where possible please include examples of how you have used these channels successfully in the past for previous promotion activities.* *(Max. 300 words)*
Please type response here

7. FINANCES AND FUNDING

Please use this section to develop your forecasted budgets for running your recovery center and explain how these costs will be covered by existing or new funding streams.

7.1 Start-up Costs

Emerging Members of RCN will receive a package of support from Recovery Café in exchange for an annual licensing fee of $5,000 for the first 2 years of your journey. Financial assistance opportunities are available for applicants who may struggle to pay the full fee. See 8.4 for more details. The package of support includes:

- **Training**: Initial 2-day training, three personalized 1-2-day immersion visits to Seattle, and RCN site visits to the implementer location
- **Resources**: Recovery Café Operations Manuals, and access to Recovery Café's online library of resources
- **Marketing support**: Listing as an Emerging Member of RCN in literature, on the website, and in fundraising efforts
- **Fundraising support**: Letter of support in fundraising efforts, help developing a funding plan, and template language for grants
- **Network support**: Introduction to other Emerging and Full Members in the RCN, access to RCN Communities Platform including RCN Member directory
- **Option to extend:** Initial support for another year for an additional fee, decided on a case-by-case basis

Organizations will incur additional costs during the start-up phase of the program dependent on existing resources. Partners should assess which apply to them. These costs include:

- Staff salaries and benefits
- Office set-up, including any improvements or renovations of the space
- Purchase of necessary supplies (e.g. food/beverages), equipment and systems
- Rent of facilities
- Utilities (set-up and ongoing)
- Internet
- Insurance
- Permits
- Travel to Seattle to participate in RCN trainings (2-day initial training; 2-day midway RCN training or conference; optional immersion visit)

Q22 *Please provide estimates and further details of these additional initial costs.* *NOTE: If you would like a budget templet, please contact David Uhl at david.uhl@recoverycafenetwork.org*
Please attach an Excel Spreadsheet

7.2 Ongoing costs

After the period of initial 2 years of start-up support, Emerging Members can become Full Members who receive ongoing support in exchange for a fee determined on a sliding scale based on budget size. This includes:

- Continuous innovations to the core model
- Ongoing coaching
- Ongoing training opportunities
- Operational and administrative support and troubleshooting
- Continued access to RCN, including: shared best practices, online library of resources, network events/summits, and quarterly conference calls for updates and Q&A
- Continued access to select data management systems

In addition to this, Recovery Café estimates partners will incur additional costs dependent on existing resources. Partners should assess which apply to them. These costs include:

- Cost of program activities
- Equipment costs (purchase and upkeep, additional technology and associated licenses)
- Administrative costs (phone costs, other office overheads)
- Staff salaries and benefits
- Rent of facilities
- Utilities
- Internet
- Insurance
- Permits
- Travel to Seattle participate in RCN trainings for select staff (e.g. annual 2-day RCN conference)

Q23 *Please provide estimates of the additional ongoing cost of delivering Recovery Café, annually for at least 3 years.* *NOTE: If you would like a budget templet, please contact David Uhl at david.uhl@recoverycafenetwork.org*
Please attach an Excel Spreadsheet

7.3 Funding Sources

Recovery Café depends on fundraising efforts. The amount of program funding partners will need to secure is equivalent to the costs outlined in 7.1 and 7.2.

Q24

Please provide details of how you intend to cover the start-up and estimated delivery costs of running your recovery center.

a. What start-up funds or gifts-in-kind are available to you at this time?

b. If you do not have current funds available, what is your plan for securing start-up funding for this program and how much start-up funding will you need?

(Max. 500 words)

Please type response here

Q25

Please provide details of how you intend to seek income from funders, including:

a. Details of funding secured to-date

b. At least five individuals, foundations, and/or government agencies you intend to approach for funding to launch your recovery center – including justifications of why they would be interested

If relevant, please also provide details of how you intend to seek income through other income streams, including experience in this area, and estimates of the amounts of income you will secure from these alternative streams.

(Max. 500 words)

Please type response here

Q26

Are you going to provide any healthcare related services reimbursable by Medicaid and/or other insurance?

(Max. 200 words)

Please type response here

8. EQUIPMENT AND FACILITIES

Tell us more about the space in which you will operate your Café, and other facilities.

Q27

Do you have a space for your recovery community? (If not, do you have a space in mind?)

a. Does/would your organization lease or own the space?
b. What is the square footage of the space?
c. What is the maximum occupancy?
d. Does the space need tenant improvements or renovation?

(Max. 300 words)

Please type response here

Q28

Tell us about your location within your community.

a. Location proximate to desired target population
b. Number of individuals at a time you anticipate serving
c. Other details as relevant

(Max. 300 words)

Please type response here

Q29

Do you intend to serve food or beverage?

a. If yes, what do you intend to serve?
b. Do you have a commercial kitchen?

(Max. 300 words)

Please type response here

Q30

Will you have access to a computer connected to high-speed internet in order to take advantage of the online RCN Communities Platform and network learning events and forums?

(Max. 200 words)

Please type response here

RECOVERY CAFÉ NETWORK

9. TIMELINES

Q31 *What is your hoped for timeline of securing a location for your Recovery Café? When do you hope to open your doors?* *(Max. 300 words)*
Please type response here

Q32 *Please provide estimates of the number of individuals that you expect to serve for the first 3 years you're open, with any relevant statistics to support these aims.* *(Max. 300 words)*
Please type response here

Q33 *Please provide a hoped for timeline for developing further community support and partnerships.* *(Max. 300 words)*
Please type response here

RECOVERY CAFÉ NETWORK

10. REFERENCES

Q34.a *Please provide 2 letters of reference from 2 entities that can speak to your organization's collective skills, ability, and desire to establish and run a recovery center. (References can be organizations, funders, faith communities, or other appropriate entities.)*
Please attach 2 letters of reference on their official letterhead

Q34.b *Please provide contact details for the two official references (e.g. organizations, funders, faith communities) that we can contact about your application.*	
1) Entity:	
Name of contact and Relationship to Org:	
Email:	
Phone:	
Website (if applicable):	
1) Entity:	
Name of contact and Relationship to Org:	
Email:	
Phone:	
Website (if applicable):	

11. SCHOLARSHIPS *(IF NEEDED)*

As mentioned in 7.1, there is an annual licensing fee of $5,000 for the first 2 years of your journey as an Emerging Member. Scholarships are available for applicants who are unable to pay the full fee. RCN is able to offer limited funding to reduce the fee to $2,500 for the first 2 years.

You may qualify for financial assistance if you meet the following basic criteria:

- You have made a good faith effort to raise the funds to meet the licensing fee.
- You are able to pay for your team's travel and lodging to the initial two-day training
- This Application demonstrates that you are ready to excel in launching a Recovery Café in your community

Q35 *What amount are you requesting? (maximum scholarship amount is $2,500)* *(Max. 100 words)*
Please type response here

Q36 *Do you anticipate needing a scholarship for your second year as an Emerging Member?* *(Max. 100 words)*
Please type response here

Q37 *How would a scholarship help you launch a Recovery Cafe?* *(Max. 250 words)*
Please type response here

RECOVERY CAFÉ NETWORK

12. OPTIONAL ADDITIONAL INFORMATION

Recovery Café is interested in any additional information that would be helpful for us to know about you, your organization, the community you are in, the Members who will be supported by your recovery community, or anything else that will help Recovery Café to support you.

Q38 *Is there anything else you would like us to know?*
Please include response here

SUMMARY OF REQUESTED ATTACHMENTS

Attachment	Relating to Question #
☐ 501c3 Determination letter (if have one)	**1**
☐ Photos, logos, brand guidelines, etc. (if have them)	**20**
☐ Start-Up Budget	**22**
☐ Ongoing Budget	**23**
☐ 2 Letters of Reference	**34b**

SUBMISSION DETAILS:

Please sign and date your submittal once complete. Applications may be sent as a PDF file with relevant attachments to david.uhl@recoverycafenetwork.org. If email is not available, please fax to (206) 374-8732, or please make a copy for your records and mail the original to the following address:

Recovery Café Network
c/o David Uhl
2022 Boren Ave.
Seattle, WA 98121

Thank you for taking the time and effort to complete this plan. We hope that it will be a useful exercise for you in helping to understand if becoming a Member of the Recovery Café Network is right for you at this time.

We will review your responses and get back to you as soon as possible.

STATEMENT OF SUBMITTAL AND ACCEPTANCE OF CORE COMMITMENTS:

As part of my application, I have read, agree with, and aspire to live out the Core Commitments of Recovery Café Network. I also agree that our organization will not engage in any discriminatory hiring practices and commit to living this value.

Printed Name: _____

Signature: _____ **Date: _____**

RECOVERY CAFÉ NETWORK

Emerging Member Benefits

Emerging Members who commit $5,000 a year for two years ($10,000 total) will receive the following from a dedicated team committed to your success:

Personalized Training and Education

- Initial two day training
- Monthly phone consultations over two years
- Three personalized one to two day immersion visits with your team at RC Seattle
- Access to the RCN's online Communities Platform including Knowledge Library
- Registration for three people of your team at the biannual Recovery Café Network summit (cohort community building, special speakers, training, etc.)
- Pre-launch site visit

Program and Resource Development

- Recovery Café Start-Up and Operations Manuals describing program, operational, and administrative functions developed over a decade
- Identification as an Emerging Member of the national Recovery Café Network in your literature, website, and fundraising material
- Letter of support for fundraising efforts
- Access to AGENCY database tool to manage Café membership and programming
- Template language for grants

Facilitated Peer to Peer Connection

- Facilitated introduction to Members of the Network
- Bimonthly conference calls with your Emerging Member cohort
- Quarterly Network-wide conference calls filled with updates and Q & A
- Member Directory on RCN's Communities Platform

Cohort 6 Launch Agenda
Monday, October 14, 2019 (Day 1)

RECOVERY CAFÉ NETWORK

Time	Event	Presenters
8:30 am	Arrival & Registration	
9:00-10:00 am	Welcome & Introductions • Review agenda	Killian Noe David Uhl
10:00-10:15 am	Break	
10:15-11:00 am	*The Heart of Recovery Café / Guiding Principles*	Killian Noe
11:00-12:30 pm	*What is the Recovery Café Model?*	Ruby Takushi
12:30-1:30 pm	Lunch	
1:30-2:30 pm	*Loving Accountability – Recovery Circles*	Ruby Takushi Killian Noe
2:30-3:15 pm	*Staff Essentials:* Gathering your team	Ruby Takushi Killian Noe
3:15-3:45 pm	*Philosophy of Fundraising*	Killian Noe
3:45-4:00 pm	Break	
4:00-5:00 pm	Team Consultation with RCN staff	Available RCN Staff

Cohort 6 Launch Agenda
Tuesday, October 15, 2019 (Day 2)

RECOVERY CAFÉ NETWORK

Time	Event/Training	Presenter
8:30 am	Arrival & Coffee	
9:00-9:45 am	Welcome	Killian Noe
9:45-10:15 am	*New Member Introduction*	Ruby Takushi
10:15-10:30 am	Break	
10:30-11:30 am	*Monitoring and Evaluation*: enrollment forms, surveys, and AGENCY info	Cami Kasmerchak Ken Tanzer
11:30-12:00 pm	*Café Activities & School for Recovery*	Ruby Takushi
12:00-12:25 pm	*Community Volunteer Program*	Carolyn Dougherty
12:30-1:30 pm	Silence, announcements, and lunch	RC Seattle Members
1:30-2:00 pm	*Access to Resources*	Tiffany Turner
2:00-2:30 pm	*Intro to Meal and Beverage Service*	Ashley Propes
2:30-3:00 pm	*Where does Recovery Café fit into your Community?*	David Uhl
3:00-3:45 pm	*Mapping Your Café Components* Workshop: Conceptual Model	Cami Kasmerchak
3:45-4:00 pm	Break	
4:00-5:00 pm	Wrap-Up • Report out from groups • Q & A • RCN recap	Killian Noe David Uhl Ashley Propes
5:00 pm	Dinner at RC Seattle (optional)	

Appendix E | Citations

Citations

1) https://bc.ctvnews.ca/b-c-getting-71-1m-to-increase-access-to-treatment-for-substance-abuse-1.4082985

2) http://www.streetohome.org/homelessness-prevention/addiction-recovery/

3) City of Vancouver Homeless Count 2019. https://council.vancouver.ca/20190612/documents/pspc1a-Presentation.pdf

4) The (Real) Barriers to Canada's Mental Health & Addiction Services, KPMG, 2018. https://assets.kpmg/content/dam/kpmg/ca/pdf/2018/11/ca-en-putting-the-pieces-together-volume-1.pdf

5) The Rationale and Science on Addiction Recovery Support Services. John F. Kelly, PhD, ABPP https://narronline.org/wp-content/uploads/2016/11/John-Kelly.pptx.

6) http://www.streetohome.org/wp-content/uploads/2017/04/ARCH-Business-Case_North-Wind-Wellness-03072019.pdf

7) Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR) David Best, Melinda Beckwith, Catherine Haslam, S. Alexander Haslam, Jolanda Jetten, Emily Mawson & Dan I. Lubman http://shura.shu.ac.uk/10842/1/Best%20-%20Social%20Identity%20Model%20of%20Recovery_main%20doc%20ART_final%20revision.pdf.

8) Stay in Your Lane: Distinguishing between a Drop-In Center, 12-Step Clubhouse, Recovery Community Center and Addiction Treatment Agency. Phil Valentine (2014) http://www.williamwhitepapers.com/pr/Recovery%20Community%20Center%20Role%20Clarity%20Valentine%202014.pdf.

9) Characterization and Evaluation of Addiction Recovery Community Centers, John F. Kelly https://slideplayer.com/slide/12190595/.

Do you have any unanswered questions?

For additional information, please contact:

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