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Professor Adrian Bonner, Specialist Services Adviser to the Salvation Army

transitions rtc

JOURNEYING TO A LIFE FREE FROM ADDICTIVE BEHAVIOUR

A Residential Therapeutic Community for 16-25 year olds with drug/alcohol problems and addictive behaviour

Transitions Residential Therapeutic Communities is registered in England and Wales as a Charitable Company Limited by Guarantee, Company no. 08805909, Charity no. 1157388 Registered Office: Transitions RTC, 3 Links Avenue, Hertford, SG13 7SR

Transitions Residential Therapeutic Communities

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Learning and legacy

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Professor Adrian Bonner, Specialist Services Adviser (incl addictions) to the Salvation Army.

“Transitions is a thrilling vision for an important mission”

Pete Greig, Founder of 24-7 prayer and Director of Prayer for HTB and Alpha International.

Council of Reference:

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Contents

Introduction

Purpose and aims of this learning and legacy document:

- Clarify the unique situation facing young people and young adults with addictive behaviour in the UK.
- Present the rationale and evidence base for Transitions innovative approach.
- Clearly explain the different options considered and elucidate the decision making process.
- Reflect on our experience and suggest learning for others who are considering setting up similar projects

This document chronicles the learning of charitable company Transitions Residential Therapeutic Communities, who set out on a journey to establish a Residential Therapeutic Community (RTC) for 16-25 year olds with drug/alcohol problems and addictive behaviour.

Transitions was founded by Mark Wood, who has both the practical experience and qualifications necessary to lead the organisation. Mark is supported by a strong team of trustees chaired by Doctor Phil Moore, a GP involved in health commissioning.

As a newly established Charitable Company Limited by Guarantee, Transitions was primarily concerned with serving London and the home counties by providing holistic treatment for 16-25 year olds with addictive behaviour. This would be unique in the UK as the only residential service offering transitional support and treatment for under-18s through to 25 year olds with drug/alcohol and other addictive behaviour.

We planned to open our first RTC in Hertford in February 2016, as a pilot project for 1 year, and as a result of our evaluation and learning from the pilot, we hoped to open further Residential Therapeutic Communities in other locations.

It is widely known in the drug and alcohol field in the UK that there are no residential treatment services for under-18s, and this has been confirmed by our research. Young people's residential rehabilitation has always been a complex and challenging arena. Before embarking on the journey to establish our first RTC we were already aware that Middlegate Lodge in Lincolnshire, often touted as the last residential rehab for young people, had closed in 2011 due to lack of funding. We then discovered a hidden gem, Companions in Stafford, but this too closed in the summer of 2014.

So why set out on this journey?

Responding to need

A report in 2013 from the Centre for Social Justice states "one in 20 adults in England (1.6 million) is dependent on alcohol and one in 100 (380,000) is addicted to heroin or crack cocaine." When combining the costs of alcohol harm and illicit drugs, the financial burden alone is a huge £35 billion.[1]

[1] No quick fix: Exposing the depth of Britain's drug and alcohol problem. Centre for Social Justice. August 2013.

Youth substance use is also a significant issue – levels of cannabis use and binge drinking in the UK are some of the highest in Europe[1], and new psychoactive substances (nicknamed 'legal highs') have made a dramatic impact on youth substance use. According to the United Nations Office on Drugs and Crime "The largest market for legal substances that imitate the effects of illicit drugs in the European Union is the United Kingdom"[2] amongst 15-24 year olds.

To cap it all off over 20,000 young people are receiving specialist support for drug/alcohol misuse on a yearly basis[3]. Other potentially addictive behaviours, such as self-harm and eating disorders are also increasing, and these are sometimes associated with drug/alcohol misuse.[4] [5]

A window of opportunity

"Addiction is a developmental disease - it typically begins in childhood or adolescence."

(National Institute on Drug Abuse).

In 2011 a government research report entitled "Specialist drug and alcohol services for young people – a cost benefit analysis" estimated the average lifetime cost of a young person becoming an adult drug or alcohol user at £46,145 - £91,964. The report demonstrated every single £1 spent on treatment for adolescents results in £5 to £8 of savings compared with addressing the problems later on.[10]

Academic research suggests 30% - 40% of teenagers who use alcohol and cannabis (moderate/heavy usage) will develop substance misuse problems in adulthood. However, for those using class A drugs, 95% will continue as adults.[6] Therefore, **treatment for young people and young adults is vital before they develop entrenched substance use and addiction**, and the UK government drug strategy recognises this. *For "young people who develop dependency, the aim is to become drug or alcohol free. This requires structured treatment with the objective of achieving abstinence".*[7]

Uniquely vulnerable - young people with drug/alcohol dependence problems

There is widespread recognition that young people in treatment for drug or alcohol problems have multiple needs, and a complete package of care is essential including treatment, supported housing,

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[2] United Nations Office on Drugs and Crime. http://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf, p.87

[3] Statistics on Drug Misuse in England: 2013. Lifestyles Statistics, Health and Social Care Information Centre

[4] *Truth hurts: report of the National Inquiry into self-harm among young people.* London: Mental Health Foundation. 2006.

[5] Eating disorders in the UK: service distribution, service development and training. Report from the Royal College of Psychiatrists' Section of Eating Disorders. March 2012. *http://www.rcpsych.ac.uk/files/pdfversion/CR170.pdf*

[10] Department for Education. Research Brief. Specialist drug and alcohol services for young people – a cost benefit analysis [Online]. Available at https://www.education.gov.uk/publications/eOrdering Download/DFE-RB087.pdf

[6] Specialist drug and alcohol services for young people – a cost benefit analysis. Frontier Economics. 2011.

[7] Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life. HM Government. 2010.

reparenting and education support.[7,8,10] Transitions holistic programme will address this (see Appendix 1).

There is also a clear link between drug/alcohol misuse and mental health problems in young people[9].

Where this is the case, extra support will be provided as necessary.

Hertfordshire's Drugs Strategy highlights concerns about failing to meet the needs of looked after children over the next 2-3 years, with numbers likely to increase, and "other vulnerable groups that are of high priority, namely young people not in education, employment or training, truants and excludees and those with unsettled accommodation."[10]

Transition from young people's to adult services

In line with national strategy recommendations concerning youth in transition to adult services, Hertfordshire's Drugs Strategy also recognises the importance of providing age appropriate treatment for 18-24 year olds. In fact several years ago the Drugscope report 'Young people's drug and alcohol treatment at the crossroads', suggested a service was created specifically for 16-25 year olds "who are developing more serious substance use problems that do not correspond to existing concepts of 'problem drug use.'"[8]

A government report on children's residential homes underlines this, as it reminds us there are a greater percentage of older children in care than previously, and those above school leaving age now make up a substantial minority. *"Transitions* become increasingly important, including access to adult services (Stein and Munro, 2008)".[10]

The focus on youth in transition

Transitions RTC planned to establish a residential service offering treatment and transitional support for 16-25 year olds with drug/alcohol and associated addictive behaviour.

This would be unique in the UK and there were 2 key reasons why we decided to go for young people aged 16 -25, rather than focusing exclusively on under 18s. One was simply practical and the other was in recognition of the identified needs of this group and lack of service provision. In order to work

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[7] Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life. HM Government. 2010.

[8] Drugscope. Young people's drug and alcohol treatment at the crossroads: what it's for, where it's at and how to make it even better [Online]. Available at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Publications/YoungPeopleCrossroadsReport.pdf (accessed on 25th May 2012).

[9] Mental illness, Offending and Substance Misuse leaflet. Royal College of Psychiatrists (2012).

http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/mentalillness,offendingand.aspx

[10] Hertfordshire Drugs Strategy Plan for 2012-2015.

[11] Living in Children's residential homes. Research Report. David Berridge, Nina Biehal, Lorna Henry. March 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184079/DFE-RR201.pdf

with young people under 16 years of age, Transitions would have needed to be registered with Ofsted as an education provider. This was felt to be too time consuming for a small charity trying to pioneer a new approach to young people's rehabilitation.

The level of demand for this type of specialist service for under-16s was unclear, whereas research has clearly demonstrated reasons to approach young people in transition to adulthood as a distinct group with unique needs concerning substance misuse. There is a clear need for this type of service especially for care-leavers, young offenders, homeless young people and young adults, and other adolescents who need an intensive package of treatment and support.

Despite the clear evidence for providing a specialist service to this age group, it is fraught with complexities.

- While 16-25 year olds with drug/alcohol problems and addictive behaviour clearly need relevant treatment, probably only a relatively small percentage require residential treatment. This age group is also not renowned for engaging in abstinence based services, which residential rehabilitation is by necessity.
- Of those who would benefit from a service like Transitions, it is likely that a significant proportion would be presenting with a dual diagnosis ie. a mental health and substance misuse problem.
- Statutory services would not consider placing under-18s in the same building as over-18s, due to safeguarding concerns, namely the risk posed to vulnerable young people by older residents.

However, none of these potential obstacles were insurmountable, and when a local family offered their home for us to pilot the project we felt this was an adventure God was leading us on.

Vision, Mission, Aims & Values

We spent the first year building our team and agreeing our vision, mission, aims and values, while we considered the next steps necessary to set up Transitions and explored different legal organisational structures.


Our Vision is:

"A Residential Therapeutic Community for young people aged 16-25 with drug/alcohol problems and other associated addictive behavioural issues."


Our Mission is:

"Transitions RTC" is about journeying with young people to support them, in adolescence, making the transition to a life free from addictive behaviours through spiritual transformation, personal development and growth, discovering their purpose and experiencing fun and freedom.

Our mission is inspired by the story of the success of a group of dispossessed homeless people, crossing the Jordan river, making the transition to the promised land and learning to live life God's way.

 We Aim to be:

- Residential
- Therapeutic
- Community-focussed
- Appropriate primarily for 16-21 year olds.
- Serving young people primarily from the home-counties and London
- A progressive, responsive and abstinence-based programme.
- Accommodating young people of both genders – initially we will provide for whichever gender is least catered for.
- A spiritual Christian response.

 We Value:

- Our shared journey to recovery and wholeness
- Abstinence as a lifestyle
- Treatment of the whole person
- Our intrinsic worth and potential as individuals
- Growing our faith
- Professional care and support
- Building wider community cohesion
- Diversity and inclusiveness for everyone

NB. See Appendix 1 for Transitions programme overview

See Appendix 2 for the evidence base to our approach

Business plan summary

Our Vision is:

"A Residential Therapeutic Community for young people aged 16-25 with drug/alcohol problems and other associated addictive behavioural issues."

Transitions holistic programme will include accommodation, meals, therapy, keyworking, lifeskills, basic literacy and numeracy, vocational development, leisure activities, creative activities, spiritual development, voluntary work and mentoring/befriending.

The Need:

Youth substance misuse is a significant issue so treatment is vital before they develop entrenched problems and addiction. There is widespread recognition that a complete package of care is essential including treatment, supported housing, reparenting and education support.

Transitions RTC will be unique in the UK as the only residential service offering transitional support and treatment for under-18s through to 25 year olds with drug/alcohol and associated addictive behaviour. We plan to open our first RTC in Hertford in February 2016 as a pilot project for 1 year for lower risk individuals. It will be a single sex home primarily serving London and the home counties.

Reintegrating Transitions RTC residents with their families, will be considered as a priority where possible and appropriate. However, resettlement will be contingent on the safety of Transitions residents and the risk to their recovery. Family counselling and reintegration support will be available.

Transitions RTC will seek to secure appropriate accommodation for young people on completion of their programme. There are also 3 social enterprises run by Spectrum (adult drug service) for people in recovery, which will support the reintegration process.

Finance and Funding: A cost effective solution with long term benefits

The total cost of the pilot for lower risk young people is £149,329 including all set-up costs. £87,400 is already raised, with an additional £18,130 in regular giving over the next 17months (including Gift Aid). This is over 70% of the total project budget. The running costs for 1 year are approximately £96,105, including all accommodation, meals, staffing and the programme as well as development and evaluation. Weekly costs are estimated at £614 per resident based on a 100% (3 people) occupancy rate. This is significantly cheaper than placing a young person in a local authority children's home (c. £2700 per week), or specialist foster placement, and compares favourably with adult residential rehabilitation.

The full Transitions RTC Shared Lives model for 5 higher risk young people will cost approximately £747 per resident, per week, based on a 100% (5 people) occupancy rate. Set up costs are £13,542. A full breakdown of funding sources see the Financial projections on page 18. Funding is predicated on regular giving continuing at the same level, 30% of the total bed weeks being funded each year at £1,000 p/wk by statutory services (this equated to 1½ places for the year). The remaining 70% of young people being eligible for housing benefit and Employment Support Allowance, and 30% of the Shared Lives Carers reinvesting their money back into the project.

In the current climate of financial instability, securing sufficient finance to enable Transitions to launch the first RTC, and maintain the service, is critical to the success of the project. Delivering a 1 year pilot helps reduce the financial commitment and demonstrate the success of the model.

The current plans for the pilot RTC are contingent on recruiting 3 families to host the individual young people. However, Transitions' profile amongst the network of local churches makes this process considerably easier.

The full RTC will only operate successfully if there are sufficient referrals to maintain a 60% occupancy rate, based on a respective total of 5 residents. This is essential due to the nature of the programme. Promotion and networking will be essential to raising awareness about the service.

Outcome Measures:

- 60% of beneficiaries being retained in their programme for at least 12 weeks.
- 50% of beneficiaries completing their programme, and therefore being drug/alcohol free for 6-12 months, as well as not being in the criminal justice system.
- 50% of beneficiaries completing their programme, discovering meaning and a purpose in life.
- 75% of beneficiaries who complete programme in recovery from addiction, 1 year later.
- 75% of beneficiaries who complete programme in education, training or work, 1 year later.

Our outcome measures will be monitored through evaluation at 2 weeks, 3 months, 6 months and 1 year follow-up. They are supported by the corresponding activities below.

60% of beneficiaries being retained in their programme for at least 12 weeks.

- People who are retained in residential treatment for at least 12-weeks experience better outcomes. In fact post-treatment outcomes continue to improve as the length of time in treatment increases.

50% of beneficiaries completing their programme, and therefore being drug/alcohol free for 6months.

- A daily structured programme with regular meal times, bed times, a variety of scheduled activities with 24 hour support.
- Intensive therapeutic support to deal with the roots of addiction and facilitate emotional, psychological, physical and spiritual growth.
- Supporting motivation through developing supportive relationships with professionals, and as part of a family with house "grandparents" and residents

50% of beneficiaries completing their programme and therefore not being in criminal justice system

- A daily structured programme with a variety of scheduled activities, keeping them occupied with meaningful tasks.
- 24 hour support and monitoring, thereby reducing the opportunities for people to offend or reoffend.
- Providing external positive role models in addition to staff eg. assigning a one-to-one volunteer mentor.

50% of beneficiaries completing their programme, and discovering meaning and a purpose in life.

- Vocational coaching and a variety of opportunities for vocational development, from work experience to establishing a social enterprise
- Spiritual awareness & development to help residents become aware of something beyond themselves. This also has significant benefits for recovery.

- Serving in the wider community eg. as a volunteer at an old people's home, and realising they can make a contribution to society.

75% of beneficiaries who complete programme in recovery from drug/alcohol addiction, 1 year later.

- Providing moving on support comprising sourcing suitable accommodation, leisure opportunities and establishing support networks for when they leave.
- Providing aftercare ie. regular opportunities for group and one-to-one support through Transitions after they have moved on from the project
- Linking them with groups who will support their personal spiritual development.

75% of beneficiaries who complete programme in education, training or work 1 year later.

- Assisting with access to relevant opportunities for residents before they leave and where possible up to 1 year afterwards.
- Maintaining motivation by providing aftercare ie. regular opportunities for group and one-to-one support through Transitions after they have left.

Research

Our aim is to produce an evaluation of the 1 year pilot project, to inform the development of our future Residential Therapeutic Communities.

Expertise:

Our **Chief Executive**, Mark Wood, has over 10 years experience in the charity sector establishing and delivering services for young people, and an MSc in Addiction Psychology and Counselling.

The charity is governed by **trustees** who have a wealth of experience, chaired by Dr Phil Moore. Phil is a local GP and nationally is on the leadership group of NHS Clinical Commissioners and Chairs the Mental Health Commissioners' Network. He is also a church leader in South West London.

There is also a small **advisory group** of experts who give input to the trustees as and when requested, and a **council of reference** that endorses our work.

Company strategy:

To introduce and commend our work to those in the addiction field, as well as churches, Christian organisations and other service providers, Transitions has established a **Council of Reference**. Membership includes well-known and nationally respected professionals working in the drug and alcohol sector as well as Christian leaders.

Due to the pioneering nature of this project the Chief Executive and trustees (see Appendix 4) have also recruited an **advisory group** including specialists in addiction, youth homelessness and property management (see Appendix 4).

Our Chief Executive is part of the International Substance Abuse and Addiction Coalition. Transitions is also **networking** with service providers, churches and Christian organisations across Hertfordshire, West Essex and North London in order to develop both referral and support networks. Some of these organisations will also work in **partnership** in the service delivery with programme opportunities for residents for example volunteering at the Methodist Church coffee shop and gardening activities/alotment projects with Mudlarks in Hertford.

Referrals:

It is anticipated that referrals will come from the following range of sources:

- Herts Young Homeless Group
- Aldwyck Housing
- The YMCA (Central Herts and Bishop's Stortford)
- Hertfordshire's Leaving Care Team / Brokerage team
- Police
- Social workers
- Caring For Ex-Offenders
- Youth Connexions
- Youth Offending Teams (part of Targeted Youth Support)
- Criminal Justice System
- Schools and colleges
- FutureHope
- Future Living
- A-DASH
- Spectrum (CRI adult drug services)
- Churches
- Christian organisations
- Self-referrals

Challenges and solutions

Fire regulations for a residential project, made it impossible to use the family's home in the manner their generosity could have enabled and which we intended. In response to the difficulties of ensuring a family home met with fire regulations, we explored a number of options including operating as a Shared Lives scheme. These are laid out below with the pros and cons.

Eventually we agreed on a creative solution which was true to the vision of providing a rehabilitation service in a family environment and we devised a model whereby additional families would host individual young people.

Shared Lives – formerly known as Adult Placement.

Shared Lives is a little known alternative to home care and care homes. It is used by around 12,000 people in the UK and is available in nearly every area. It is a form of support where vulnerable adults and young people over 16 live at home with a specially recruited and trained carer and their family. The service runs in a similar way to a Foster placement, but this service is specifically designed for adults and young people aged over 16.

Long term accommmodation can be provided for between 1-3 people in the Shared Lives carer's home. Shared Lives carers are recruited, trained and approved for the scheme which aims to be informal with the Shared Lives Carer and their families having a flexible approach.

Pros	***Cons***	***Funding implications***	***Issues to be resolved***
• Family model with national support around regulation, policies etc • Keeps project together and retains family feel. • Good potential for replication. • Can start with 3 people. • Programme is unregulated.	• Would probably need waking night support to help families and residents for first 2 – 4 weeks of a new young person's stay. • Need another family house and/or move on house to accommodate 5 yp.	• The standard amount for Shared Lives carers is up to £300 per person per week, but could be more for the young people we are targeting. This covers accommodation, food and utilities, paid to the family. Families are self-employed as Shared Lives carers. • May need funding separately for day programme. • Cost about £5000-10,000 to set up for policies, support etc	• Placing under 18s is not common, but there is a precedent. This may positively affect funding. • The young people will have more freedom, but it is possible to make accommodation conditional on attending a day programme etc.

<u>The practicalities of running Transitions as a Shared Lives scheme</u>

Shared Lives carers are self-employed but are entitled to qualifying care relief for the payments they receive.

The qualifying amount is made up of 2 parts:

- a fixed amount of £10,000 for each household for a full year (if more than 1 carer, this is shared)

- a weekly amount for each child or young person:
  - £200 for children under 11
  - £250 for children aged 11 or over

If the person/couple is a carer for less than a year, they can only use a proportion of the £10,000 fixed amount.

https://www.gov.uk/government/publications/qualifying-care-relief-foster-carers-adult-placement-carers-kinship-carers-and-staying-put-carers-hs236-self-assessment-helpsheet/hs236-qualifying-care-relief-foster-carers-adult-placement-carers-kinship-carers-and-staying-put-carers-2015

Most Shared Lives schemes are members of Shared Lives Plus, the UK network for family-based and small-scale ways of supporting adults.

Shared Lives Carers are expected to attend some training, and would be vetted and approved by Shared Lives Plus if Transitions opted to join.

Shared Lives Carers are expected to provide a level of care, but it is not realistic for them to be available 24 hours a day. In residential rehabilitation settings it is normal that residents are not allowed to go out unsupervised for the first 4 weeks.

In order for Transitions to effectively rehabilitate 16-25 year olds with drug and alcohol problems and addictive behaviour it seems sensible to ensure residents have 24hr support during their first 4 weeks.

Shared Lives placements can only accommodate a maximum of 3 residents, in addition to the Shared Lives carers and any family guests. In order to provide this level of support we will need to employ *waking* night support staff. This is because *sleep-in* night support would be included in the numbers and therefore would reduce the amount of young people we could accommodate in the house to 2.

It is acceptable to make the accommodation contingent on residents attending a day programme. This will be written into the tenancy or license agreement.

See Appendix 4 re costings

Our board agreed to pursue this option, but due to our model being a hybrid between Shared Lives and residential rehabilitation it was later decided not to become a Shared Lives scheme. In the meantime changes in circumstances for the family who had offered us their home meant we had to consider recruiting host families for each individual young person.

Subsequently we became aware of a host family scheme operated by Hertfordshire Partnership Foundation Trust (NHS Trust), which had been in operation for 4 years. This scheme was for people experiencing an acute mental health episode in Hertfordshire, as an alternative to admission to hospital for psychiatric treatment.

Transitions invested in developing all the appropriate documentation for operating our Residential Therapeutic Communities utilising host families, as well as promotional material such as an advert, a flyer, an expression of interest form.

Our host pack includes:

- Host information sheet
- H & S Environmental checklist

- Recruitment process
- Host roles and responsibilities
- Host family agreement
- Host family application form
- References and consent form
- License agreement
- Three way plan (between Transitions, the host and the young person)

2 days of training were also devised to prepare potential hosts for the role.

However, despite a variety of strategies we were simply not able to recruit host families in the locality.

Regulation – residential substance misuse treatment/rehab or supported housing

In the preparation phase for launching Transitions, we wrestled with the issue of if and how the project would be regulated.

Residential rehabilitation

The Care Quality Commission (CQC) is the independent regulator of health and social care in England.

There 2 key areas to address when considering whether a residential project providing a service for people with substance misuse problems should be registered with the CQC.

The first is whether accommodation is provided with the treatment, and the second concerns the definition of treatment.

- Any project or service in England providing residential substance misuse treatment/rehabilitation is highly likely to be required to register with the CQC. The regulated activity which this comes under is "Accommodation for persons who require treatment for substance misuse".
- This applies where housing is provided *together with* treatment for people with drug/acohol problems even if they are provided on separate sites. For example, the treatment may be delivered in a community setting (a day centre or community centre), while the participants are accommodated in separate facilities geographically.
- However, the accommodation and the treatment must be linked so that the accommodation is provided because someone requires and accepts treatment ie. the accommodation is conditional upon the residents participating in treatment.

The CQC use the following definition of substance misuse treatment:

"Structured drug and alcohol treatment consists of a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone. Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets

out clear goals which include change to substance use, and how other client needs will be addressed in one or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending. All interventions must be delivered by competent staff, within appropriate supervision and clinical governance structures. Structured drug and alcohol treatment provides access to specialist medical assessment and intervention, and works jointly with mental and physical health services, and safeguarding & family support services according to need. In addition to pharmacological and psychosocial interventions that are provided alongside, or integrated within, the keyworking or case management function of structured treatment, service users should be provided with the following as appropriate: harm reduction advice and information; BBV screening and immunisation; advocacy; appropriate access and referral to healthcare and health monitoring; and crisis and risk management support."

Therefore, if a residential service is providing detoxification, or structured drug counselling and relapse prevention for its residents, it would fall within this definition.

Recovery Houses

Projects which house people with substance misuse problems, but which do not provide a structured treatment programme (as defined above) do not need to register with the CQC.

These services are also known as quasi-residential, third-stage accommodation (and some second stage) or dry-houses. They are normally considered supported housing, or could be considered specialist supported housing.

- 'Supported housing' is defined as accommodation for specific groups with support services in place to enable them to adjust to independent living or to enable them to live independently.
- 'Specialised supported housing' usually has to offer 'a high level of support' for residents, receive no or negligible public subsidy, and have been commissioned in line with local health, social services or Supporting People strategies.
- 'Specified accommodation' includes most housing where care, support or supervision is provided to the person living there. It is a new definition of supported housing that was established by the government specifically to protect vulnerable residents from the benefit cap and Universal Credit.

Benefits and funding for supported housing

A 16 or 17 year old *leaving care* should be paid for by Children's Services or the Drug and Alcohol Team.

This has not been budgeted for at present, because it has not been possible to ascertain how many referrals are likely to come from the leaving care team.

To claim housing benefit, there has to be a liability to pay rent, so technically, housing benefit would not be payable if HCC (ie. Children's Services or the Drug and Alcohol Team) agreed to pay the full cost of the accommodation. Similarly, means-tested ESA would have to take into account the income that HCC gave the young person to live on, so this could reduce or extinguish the ESA.

However, the key issue is for 18+ – why **should** HCC pay the full cost of the accommodation and the young persons personal spending money, when that can be met from within the benefit system? It's the same principle that HCC use when funding 'Staying Put' for formerly fostered children, and when assessing the charge for residential care for older and disabled people – it is expected and assumed that the individual claims whatever benefits are due to them from the DWP or the local council, as this defrays some of the cost that HCC would otherwise incur. It would be very bad practice of HCC to do otherwise, almost negligent in fact, as they would be spending money on something that the benefit system could at least partially assist with.

Starting over

Now the dust has settled and we have had the opportunity to reflect on our approach, here is what we might do differently if we started all over again.

Start on a smaller scale

- While we had reduced the scale of Transitions, it was still a big vision for a specialist project. Perhaps if we had started with a significantly smaller scale pilot with spaces for 1 or 2 individuals, primarily referred through local churches or other local agencies this would have made better use of our resources and attracted greater funding.
- Regardless of the scale I would recruit a team more quickly to reduce isolation for the Chief Executive, share the load and increase the perspectives on the ground.

Make an early decision around regulation… and stick to it

- Due to the innovative nature of Transitions vision it was unclear about whether we needed to be regulated by the CQC, and this was discussed on a number of occasions. It may be that bringing in a consultant to address the trustee body at an earlier stage would have helped us to have greater confidence in our decision.

Referral and funding sources

- With the low numbers of referrals for residential treatment in the 16-25 age group, it seems that it may be better to start off with a less specialised approach. Starting the project as supported housing, which is a less regulated sector, would have enabled greater progress in the early stages. The project could then be aimed at young people who need intensive support for a variety of issues but which cannot be catered for in a generic supported housing project.
- Identifying a church with an existing ministry to people with these needs would be an alternative approach. A church which could benefit from a service like Transitions serving them, could provide referrals and also be a source of funding, or help with fundraising.

More infrastructure less organisational structure

- Hertford was a small town to support another Christian initiative with a vision like Transitions RTC. Initially we did not see this as a problem because we were expecting to receive referrals from London and the South-East, due to the unique nature of the service. However, it is likely that a larger town with identified needs in this area would make planting an innovative project like Transitions easier. Establishing a partnership with a

single large church at the start would also make resourcing the project easier in the earlier stages.

- Another possibility is approaching a larger charity to take advantage of their infrastructure, to reduce the burden in the early stages with limited staffing.
- We gathered a large group of excellent trustees, eventually totalling 9 people. However, part of the reason for needing a larger number was the difficulty in getting sufficient numbers together in order to be quorate for meetings. In hindsight a smaller core group may be more effective, perhaps making greater use of key advisors for different meetings.
- While gifted and godly people are often in demand and therefore busy, frequent meetings with host families are essential to the success of the project. Organising early training is advisable, even if it has to be repeated in the lead up to launching.

APPENDIX 1: PROGRAMME OVERVIEW

Programme stages

- The initial induction phase takes 2 weeks
- Second phase lasts 3-6 months
- Third phase/moving on is 1-3 months
- Aftercare continues beyond the third phase

Elements

- Residential accommodation is in single rooms in family houses
- Shared bathroom, shower and kitchen facilities
- 3 meals a day (at least 1 shared communal meal)
- A drug and alcohol free environment
- One-to-one and group counselling
- Keywork sessions
- Lifeskills including cooking and budgeting
- Vocational development
- Basic literacy and numeracy skills / reading, writing and basic maths – if needed
- Opportunities for social enterprise development
- Leisure activities eg. sport
- Creative activities eg. art and music
- Spiritual development in a Christian context
- Voluntary work
- Mentoring/befriending provided by trained volunteers (in addition to staff support)

APPENDIX 2: EVIDENCE BASE FOR TRANSITIONS APPROACH

The UK government drug strategy states "One of the best predictors of recovery being sustained is an individual's 'recovery capital' – resources necessary to start, and sustain recovery from drug and alcohol dependence," identified by Granfield and Cloud (2001), who showed people in sustained recovery had jobs, a safe place to live, access to healthcare, and stable relationships at home and with peers. They also reached a turning point - usually after experiencing a significant, meaningful spiritual event in life. The government asserts "we will support services to work with individuals to draw on this capital in their recovery journey".

According to surveys cited by British Religion in Numbers (http://www.brin.ac.uk/news/2011/psychics/) between 32-35% of the population described themselves as spiritual, and Hay (2002) references a survey which "showed that over 75% of the sample claimed that they were personally aware of a spiritual dimension to their experience" (p. 4).

The role of religion and spirituality has received increasing attention in the health literature (Flannelly, Galek, Bucchino, & Vane, 2006) and a large volume of work has been produced on their influence on health and wellbeing (e.g. Religion and Belief Matter: An Information Resource for Healthcare Staff http://www.scottish interfaithcouncil.org/ resources/ Religion+and+ Belief.pdf).

There is growing interest in engagement with the religious/spiritual aspects of client's lives so as to improve therapy (Coyle & Lochner, 2011), and numerous studies have established the beneficial effects of spirituality and religion in prevention, treatment and recovery from addiction (Miller, 1998; Miller & Thoresen, 1999; Pardinia, Plante, Sherman & Stump, 2000). Piedmont (2001) even observes:

perhaps the clearest demonstration of the value of spirituality in the area of rehabilitation concerns treatment for chemical dependency (e.g., Borman & Dixon, 1998; Green, Fullilove, & Fullilove, 1998; Warfield & Goldstein, 1996), where this construct is seen as the central curative factor in recovery (p. 4).

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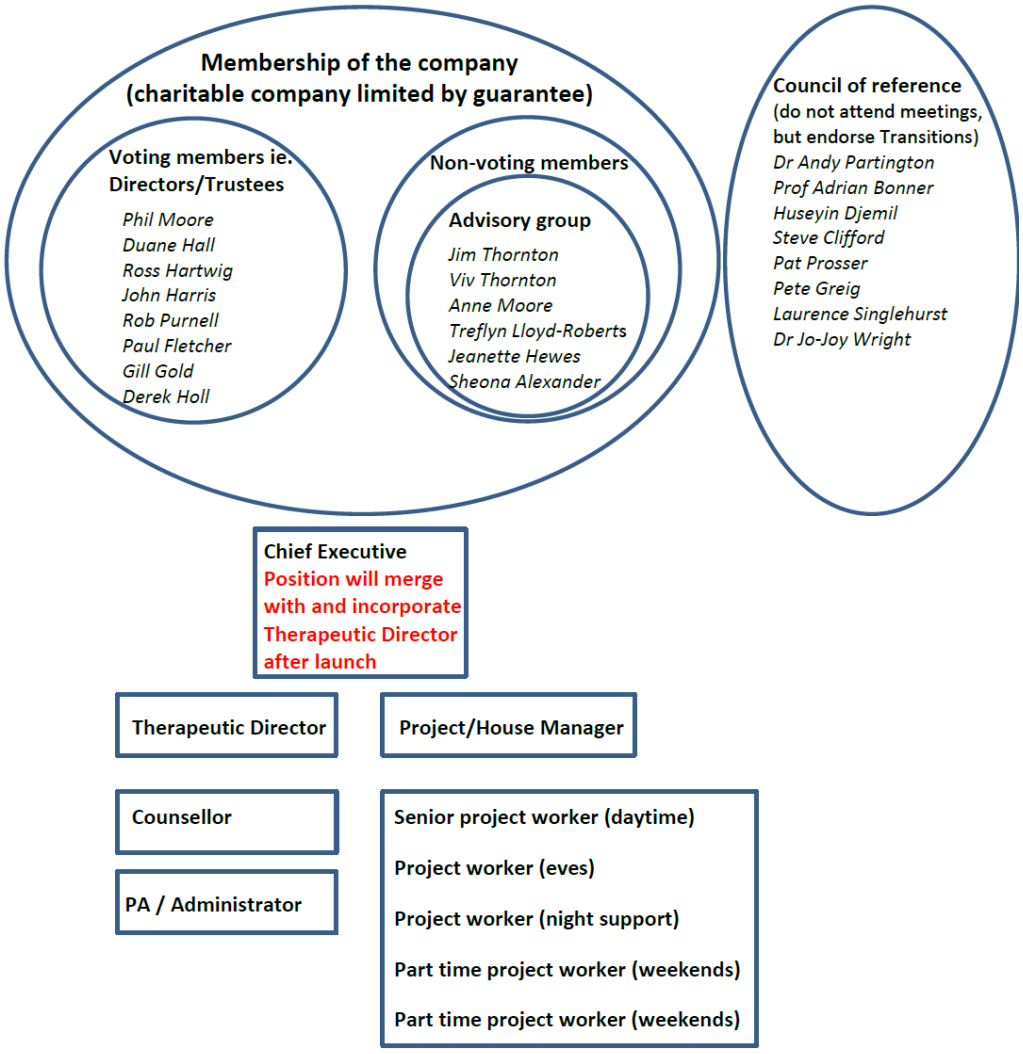
Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life. HM Government. 2010.

APPENDIX 3: ORGANISATIONAL STRUCTURE



Currently there is a board of trustees chaired by Dr Phil Moore, a GP involved in health commissioning with particular experience in mental health, and the group includes those with experience in business, youth housing, church leadership, accountancy, youth work and children's work.

We also have a small **advisory group** of individuals who add their expertise, wisdom and advice to the deliberations of the trustees as and when requested. They have experience in property development, nursing, church leadership and pastoral care, the international addiction field, training and development for those in recovery, youth work and youth housing.

The **Council of Reference** is a body of distinguished individuals from church and church-related organisations as well as those with addictions related knowledge and skills who lend credibility to Transitions RTC.

Staffing

In order to run Transitions RTC effectively on a daily basis, 6 members of staff will be required. Night cover will be provided by the Shared Lives Carers.

All staff will be suitably qualified and experienced in line with relevant professional or National Occupational Standards.

About our trustees and advisory group

Dr Phil Moore, a GP involved in health commissioning, mental health strategy and a church leader in South West London.

Duane Hall, currently a housing support officer and former youth worker.

John Harris, a semi-retired director of an engineering firm.

Ross Hartwig, consulting engineer, former children's worker and church leader.

Rob Purnell, serves as team leader for a new church with a background in marketing.

Paul Fletcher, works as a financial director for a large national firm based in London.

Gill Gold, manages youth housing projects for Aldwyck.

Jim Thornton, Director of Hurford Salvi Carr, a property company. Jim is a director of numerous companies.

Viv Thornton, Manager of St Andrew's Centre for wholeness and wellbeing, with a background in nursing.

Anne Moore, involved in Pastoral Care for many years and part of Molesey Community Church leadership team.

Treflyn Lloyd-Roberts, General Secretary of ISAAC, with experience of Christian addiction services worldwide.

Sheona Alexander, Manager of the New Hanbury Project at Spitalfields Crypt Trust, a personal development and training centre for people in recovery from addiction. Sheona is also a former youth work manager.

Jeanette Hewes, founder of Corban, a project housing young people aged 16 and up, and former Manager of Out4Good a housing project for Ex-Offenders.

APPENDIX 4: SHARED LIVES - ONGOING COSTS AND FUNDING

Costings

Set up costs

- Transitions would need to register with the Care Quality Commission which would cost approx. £1662. Registration with CQC is only required where the service will be delivering personal care. However, this is defined as not only hands on physical support, but also prompting with washing, teeth cleaning, eating etc, so it is the sort of thing that our Carers would or could easily be asked to support.
- Transitions would need a Registered Manager with suggested salary of approx. £30,000 - £32,000. *This will be our Project Manager so we will not need a dedicated additional salary for this.*
- A scheme worker – it has been suggested that this is a part time person who would recruit/assess/ monitor/supervise and review the work of the Shared Lives Carers. They could also look at further recruitment depending on success of the initial start-up. Cost of this would be approx. £25000.
  NB. Because Transitions is a small scheme part of this is included in the Project Manager's role and part of it in the Project Worker's role.
- It has been recommended to purchase a start-up pack from Shared Lives Plus, which involves access to the following: policies and procedures, information and advice, access to better value and specific insurances, access to training and 1 day of consultancy with Community Catalysts. This costs approx £2,750.

Ongoing costs and funding

We have been advised to pay the recommended rate to Shared Lives Carers, which can be up to £300 per week – this doesn't include a payment to cover the Shared Lives admin.

Costs breakdown	**Costs amounts**	**Funding source**	**Funding amount**
Shared Lives Carers	£250 per resident, per week	Housing benefit	£250 per person, per week if LHA?
Shared Lives Admin	£115, per person, per week	Possible social care funding	£115? Per person, per week
Waking night support	£66 pp, p/wk for 3 in main family house only		£66 per person, per week (only for 3 people in the main family house) *NB. If LHA is granted*
Bills and food	Approx. £60 per resident, per week	Employment Support Allowance, assessment phase	£60 per person, per week

		(individual benefits)	
Social/leisure	£15 per resident per week	Increase in ESA, after assessment phase.	£15 per resident per week
Training		Free due to being on benefits	

A note on benefits

Individual benefits

Young people aged 16-25 are entitled to ESA (Employment & Support Allowance) if they are unfit for work. It is paid as follows:

£57.90 per week - during the assessment phase which lasts 13 weeks

£73.10 per week – after the assessment phase, the amount rises to £73.10, as long as they are considered unfit to work.

In addition, if they can also get:

£29.05 or 36.20 – this is extra, after 13 weeks. £29.05 is if they are capable of work-related activity, £36.20 is if they are in the support group.

These benefits cover everything apart from rent. **So after 13 weeks, they are entitled to a total of £102.15 – 109.30 per week.**

NB. Deductions can be made from ESA to pay the landlord (including the meal/fuel charges) if it is in the 'overriding interest' of the claimant, or if they are in 8 weeks arrears.

Housing Benefit

If a person is claiming ESA then 100% of the eligible rent is funded.

Eligible rent means the reasonable rent for a suitable property in your area. It includes service charges (eg for lift maintenance or a communal laundry) but not things like heating.

We may be able to get LHA exempt Housing Benefit, but if not the following rates apply:

Shared Accommodation Rate: £74.79 per week

One Bedroom Rate: £146.57 per week

Two Bedrooms Rate: £186.46 per week

Three Bedrooms Rate: £230.28 per week

Four Bedrooms Rate: £293.79 per week

Gary Vaux from the Money Advice Unit emailed me to say the following:

"Your service-users may be in 'exempt accommodation' as they are in accommodation which a voluntary agency has provided (the HB service may argue about this, as the host is providing the accommodation, not you) and the host is also supplying care and support. If the HB Service allow exempt accommodation status, the local housing allowance rules don't apply. They can still restrict the rent to what they consider reasonable for its size etc but if the client is incapable of work, the HB Service has to prove that there is cheaper suitable alternative accommodation. Which is unlikely for young substance misusers with support needs – an ordinary bedsit is not a suitable alternative."

Summary

Shared Lives is intended to be a cost effective way of providing care. However, in our case there are 2 factors which reduce this cost effectiveness:

- Ensuring that the main family's house is covered for 24hours a day, during the first 4 weeks. As stated earlier this includes staff cover for the evenings and Waking Night Support. WNS is currently budgeted for one third of the year to cover premature departures and arrivals.
- From 4 weeks onwards, ensuring the main house continues to have staff coverage during the evenings, as well as the day.

From 3 months on the budget is costed for 5 residents. In real terms it costs only £6,731 more per year to accommodate 5 people rather than 3, due to economies of scale. The other additional costs in terms of Shared Lives etc is covered by benefits which "come with" the young person.

Going forward

For the first 3 months our budget is for 3 residents at the main family's house, and from then on the budget is for 5 residents. At 3 months, at least one resident should be able to move on to accommodation with less intensive support. This will free up at least one space at the main house, but the new resident will need to be the same sex as the existing residents.

Move on accommodation will be with Shared Lives Carers, most likely with one resident per family. We will need to recruit these families. There will be no Waking Night Support or evening staff for these families, so the Shared Lives carers will be more involved. However, residents who are eligible to move on will need less support. (After discussion we may decide to increase this to 4 months.)

APPENDIX 5: CQC DEFINITIONS OF RESIDENTIAL TREATMENT AND RECOVERY HOUSES

Residential	A structured drug and alcohol treatment setting where residence is a condition of receiving the interventions. Although such programmes are usually abstinence based, prescribing for relapse prevention or for medication assisted recovery are also options. The programmes are often, although not exclusively, aimed at people who have had difficulty in overcoming their dependence in a community setting. A residential programme may also deliver an assisted withdrawal programme. This should be sufficiently specialist to qualify as a "medically monitored" inpatient service – and it should meet the standards and criteria detailed in guidance from the Specialist Clinical Addictions Network[1]. This level of support and monitoring of assisted withdrawal is most appropriate for individuals with lower levels of dependence and/or without a range of associated medical and psychiatric problems. Within the residential setting, people will receive multiple interventions and supports (some of which are described by the intervention codes below) in a coordinated and controlled environment. The interventions and support provided in this setting will normally comprise both professionally delivered interventions and peer-based support, as well as work and leisure activities.
Recovery house	A recovery house is a residential living environment, in which integrated peer-support and/or integrated recovery support interventions are provided for residents who were previously, or are currently, engaged in treatment to overcome their drug and alcohol dependence. The residences can also be referred to as dry-houses, third-stage accommodation or quasi-residential. Supported housing that does not provide such integrated substance misuse peer or recovery support as part of the residential placement is not considered a recovery house for this purpose. Recovery houses may be completely independent, or associated with a residential treatment provider or housing association. Some will require 'total abstinence' as a condition of residence whereas others may accept people in medication assisted recovery who are otherwise abstinent.

Structured drug and alcohol treatment consists of a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone. Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in one or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending. All interventions must be delivered by competent staff, within appropriate supervision and clinical governance structures. Structured drug and alcohol treatment provides access to specialist medical assessment and intervention, and works jointly with mental and physical health services, and safeguarding & family support services according to need. In addition to pharmacological and psychosocial interventions that are provided alongside, or

integrated within, the keyworking or case management function of structured treatment, service users should be provided with the following as appropriate: harm reduction advice and information; BBV screening and immunisation; advocacy; appropriate access and referral to healthcare and health monitoring; and crisis and risk management support.

C2 - Psychosocial

The psychosocial intervention field and its sub-interventions should be used by both prescribing and non-prescribing services.

They should be used to report structured psychosocial interventions delivered alone, as well as psychosocial interventions

integrated with or additional to a pharmacological modality/intervention.

Recovery support interventions that are integral to or provided alongside a pharmacological intervention and/or psychosocial

interventions should also be recorded using recovery support intervention codes.

Type	Definition
Motivational interventions	Motivational interventions aim to help service users resolve ambivalence for change, and increase intrinsic motivation for change and self-efficacy through a semi-directive style and may involve normative feedback on problems and progress. They may be focused on substance specific changes and/or on building recovery capital. Motivational interventions can be delivered in groups or one-to-one and may involve the use of mapping tools. Motivational interventions require competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision. Motivational interviewing and motivational enhancement therapy are both forms of motivational interventions.
Contingency management	Contingency management (CM) provides a system of reinforcement or incentives designed to motivate behaviour change and/or facilitate recovery. CM aims to make target behaviours (such as drug use) less attractive and alternative behaviours (such as abstinence) more attractive. CM requires competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision.
Family and social network interventions	Family and social network interventions engage one or more of the client's social network members who agree to support the client's treatment and recovery. The interventions use psychosocial techniques that aim to increase family and social network support for change, and decrease family and social support for continuing drug and/or alcohol use. These

	interventions may involve the use of mapping tools. They require competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision. Examples: social behaviour and network therapy (SBNT), community reinforcement approach (CRA), behavioural couples therapy (BCT) & formal family therapy.
Cognitive and behavioural based relapse prevention interventions (substance misuse focused)	Cognitive and behavioural based relapse prevention interventions develop the service user's abilities to recognise, avoid or cope with thoughts, feelings and situations that are triggers to substance use. They include a focus on coping with stress, boredom and relationship issues and the prevention of relapse through specific skills, e.g. drug refusal, craving management. They can be delivered in groups or one-to-one and may involve the use of mapping tools. They require competences over and above those required for keyworking, and delivery within a clinical governance framework that includes appropriate supervision. Examples: CBT based relapse prevention (which may include mindfulness and 'third wave' CBT), behavioural self-control (alcohol).
Evidence-based psychological intervention for co-existing mental health problems	NICE guidelines for mental health problems generally recommend a stepped care approach. Low intensity psychological intervention for co-existing mental health problems, include guided self-help or brief interventions for less severe common mental health problems. High intensity psychological therapies (such as cognitive behavioural therapy) are recommended for moderate and severe problems. Typically formulation-based and delivered by clinicians with specialist training who are registered with a relevant professional/regulatory body. They can be delivered in groups or one-to-one. Both low and high intensity interventions require additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.
Psychodynamic therapy (substance use focused)	A type of psychotherapy that draws on psychoanalytic theory to help people understand the developmental origins of emotional distress and behaviours such as substance misuse, by exploring unconscious motives, needs, and defences. Psychodynamic therapy requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision. Therapists should be registered with an appropriate professional/regulatory body.
12-step work	A 12-step intervention for recovery from addiction, compulsion or other behavioural problems. Interventions are delivered within a clinical governance framework that includes appropriate supervision. The aim of 12-step work is to facilitate service users to complete some or all of the 12 steps.
Counselling – BACP	A systematic process which gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense

Accredited	of well-being. This requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.
Other	An intervention based on established psychological models/theories that have an evidence base, and that is undertaken by a worker with the required competences with adequate supervision and clinical governance arrangements This category can only be used where an intervention is not covered by individual, or a combination of, categories above. It is anticipated that use of this category would be relatively uncommon.

C3 - Recovery Support

During structured treatment, recovery support interventions should be recorded for interventions delivered alongside and/or integrated with a psychosocial or pharmacological intervention.

Recovery support interventions can also be delivered and recorded outside of structured treatment, following the recording of an exit from structured treatment.

Recovery support type	Definition
Peer support involvement	A supportive relationship where an individual who has direct or indirect experience of drug or alcohol problems may be specifically recruited on a paid or voluntary basis to provide support and guidance to peers. Peer support can also include less formal supportive arrangements where shared experience is the basis but generic support is the outcome (e.g. as a part of a social group). This may include mental health focused peer support where a service user has co-existing mental health problems. Where peer support programmes are available, staff should provide information on access to service users, and support access where service users express an interest in using this type of support.
Facilitated access to mutual aid	Staff provide a service user with information about self-help groups. If a service user has expressed an interest in attending a mutual aid group, staff facilitate the person's initial contact with the group, for example by making arrangements for them to meet a group member, arranging transport, accompanying him or her to the first session and dealing with any concerns. These groups may be based on 12-step principles (such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous) or another approach (such as SMART Recovery).
Family support	Staff have assessed the family support needs of the individual/family as part of a comprehensive assessment, or ongoing review of their treatment package. Agreed actions can include: arranging family support for the

	family in their own right or family support that includes the individual in treatment.
Parenting support	Staff have assessed the family support needs of the individual as part of a comprehensive assessment, or ongoing review of their treatment package. Agreed actions can include a referral to an in-house parenting support worker where available, or to a local service which delivers parenting support.
Housing support	Staff have assessed the housing needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and has agreed goals that include specific housing support actions by the treatment service, and/or active referral to a housing agency for specialist housing support. Housing support covers a range of activities that either allows the individual to maintain their accommodation or to address an urgent housing need.
Employment support	Staff have assessed the employment needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and agreed goals that include specific specialised employment support actions by the treatment service, and/or active referral to an agency for specialist employment support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three way meeting with the relevant advisor to discuss education/employment/training (ETE) needs. The referral can also be made directly to an ETE provider.
Education & training support	Staff have assessed the education and training related needs of the individual as part of the comprehensive assessment, or ongoing recovery care planning process and agreed goals that include specific specialised education & training support actions by the treatment service, and/or active referral to an agency for specialist education & training support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a 3 way meeting with the relevant advisor to discuss ETE needs. The referral can also be made directly to an ETE provider.
Supported work projects	Staff have assessed the employment related needs of the individual as part of the comprehensive assessment, or ongoing recovery care planning process and agreed goals that include the referral to a service providing paid employment positions where the employee receives significant on-going support to attend and perform duties.
Recovery check-ups	Following successful completion of formal substance misuse treatment there is an agreement for periodic contact between a service provider and the former participant in the structured treatment phase of support. The periodic contact is initiated by the service, and comprises a structured check-up on recovery progress and maintenance, checks for signs of lapses, sign posting to any appropriate further recovery services, and in

	the case of relapse (or marked risk of relapse) facilitates a prompt return to treatment services.
Evidence-based psychosocial interventions to support substance misuse relapse prevention	Evidence based psychosocial interventions [as described in Section 4. Psychosocial] that support on-going relapse prevention and recovery, delivered following successful completion of the formal phase of structured substance misuse treatment. These are interventions with a specific substance misuse focus and delivered within substance misuse services.
Evidence-based mental health focused psychosocial interventions to support continued recovery	Evidence based psychosocial interventions (as described in section 4) that support on-going relapse prevention and recovery, delivered following successful completion of structured substance misuse treatment. These are interventions with a specific substance misuse focus and delivered within substance misuse services.
Complementary therapies	Complementary therapies aimed at promoting and maintaining change to substance use, for example through the use of therapies such as acupuncture and reflexology that are provided in the context of substance misuse specific recovery support.
Other	A recognised recovery activity or support intended to promote and maintain a service user's recovery capital, which is not captured by an individual type or combination of types above.

APPENDIX 6: FINANCIAL PROJECTIONS

Budget summary for the first 3 – 4 years, includes pilot project in year 2

Expenditure breakdown	Year 1 (13 mths) Jan '15 – Jan '16	Year 2 - Pilot Feb '16 - Jan '17
Host families (supported lodgings?) Accommodation, support, food and bills	-	20,491
Workers, Staff salaries incl cover NI, pension auto enrolment and payroll	19,674 3,998	54,750 8,477
Staff CPD	1,000	600
Volunteers (incl external training yr 1)	700	720
Equipment, furniture renewals/repairs	1,061	1,440
Training + leisure for residents	-	2,346
Expenses incl travel	1,669	1,069
Admin, promo, recruitment, fundraising	5,053	1,202
Regulation and insurance	-	5,000
FULL TOTAL	33,155	96,105

Full Shared Lives model, year 2 set up costs run concurrently with the pilot.

Expenditure breakdown	Year 2 Set up costs Feb '16 – Jan '17	Year 3 First yr running costs Feb '16 - Jan '17	Year 4 Regular running costs Feb '17 – Jan '18
Shared Lives placement Accommodation, carers, food and			

bills Membership for workers Admin costs	- - 2,750	65,523 375 28,981	67,788 375 29,980
TOTAL for Shared Lives	2,750	94,879	98,143
Workers, Staff salaries incl cover NI, pension auto enrolment and payroll NB.Percentage covered by Shared Lives	3,167 452	89,843 13,233 -28,981	90,336 13,306 -29,980
Staff Supervision & CPD	-	3,840	3,840
Volunteers (incl external training yr 1)	1,000	1,160	1,160
Venue hire for day programme	-	5,214	5,214
Equipment renewals/repairs	875	300	300
Training + leisure for residents	-	3,780	3,910
Expenses incl travel	206	1,520	1,520
Admin, promo, recruitment, fundraising	3,430	2,052	2,088
Regulation and insurance	1,662	5,000	5,000
TOTAL for day programme	10,792	96,961	96,694
FULL TOTAL	13,542	191,840	194,837

Funding sources and projections for the first RTC pilot project

Source	Raised	Target	Notes
Items in kind	(£4,000)		Website design and build
Items in kind	(£1,200)		Logo/Identity & leaflet design + printing
Trusts/grants	£11,000	£17,500	
Individuals & church donations	£17,912	£10,399	

Monthly standing orders (accrued total). *Currently £890 per month.* Includes £100 per mth from Hertford Community Church	£11,615	£15,130	Target is based on standing orders continuing at same level.
Gift Aid received Claim waiting to be processed	£1,373 £5,000	£3,000	Target amount is based on existing regular giving only.
Businesses/Corporate Tricordant, Freshtracks, Annox, IPSOS Mori	£8,700	£10,000	
Eligible Benefits (Housing and ESA)	£21,391		LHA exempt status will result in increased amount
Fundraising events including 3 peaks challenge, Ladies Tea and Hertford Symphony Orchestra Concert	£10,409	£5,000	
Social Enterprise		£900	Residents will run this project
TOTAL does not include gifts in kind	£87,400	£61,929	TOTAL NEEDED = £149,329 £129,260 (Jan 15 – Jan 17) + £20,069 (Dec 13-14)

See below for Shared Lives model

Funding sources and projections for Shared Lives project – annual running costs (year 4 onwards)

Source	Target	Notes
Trusts/grants/crowdfunding	£10,000	
Individuals & church donations	£9,468	
Reinvestment of Shared Lives Carers (30%)	£15,642	
Monthly standing orders (accrued total). *Currently £890 per month.*	£12,000	Target is based on standing orders continuing, with a projected increase of c. 10%
Gift Aid	£4,000	Target is based on 75% of donations and regular giving above being eligible for Gift Aid
Businesses/Corporate	£5,000	
Statutory funding (eg. Herts County Council)	£78,210	Based on 30% of total bed weeks being funded each year at £1,000 p/wk.
Eligible Benefits (Housing and ESA)	£24,637	Based on 70% of young people being funded in this way
Shared Lives admin paymt	£29,980	Subject to confirmation
Fundraising events etc	£5,000	
Social Enterprise	£900	Residents will run this project
TOTAL	£194,837	Annual running costs = *£194,837*