Mental Health Conference

Recovery: Building Hope for the Future

10th October 2018

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New DBT Unit: Lakeside

Dr Victoria Vallentine (Consultant Clinical Psychologist & CAT Therapist)
Elise Stephen (Principal Clinical Psychologist & Accredited DBT Therapist)

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AIMS:

- Who the unit is for?
- What is EUPD?
- Why DBT and what is DBT?
- What does our service look like?

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Who is it for?

Patients with features of:
Borderline or Emotionally Unstable PD
(BPD or EUPD)

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What is EUPD?

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What does this look like on the ward?

- Deliberate self-harm
- Suicide attempts
- Easily triggered to become emotional – angry, distressed
- Loving you one day, hating you the next
- Interpersonal difficulties with staff and other SU's
- Wanting a lot of staff time and attention
- Crying, shouting
- Upset if they feel ignored or abandoned by you
- Becoming overly attached to certain staff members and withdrawing from others
- Isolating

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DSM Criteria

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, Substance Abuse, reckless driving, binge eating).

(5) recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

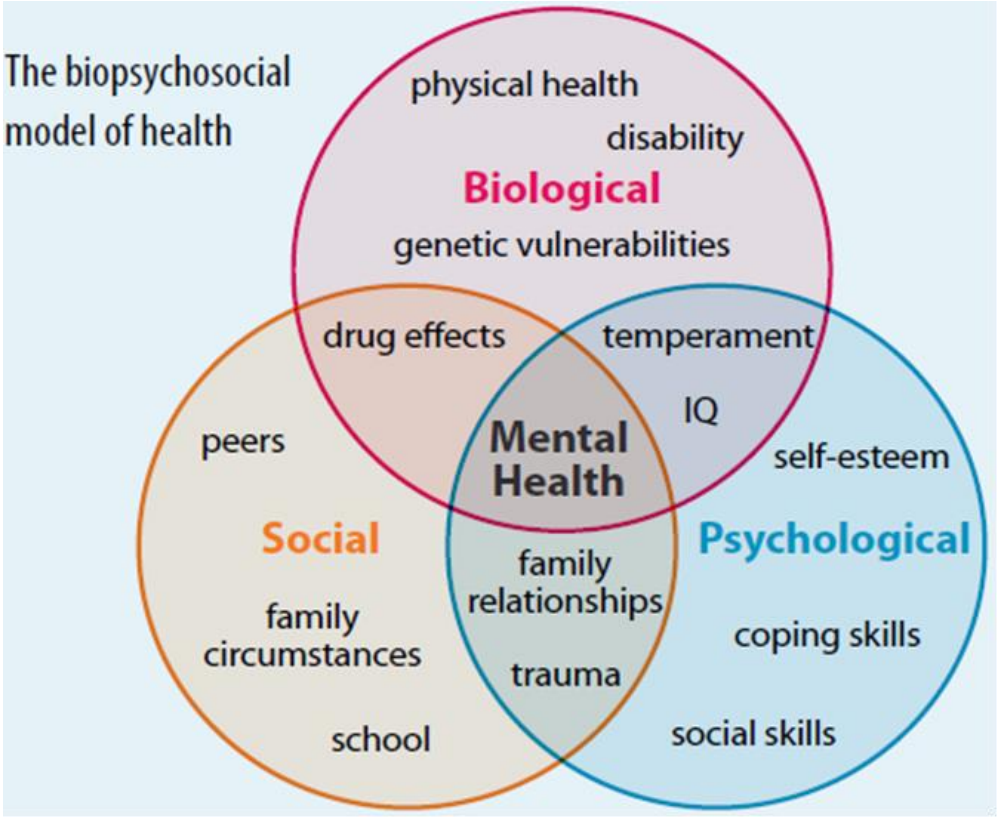
(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

DSM Criteria

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms



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Borderline PD

- BPD is primarily a disorder of the emotional regulation system
- It results from biological irregularities (which make someone more emotionally vulnerable) and invalidating environment which interact and change over time
- Lets look at emotional vulnerability in more detail

Emotional Vulnerability

❑**High Sensitivity**
- Immediate reactions (impulsivity)
- Low threshold for emotional reaction

❑ **High Reactivity / Intensity**
- Extreme Reactions
- High arousal interferes with cognitive thinking

❑**Slow return to baseline**
- Long-lasting reactions
- Contributes to high sensitivity to next emotional stimulus

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Why DBT?

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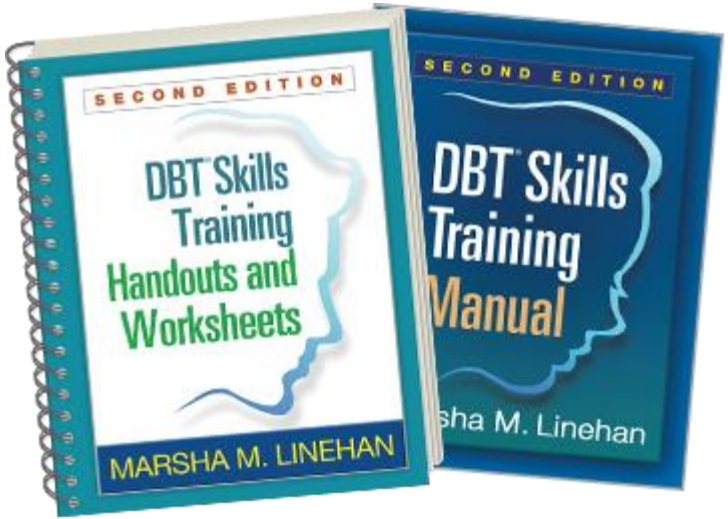
Rationale

Why DBT for EUPD?



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Why DBT for EUPD?

- NICE guideline recommended treatment for EUPD
- Evidence base
- Designed for working with complex clients

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Evidence Base:

Randomised controlled trials (RCTs) have indicated that full-programme DBT is effective in:

- Reducing rates of general hospital admission
  - DBT has also been shown to reduce rates of hospital admission, A&E visits, suicide attempts and episodes of self harm (Abdelkarim et al., 2017).
- Reduction in self-harm and aggression
  - A study in a low secure forensic setting evidenced reduction in self-harm, aggression, and staff and patient reported symptoms of EUPD over 12 months of treatment (Fox et. al, 2014).
  - Improving overall psychopathology, behavioural control and social adjustment (Koons et al., 2001; Kröger et al. 2006).
  - Reducing self-harm, impulsive behaviours, anger, aggression and affective instability (Verheul et al., 2003; Shelton et al. 2009; Soler et al. 2009
- Long term effects:
  - There is evidence to suggest that benefits are maintained 2 years post-treatment after inpatient DBT treatment (e.g. Kleindienst, 2008).

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Difficulties with treatment of this client group:

- Staff burnout
- Increased incidents
- Patient dissatisfaction
- Complaints
- Therapies not supported
- Judgments/negative attitudes to patients expressed
- Witnessing poor/inconsistent boundaries
- Low morale/powerlessness

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What is DBT?

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The History of DBT

- It was 'founded' when in 1993 Marsha Linehan *(rhymes with dinner-han, though lots of people rhyme it with liner-han) wrote the books:*
  1. Cognitive Behavioural Treatment of Borderline Personality Disorder, and a companion volume
  2. Skills Training Manual for Treating Borderline Personality Disorder.
- It was these books that introduced what we now refer to as Dialectical Behaviour Therapy
- There are now new skills training manual editions

Who is it For?

- Originally developed for individuals with BPD, but can be used now to treat a range of difficulties
- On the new unit, we will likely see:
  - Self harm/violence
  - Emotional dysregulation
  - Interpersonal difficulties
  - Extreme behaviour

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What does dialectical mean?

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Different points of view….

- Looking at things from different angles…

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The word ‘Dialectical’

- A *dialectic* is a discussion intended to resolve differences between two views and reach an agreed truth.

- So it is discussion aimed at resolving two apparently conflicting positions, such as *Your emotions and behaviour are valid* and *You would do well to moderate your emotions and change your behaviour*.

- It contrasts with a debate, where each of the protagonists is trying to prove the other wrong, and themselves right.

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Dialectical

- ‘dialectic’ has the distinct advantage of clearly recognising the fact of a tension between:

- the emotions and behaviour being valid, and
- the emotions and behaviour working badly for the person.

- My favourite: ‘The client is doing the best she can…And she needs to do better’

- It often proves helpful to bear this ‘dialectic’ in mind.

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Behavioural

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Behavioural Therapy in a Nutshell: Don't Shoot the Dog

- What do I need to do to see MORE of the behaviour I want to see, and LESS of the behaviour I don't want to see?
- Reinforcement – what does it mean?

- Lets play a game ☺

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Basic Principles

- **Primary Targets to decrease:**
  1. Life threatening behaviours (also aggressive behaviours/behaviours that keep them detained under MHA)
  2. Therapy interfering behaviours
  3. Quality of life interfering behaviours

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Basic Principles

- **Primary Targets to increase**:
  1. Mindfulness
  2. Interpersonal effectiveness
  3. Emotional regulation
  4. Distress tolerance

These four elements also form the skills modules taught in groups.

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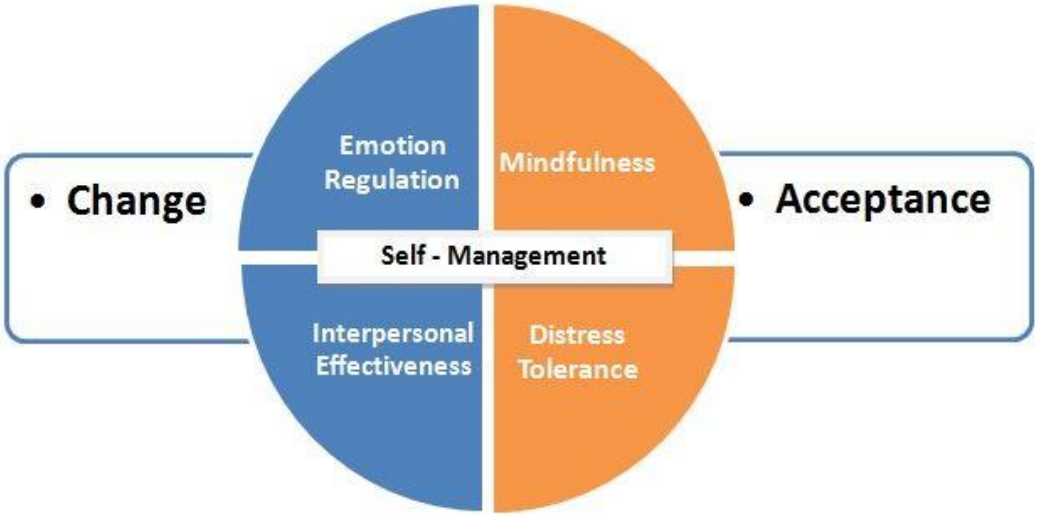
Modules OVERVIEW



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Key Aspects

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Helping people IDENTIFY their emotions

- Identifying emotions correctly is the first step to being able to regulate them
- And then knowing what action we might need to take
- Helping patients identify emotions – you might need to take an educated guess for them…
  - You look angry, do you think you might be?
  - If I thought people were after me, I might feel scared, is that how you feel?
- Then can help them reduce the emotion or problem solve the issue with other skills

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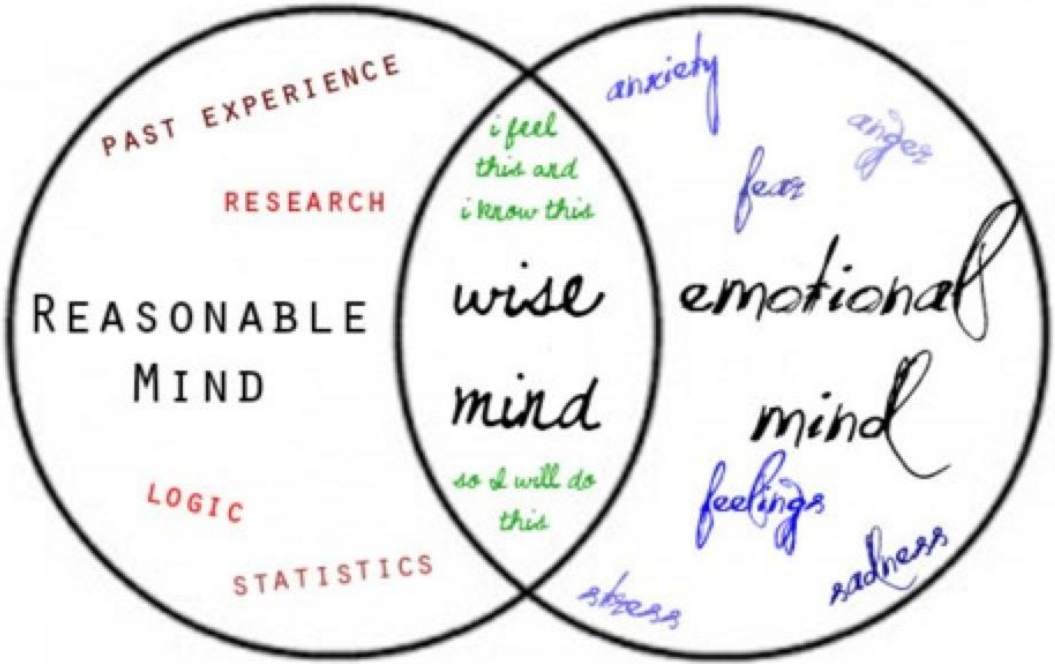
States of mind



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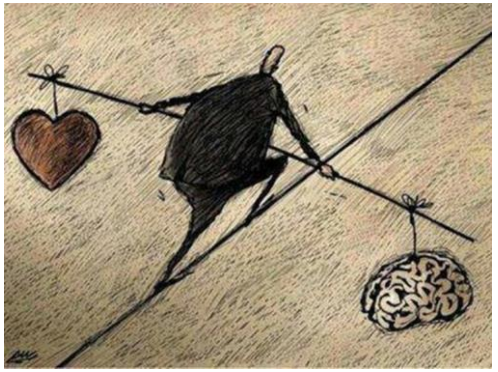
Achieving Wise Mind

- Wise Mind or Wisdom depends on all ways of knowing something….
- Mindfulness skills are used for balancing "emotion mind" and "reasonable mind" to achieve "wise mind"



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The DBT Approach

- Dialectical Behaviour Therapy (DBT), developed by Marsha Linehan, was designed as a treatment for individuals diagnosed with EUPD (Linehan, 1993a).
- DBT aims to assist individuals to change their patterns of unhelpful behaviour (e.g. deliberate self-harm (DSH), suicidal thinking, aggression and substance abuse).
- Generally, a programme of DBT lasts approximately one year and includes a group-based skills training component, individual therapy, telephone coaching (or ward-based coaches in inpatient settings) and therapy consultation groups (Linehan, 1993b).
- The group-based skills training component consists of weekly sessions, each lasting around two hours, while 1:1 sessions are weekly 50 minute sessions.
- Coaching occurs around the clock in inpatient settings.
- The full DBT programme consists of four core modules: core mindfulness, emotional regulation, interpersonal effectiveness and distress tolerance.

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Overall advantages of a DBT:

- DBT encourages the use of the same strategies used to treat the client to treat the staff, to improve their motivation and capability to treat the client (Swales, 2010).
- Validation and letting go of judgements of the patient is essential in DBT (Linehan, 1993).
- DBT is a team-based approach that reduces staff burn-out and stigma (Haynos et al., 2016).

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Specific advantages of a DBT unit:

A DBT unit improves:

- ➢Staff understanding of patients
- ➢Staff understanding function of behavior
- ➢Staff approach (i.e. boundaries, consistency)
- Team dynamics and environment (Improved team work and functioning)
- Patient outcomes – including post-treatment
- Staff approach (boundaries, non-judgmental stance)
- Buy-in for DBT (getting patients to group, help with homework etc)
- Staff ability to support patients with DBT skills
- Consistency and boundaries – essential with this client group

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Lakeside accomplish service:

- Beautiful fully refurbished and decorated unit (designed to reduce risk of self-harm and suicide risk and limits obs needed)
- 12 beds with en-suite
- Open plan kitchen/dining
- BPS recommended therapy spaces (i.e. windows, quiet space)
- First aid room to reduce reinforcement of self-harm behaviour
- Private outdoor area
- Community access links, i.e. college, vocational/volunteer opportunities.
- DBT ethos used by all staff on the ward
- All staff trained to the level of skills coaches
- 24 hour skill coaching available
- 4 intensively trained nurses

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Meet the team:

- A DBT expert external supervisor
- An sfDBT accredited DBT programme lead
- Elise Stephen, 12 years DBT experience
- 7 intensively trained DBT therapists (2 nurses, 1 ward manager, 2 Psychologists, 1 SLT, 1 OT)
- A full compliment of round the clock DBT skills coaches


SfDBT UK and Ireland established 2012

In collaboration with The Linehan Institute USA

Elise Stephen

has fulfilled the requirements of the Society for DBT UK and Ireland for accreditation in Dialectical Behaviour Therapy and is hereby entered onto the register of Accredited DBT therapists for a period of five years.

Janet Feigenbaum, Chairman of the Board of Accreditation

29th March 2018
Date of Accreditation

29th March 2023
Renewal date

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Who we will be supporting

Adult females with features/diagnosis of EUPD

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Inclusion criteria:

- Adult females with features of/diagnosis of Emotionally Unstable Personality Disorder (EUPD)
- Sectioned under the Mental Health Act (1983)
- Emotional dysregulation or interpersonal dysfunction
- Clearly identified target behaviours able to be addressed within DBT (i.e. self-harm, violence/aggression, substance misuse etc)
- Patients with IQ of 70 or above, to allow them to in and benefit from DBT delivered according to standard protocol
- Motivated for treatment and willing to sign contract of agreement - assessment addresses this
- Funding able to be provided for a minimum of one year of treatment

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Exclusion criteria:

- An inability to engage with the programme due to IQ/ level of cognitive functioning, degree of psychosis or level of stabilization.
- Lack of commitment and/or motivation to work on appropriate behavioural treatment goals.
- Unwillingness to adhere to contractual agreement of the unit (i.e. traffic light system of restrictions).

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Expectations:

- 12 months funded treatment
- Every effort is made to ensure drop-out does not occur, and patients achieve their goals and are reintegrated into the community
- This includes transparent contingencies to assist individuals to remain engaged in treatment
- Adherence to the DBT contingencies. These have been shown to be crucial in the effectiveness of inpatient DBT and include:
  - Re-engagement of de-motivated patients- attendance is crucial to treatment success
  - If an individual misses 4 sessions in a row of group or 4 sessions in a row of 1:1 therapy they are out of the programme.
  - Commissioners will be contacted to inform them that their patient is no longer in treatment and that they need to find another placement.
  - In the time they are waiting for another placement they can be supported to return back into DBT (best outcome) or they will be supported towards discharge.
  - Positively, if someone had graduated DBT they would be supported to access further treatment if required until they moved on.

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Referral and treatment process:

- Individual is referred
- DBT team review referral
- 2 intensively trained DBT therapists visit patient to assess
- Patient and commissioning/external team are advised of contractual agreements of admission
- Patient is accepted or declined
- If accepted, patient is admitted and commences pre-assessment outcome measures and DBT skills group immediately upon admission
- Patient is assigned a 1:1 therapist and commences 1:1 pre-treatment followed seamlessly by 1:1 therapy (occasionally there may be a short waitlist for 1:1 work to commence, which is standard in DBT)
- Patient can access trauma work after 2 months incident free alongside other treatment contingencies being met (i.e. engagement, skills use, no enhanced observations)
- Patient engages in treatment for 12 months and then recommendations are made for discharge/further treatment

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Outcome measures

- The primary outcome measure will be reduction in incidents logged on our incident reporting system, RADAR

- Patients will also complete the following self report outcome measures pre- and post-DBT:
  - Novaco Anger Scale and Provocation Inventory (NAS-PI)
  - Inventory of Altered Self Capabilities (IASC)
  - Kentucky Mindfulness Skills (KIMS)
  - Difficulties with Emotion Regulation Scale (DERS)

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That’s all folks!

Questions and feedback forms

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PSYCHESOMA

Mind and Body Working Together

We are dedicated to helping clients with mental health and learning difficulties through physical exercise. We make an amazing difference to their lives.

THE BACKGROUND

- Growing body of research showing the importance of physical activities on mental health
- A programme of physical activity is a natural therapy that leads to:
  - Lower levels of medication
  - Reduced level of undesirable side-effects from medication
  - Higher levels of wellbeing
  - Facilitates response from those 'Resistant to Treatment’

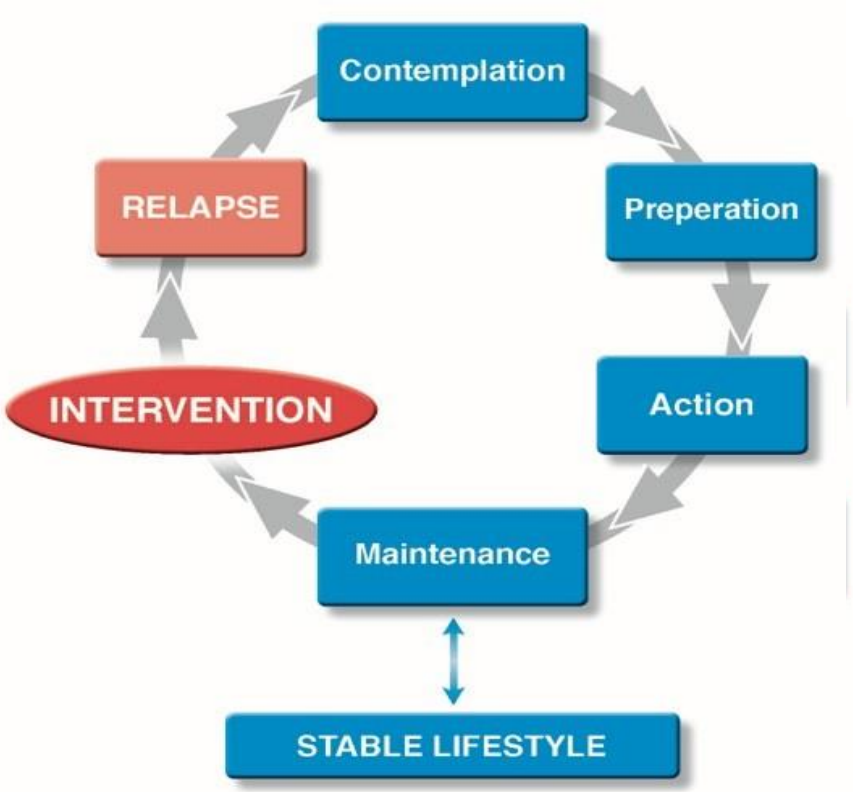
THE SCIENCE

- Aerobic exercise leads to:-
  - an increase in blood flow to the brain
  - an effect on the Hypothalamic-Pituitary-Adrenal axis
  - the release of Cortisol, Oxytocin, Endorphins and Corticosteroids
- This promotes a feeling of increased wellbeing and mood state improvement
- One of the effects is emotional openness which helps form a bond of trust with the physical trainer
- Our trainers are selected for and trained in their ability to foster these bonds
- The insights gathered by the physical trainer are fed back to the Clinical Team and vice-versa

THE HEALTH BELIEF MODEL

- The role of a physical trainer in mental health environment is very different to other settings, where the client has already formed a desire to improve health and fitness.

- We have to be there to support contemplation and preparation in addition to the action and maintenance phases, and to prevent lapses becoming relapse.



THE PSYCHESOMA TRAINER

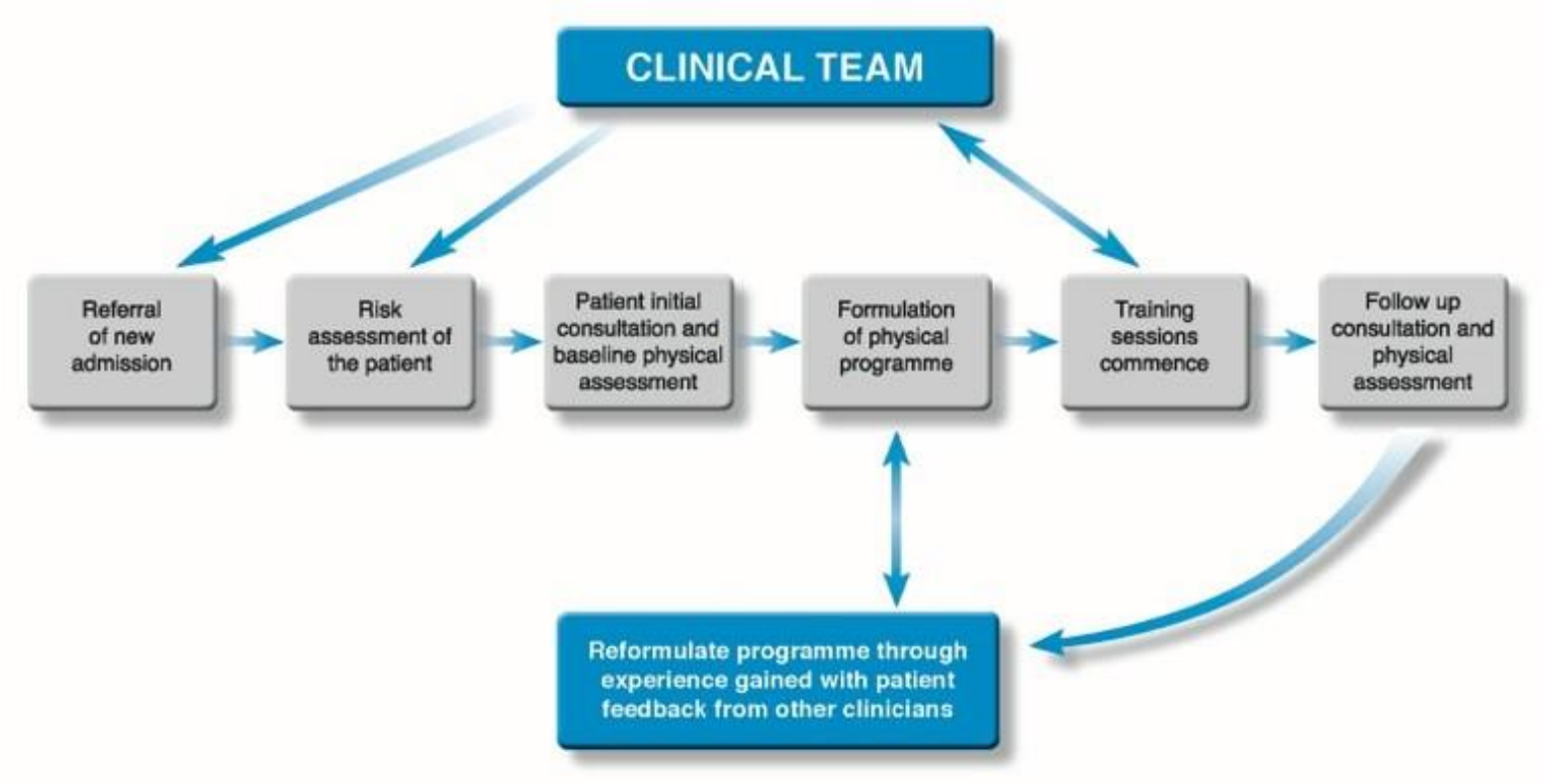
KEY SKILLS

The Psychesoma Approach

- No need for a dedicated exercise space
- Training in full view encourages participation and peer support
- Teach that resourcefulness is enough to create “a gym” wherever you are
- Community based exercise where desired and appropriate
- What matters more than anything else is that they know that they are welcome, that they can exercise effectively anywhere at any time, and that they have the support of the professional team at Psychesoma.

The Psychesoma Approach

- A model of care integrated with other professionals at all stages:-
  - Evaluation of client
  - Development of programme
  - Application of programme
  - Feedback of results into physical, psychological and medical programmes helps all interventions
  - Physical intervention to lead to change of lifestyle


CLINICAL TEAM
Referral of new admission
Risk assessment of the patient
Patient initial consultation and baseline physical assessment
Formulation of physical programme
Training sessions commence
Follow up consultation and physical assessment
Reformulate programme through experience gained with patient feedback from other clinicians

Our Experience

- A background of more than 20 years working with clients with mental health and learning difficulties
- Currently working in seven settings with over 50 clients, from secure units to supported living
- Clients' challenges include:-
  - Senile dementia
  - Korsakoff syndrome
  - Acute mental illness, including those Sectioned under the Mental Health Act 1983
  - Learning difficulties
  - Autism

Efficient and Effective

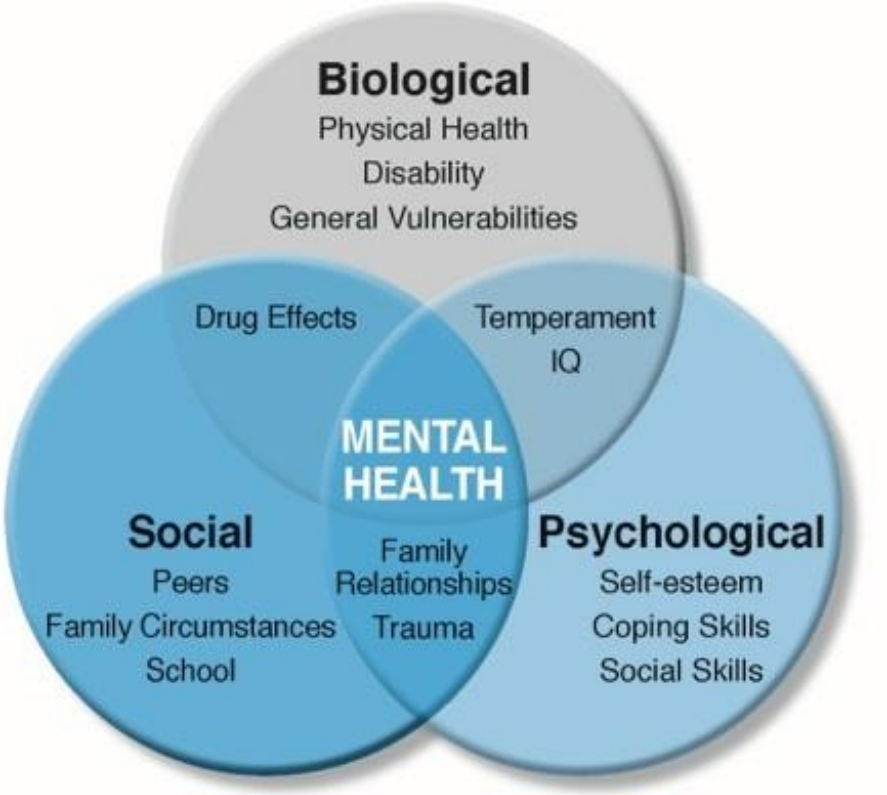
- You buy hours of trainer time on a flexible basis
- Trainers provided are trained, deployed and managed by Psychesoma
- Sickness and holidays are covered
- No recruitment costs or effort
- No payment for travel time or expenses
- No national insurance, pensions, insurance, HR issues, redundancy costs

IN CONCLUSION

- Specialist, experienced physical trainers
- A member of the clinical teams
- Fully integrated into existing facilities
- Improved outcomes
- Flexible and efficient service

APPENDICES

BIOPSYCHOSOCIAL MODEL



PSYCHESOMA
Mind and Body Working Together

EVIDENCE MODEL

- Evidence is gathered using validational outcomes and evaluation exercises
- Research methods include the gathering of:-
    - observable (physical trainer) evidence
    - non-observable evidence (physical trainer, psychologist, OT and other members of the Clinical Team)
- Research methods include HoNOS, Rosenzweig self-esteem measures, General Health Questionnaire (GHQ)

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Carers and recovery

Craig Hart, Lakeside

A REAL AND LASTING DIFFERENCE FOR EVERYONE WE SUPPORT

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During this presentation I am aiming to introduce both the key role that carers can play in the recovery of people we support

And

The concept of ‘carer recovery’ – the belief that carers themselves may need support to achieve their own “recovery” when someone that they care for or support is in receipt of mental health services.

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Within a Mental Health context ‘Recovery’ generally has two different meanings.

- Clinical recovery
- Personal recovery

Both of these tend to focus on the individual in receipt of support.

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"Recovery is the process of developing a new sense of self, meaning and purpose in life – the journey of the individual and those close to them in rebuilding a satisfying, hopeful and contributing life with a diagnosis of mental health problems"

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Key element in Recovery model is the importance of **Hope** and the belief that sufferers can **take control** of their symptoms and lead a life managing these instead of being managed by them.

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Role for Family and Friends in Recovery

Family members and friends have a unique role to play in recovery because they know the person well, often before the onset of their mental illness.

Therefore families and friends can serve as a reminder that the person is not solely a someone with a mental health problem, but someone with talents and abilities, a person with qualities, interests, skills, beliefs and ambitions.

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- Family and friends support in this process is vital for many.
- Family members may have supported someone for many years through several periods of crisis and in patient admissions.
- Family members may have requested support and information on many occasions without being heard.
- Pursuing recovery does not mean discharge, neglect or isolation and far from excluding family and friends it should be **actively drawing** on their support.

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Some quotes from patients and carers

"I would not be here if it were not for my family"

"We assumed blame – we had let her down. An overwhelming sense of guilt swept over us. However we then began to enforce the possibility improvement – often tiny steps combine to achieve remarkable progress"

"Over the last 7 years we have learned patience. There are no quick fixes to recovery"

"I have now learned to walk alongside my sister instead of trying to tell her what to do"

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How friends and family can support recovery

Many familiar ways in which family and friends can help, for example:

- Often you can identify triggers
- Know what over time seems to help
- Support and reassurance
- Practical help to alleviate more distress

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New Ways

- Recovery Planning
- Building on Strengths
- Developing Relationships
- Handing Back Control

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Recovery Planning

Family and friends can help by:

- Helping people hang on to roles and relationships that are important to them
- Help them work towards their own personal **goals** (not ours)
- Help them develop their own Recovery Plan

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Building on Strengths

- Remind someone of the positives
- Pointing out how they have tried and what has been achieved
- Remind them of little things they have forgotten
- Holding on to own hope when someone feels it is impossible to see light at the end of the tunnel

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Developing helpful relationships

Family and friends often talk about the difficulty of treading a tightrope between encouraging someone to do more and allowing them to rest and be supported. This isn't easy but it is important for everyone (patient and family) to talk together about what helps in their relationships and what they find difficult. These discussions can be supported by staff.

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Handing back control

Family and friends can easily get trapped into a position of doing more and more for their family member e.g. controlling finances; paying rent; shopping. As someone recovers often family and friends can find it hard to hand back control as it may feel ‘risky’ but decisions on how to move forward safely need to be shared between family, friends and hospital professional team.

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Introducing concept of Carer Recovery

Family and friends often need to embrace their own recovery and it is not uncommon for patients to have made significant progress towards their goals only to find family and friends have not had the same support and opportunity to move on and remain stuck in their ‘loss’ and the ‘trauma’ of the consequences of their family member’s distress and onset of illness.

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What can Lakeside do to support families?

- Identify who is important to the patient – a ‘ carer’ does not have to be physically looking after someone 24/7 but can be someone who offers emotional support and is helping someone cope with a mental health problem often travelling long distances to do so.

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Tackle stigma – some carers feel other people look down on them as their experience is different from their own. Some carers keep their worries a secret and don't tell employers etc. and have stress asking for time off.

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- Understand the impact of caring
- Keeping families and friends involved in the care
- Reduce isolation – having someone to talk to:
- - hospital staff

    - Carers Direct 0300 1231053

    - www.carersuk.org
      (link to local support services for carers)

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Carer Peer Support

Carers can become isolated and feel alone in their experiences. Some find that it helps to meet with other carers in groups. Local resources can be identified.

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Carer Recovery Plans

There are a multitude of tools available to aid in identifying and supporting carers needs. Including;

- WRAP
- Carers Star

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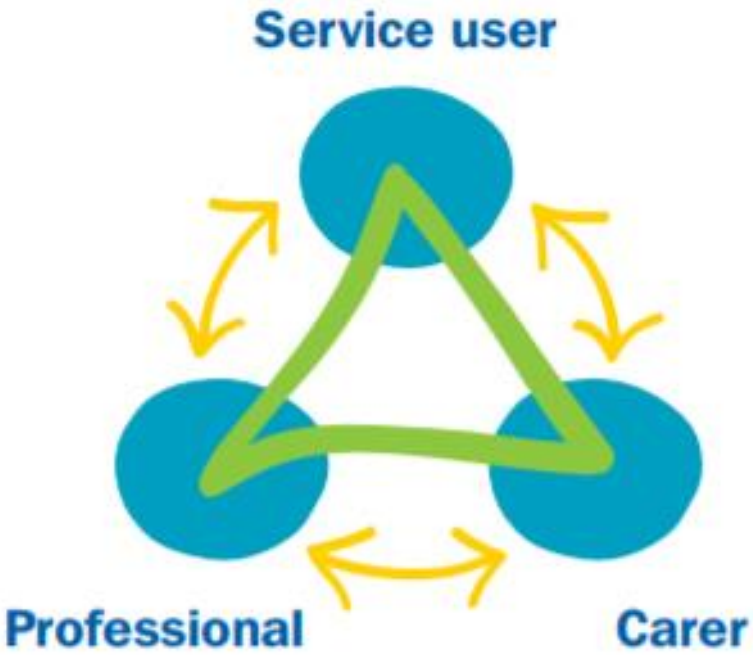
The Triangle of care



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Six Principles of the Triangle of Care

The Triangle of Care – Carers Trust

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are 'carer aware' and trained in carer engagement strategies
3. Policy and practice protocols re: confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6. A range of carer support services is available

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Thank You.

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RECOVERY COLLEGES: Bringing out the amazing in people

Michael

Gayle

Amy

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How did it all begin?

- Recovery movement which developed quite steadily from the late 1980s onwards.
- The first Recovery College was established in 2009 by in South West London and a second College was quickly established in Nottingham'.
- *'A way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*' (Anthony, 1993).
- Although many mainstream mental health services have tried to embrace the idea of being recovery-focused, the establishment of colleges offers greater opportunities to break down the barriers between staff and users and to focus on strengths rather than difficulties.
- CQUIN

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What is it about?

- Increase in quality of life
- Fundamental to recovery ethos
- Engagement in meaningful daily activities can reduce symptoms
- Focus on the person not the illness
- Abilities and strengths
- Link to social inclusion
- Taking part in social, educational, training, volunteering and employment opportunities can support the process of individual recovery
- A significant proportion of people with mental disorders continue to have persistent and disabling symptoms and are unable to get back to their previous occupations and social roles

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What is it all about?

Educational rather than a clinical or rehabilitation approach to improving mental health.

Co production, co-delivery and co-participation in the learning.

Strengths rather than problems.

Individual learning plans which guide a journey through their studies.

Subjects that would not be available in the local further education colleges

- *Understanding recovery*
- *Understanding mental health conditions*
- *Looking at mental health services and treatments*
- *Personal growthwellbeing and health*
- *Life skills, managing money, moving towards other education or employment*
- *Peer-support skills*

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Lakeside Recovery College Development

- Why set up a Recovery College at Lakeside?

- Choice
- Inclusion
- Opportunity

- Our goals and outcomes for the future

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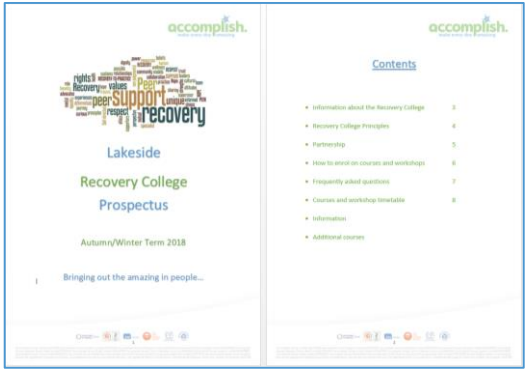
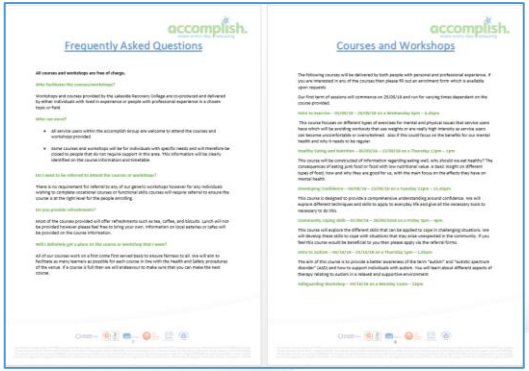
Prospectus

- Recovery Model
- Key messages
- Partnership
- Courses and Workshops
- Person Centred





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Health and Wellbeing

- Self-Esteem
- General Health and Mental Health
- Stress Management
- Skills Development
- Desire to Develop

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Why does it matter?

Parity of Esteem: Part of not equal to!

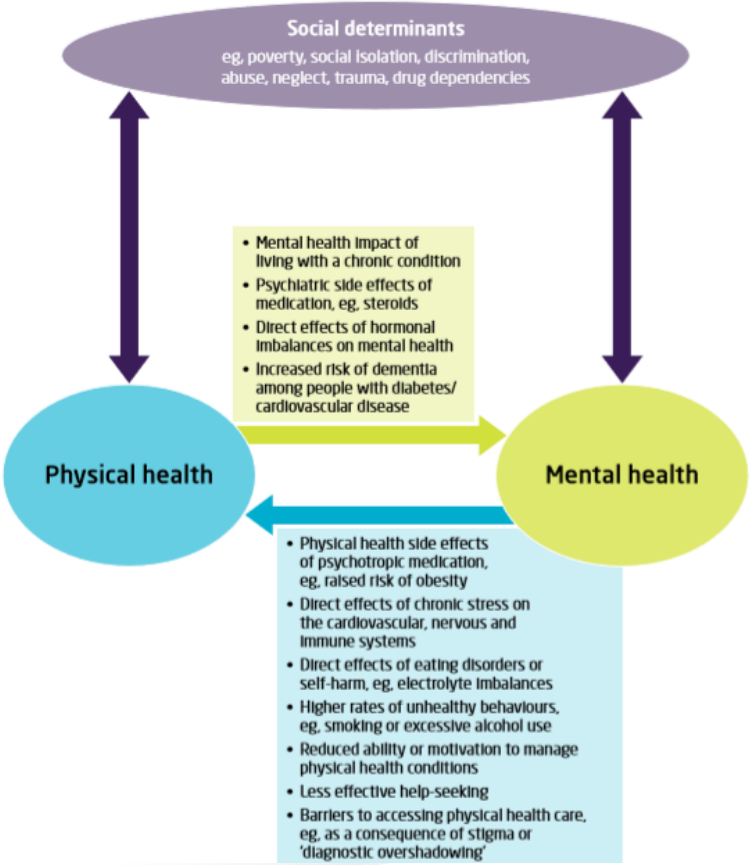
Chronic medically unexplained symptoms

Reduced life expectacy

Whole person approach

Quality of Life

Health risk behaviours



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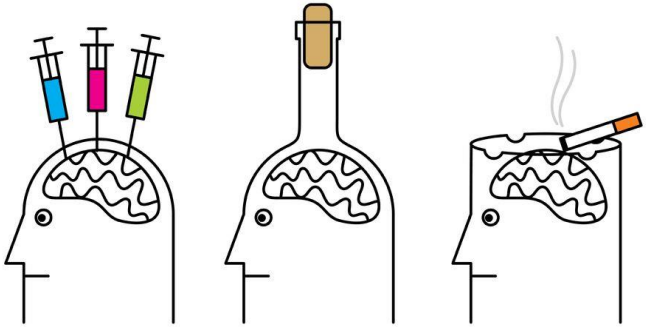
Mortality 3.6x rate in general population 2010/2011

- X4 respiratory diseases
- X4 digestive diseases
- X3 circulatory diseases

- Five year forward 2016
- NAS
- CQUIN 16/17



1. Action on ... Support to quit smoking
2. Action on ... Tackling obesity
3. Action on ... Improving physical activity levels
4. Action on ... Reducing alcohol and substance use
5. Action on ... Sexual and reproductive health
6. Action on ... Medicine optimisation
7. Action on ... Dental and oral health
8. Action on ... Reducing falls

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Community Skills

- Preparing for a life after services
- Practical knowledge
- Independence
- Empowerment

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Why does it matter?

- Increase in quality of life
- Fundamental to recovery ethos
- Engagement in meaningful daily activities can reduce symptoms
- Abilities and strengths
- Rehabilitation/habilitation
- A significant proportion of people with mental disorders continue to have persistent and disabling symptoms and are unable to get back to their previous occupations and social roles

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Physical Fitness

- Increase in mental wellbeing
- Stress/Anxiety management
- Variety
- Social Skills Development

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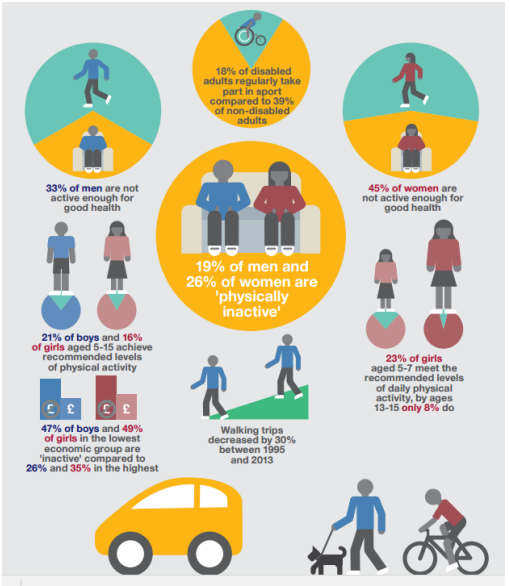
Why does it matter?



Few side effects

Protective factor for dementia/depression (20%-30%)

Reduces stress

Low habitual activity- Hypokinetic diseases
(Reduced mental wellbeing; CHD; Diabetes; Osteoporosis; Hypertension; cancer)

150 mins moderate activity

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Patient Quotes

- Healthy Eating and Nutrition –

"I really enjoyed this session and I have learned more as well"

- Developing Confidence –

"Really liked the session"

"I really enjoyed the sessions and hope to do more soon"

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Co-Production and the future

- Developing our patients
- Training and Development
- Bespoke courses
- Patient led courses

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Principles

- 1. Co- production
- 2. Physical Base
- 3. College principles
- 4. For everyone
- 5. Personal tutor
- 6. Not a substitute for assessment & treatment
- 7. Not a substitute for mainstream college
- 8. Reflects recovery principles in all aspects of its culture and operation

The model emphasises that, while people may not have full control over their symptoms, they can have control over their lives

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Amy's story

" I want to share my experiences of joining the recovery college at Lakeside....

"Initially I didn't know what I was going into and what to expect out of it, I have never done anything like the recovery college before. I signed myself up to attend healthy eating, developing confidence and intro to community skills"

"When I first started healthy eating I started to learn about a balanced diet, different foods such as meats. I also learnt how much water a person should drink in hot weather to keep hydrated

" In developing confidence I learnt about what confidence is and how to build it"

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“In intro to community skills I learnt about use of time, so how to use your time wisely in the community and to know what time you have to be at places such as work, college etc. Also how to plan and manage your time by doing activity and working”

“Whilst out in the community each person may have a supporting tool such as a checklist to see what your interests are and what you like and don’t like; other useful supporting tools are personalised timetables, calendars and mobile phones”

“There are other useful things I have learnt: Road safety, crossing points, hazards, accidents and busy roads. These are the types of risks you could come across whilst out in the community ”

“If you are in the community what to do if you or someone else needs help. So if you are out and you needs help some useful things you can do: Use your phone to call emergency services if its medical, family member contacts, approach someone in the community/ shops if you are lost or need help”

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“ The recovery college has changed me in different ways and has taught me different skills that I didn’t think I had. For instance after attending developing confidence I have noticed that my confidence has grown and I now get involved in extra activities that I never previously would have such as:

- Helping to run new recovery college courses
- Helping to interview new staff
- Volunteering at local businesses
- Chairing patient forum
- Talking at events such as this”

Thanks for listening about my experiences of joining Recovery College

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Resources

- *Mental Health foundation*
- *Department of health (2016): Improving the physical health of people with mental* health problems: Actions for mental health nurses
- *National Institute of Mental Health (2014) Combating Early Death in People with Serious Mental Illness*
- *NHS England (2016). The five year forward view for Mental health*
- *Mental Health foundation (2015) Fundamental facts about mental health*
- *IMROC recovery colleges*
- *Kings Fund: Bringing together physical and mental health: A new frontier for integrated care*

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Transitional Support Model

A Progressive Supportive Pathway towards Independence and Recovery

Matthew Fullylove Business Development Manager

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The Recovery Model

The use of the Recovery Model within residential settings.

- places value on people's perspectives and enables empowerment and choice
- provides belief that positive growth is a possible and realistic goal
- focuses on people's potential rather than their problems
- provides holistic support, covering all the dimensions of recovery
- self-management of Mental Health and relapse prevention is the ultimate goal

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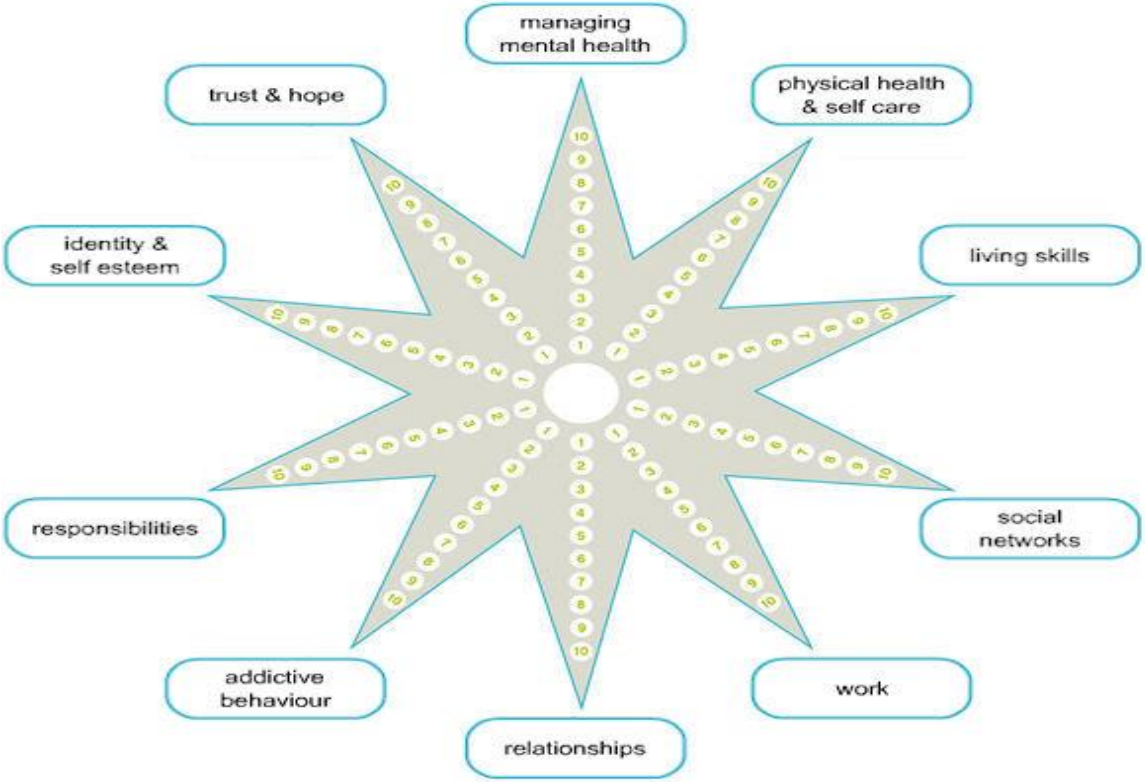
The Recovery Star Model (developed by Triangle Consulting)



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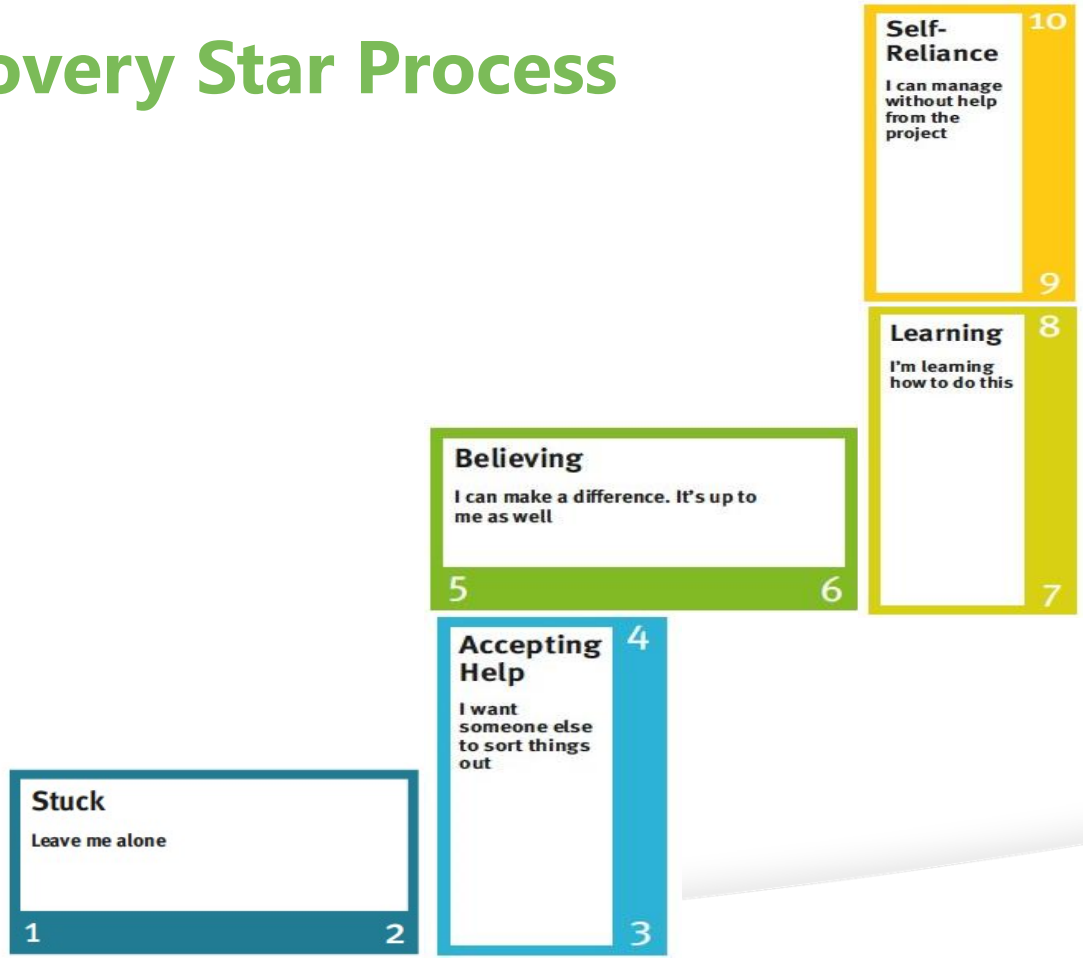
The Recovery Star Process



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Transitional Support Model

The creation of our semi independent studio apartments, enables people who want to live more independently, take those first steps to greater independence within a safe risk managed environment.

- Offers people a carefully planned and risk managed independent pathway within a residential setting.

- Proven successful in providing a rehabilitation, focused transition from residential services, towards independence or community supported living services.

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Transitional Residential Support

Progression Pathway

Our Studio apartments offer a clear progression pathway.

- The pathway provides an opportunity for self development and maximum growth.
- Provides a private space for staff to enable skill development or coaching sessions.
- People can trial independence in a setting which has 24 hour staffing support.
- Safe, risk managed environment.
- Enabling people to live more independently.

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71 people have successfully journeyed through our transitional models on to more independent living over a period of two years.

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Thank you

Peter Battle
Chief Executive Officer

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