

The Naomi Guide

including The Eating Disorders Programme



Mental healthcare : for people, not for profit



INVESTOR IN PEOPLE

Contents

- 1.1 Description of Service Model for Naomi 1
- 1.2 Naomi Philosophy 3
- 1.3 Our Approach 4
 - Cognitive Behavioural Therapy (CBT) 4
 - Being part of a living learning community 4
 - The Group Programme 5
 - The Naomi Unit Group Programme 6
 - Care Programme Approach 7
 - The Multidisciplinary Team 7
- 1.4 How We Manage Risk 11
 - Naomi Code of Conduct 11
 - Rules and Boundaries 11
- 1.5 Other Issues 15

Appendix 1 - The Eating Disorders Programme



1.1 Description of Service Model for Naomi

Naomi is a specialist service for adults using a treatment approach informed by Cognitive Behavioural Therapy (CBT) in a therapeutic environment which promotes recovery from a range of problems. These include eating disorders and mood disorders. We do admit people who are detained under the Mental Health Act although the programme requires a high level of commitment and motivation to change and we would therefore be looking towards supporting the person to be discharged from the section.

Naomi is a modified therapeutic community that empowers patients to take personal responsibility valuing their contribution to a living learning community. We have close links with our neighbours the Acorn Programme. This unit is run on therapeutic community lines for people with self-defeating behaviours. People may begin their recovery journeys on Naomi and then move to Acorn if for example they have concurrent alcohol or eating disorders or if they are working towards coming off a section of the Mental Health Act.

On Naomi we strongly encourage people to regain and retain their independence. We recognise that everyone is unique and tailor their programme according to individual need.

We work very closely as a Multidisciplinary Team (MDT) consisting of CBT therapists, Dietitian, Drama Therapist, General Practitioner, Nurse Therapists, Occupational Therapist, Practice Nurse, Pharmacist, Psychiatrist, Psychologist, Physiotherapist, Registered Mental Health Nurses, Social Worker and Support Workers. The nursing team is experienced and we only use bank staff when necessary.

The predominant therapy model used on Naomi is Cognitive Behavioural Therapy. This is the case in both individual work and the group programme.

All members of the MDT, including all of the nurses, support workers and other staff such as the Pharmacist have received basic training in CBT. Some members have received training at a higher level including our Nurse Therapists and CBT Therapists and Psychologists. Many are accredited with the BABCP. Staff receive individual supervision as well as team supervision. They work in teams so that patients are attended to by therapy teams leading to a coherent therapeutic experience.

Patients receive weekly individual CBT therapy with their Therapist and their Named Nurse. They also receive interventions at other times with members of their therapy team. They also take part in the group programme which is influenced by CBT and tailored to reflect the different stages of recovery. We do recognise that individual therapy is important in parallel to allow more in-depth exploration of individual's experiences.

We believe that groups are a powerful and beneficial way for people to learn about themselves through other people's experiences and through the relationships they develop within the group.



We recognise that people have needs that extend well beyond the problems which have lead to their coming to Naomi and provide help regarding: finances, housing, occupation, education as well as practical issues related to eating and simply 'being' in society.

We also know that people's problems have an impact on families and we offer individual support to families and a multi-family carers support group.



1.2 Naomi Philosophy

Naomi is a community made up of patients and staff. We are located within the wider community of The Retreat and aspire to adhere to the Quaker principles which underpin our philosophy.

Our principles on Naomi are outlined below:

- We believe that we are all human beings and deserve to be respected and treated as equals.
- We believe that everyone is entitled to be listened to non-judgementally.
- We believe that all human beings need privacy and a space to call their own.
- We encourage a culture of openness and honesty. We believe that secrets are often unhealthy and unhelpful, and therefore we discourage them.
- We believe that a safe, calm and comfortable environment promotes recovery, and we aim to provide this.
- We believe that reintegration into the wider community is part of recovery, and we encourage patients to actively engage with community resources throughout their admission, where possible.
- We believe in being open-minded and forward thinking. We acknowledge the need to be flexible and to be open to change in order to keep up with the needs and wishes of Naomi unit and the wider community.
- We believe that to effect change, therapy should support the exploration of personal experience, in order that you understand where and why things have gone wrong.
- We believe that mental health problems require a holistic approach. Our treatment plans focus on psychological and social interventions, and we recognise that medication can play a role in recovery.



1.3 Our Approach

Cognitive Behavioural Therapy (CBT)

This is the main therapy the staff will use on the unit to help you to think about yourself, the world and other people. It is a way of talking about how what you do affects your thoughts and feelings. CBT can help you to change you thoughts (cognitions) and what you do (behaviours). This can help you recover. The main focus of CBT is on the “here and now” rather than the past.

There is evidence to show it can be helpful in treating:

- Anxiety
- Depression
- Panic
- Agoraphobia and other phobias
- Social phobia
- Bulimia
- Obsessive compulsive disorder
- Post traumatic stress disorder
- Schizophrenia

CBT works by helping you to make sense of overwhelming problems by breaking them down into smaller more manageable parts. You will be taught some of the CBT skills in groups but will also meet with your individual therapist for between 30 and 60 minutes a week. Part of your therapy may be to complete “homework tasks” and a diary. Your named and associate nurses will help you with these tasks, but they will require your active participation.

Staff may also teach you some DBT skills (Dialectical Behaviour Therapy). DBT has been developed from CBT and is particularly effective in helping people who self harm. It teaches specific skills to help people manage their mind, emotions, relationships and distress in helpful ways.

Being part of a living learning community

Naomi is a modified therapeutic community. We believe that the most effective kind of residential or day treatment is where all members are involved in creating and maintaining the therapeutic environment. Change is assisted by belonging to, and involvement in, a group in a culture of enquiry and openness with a secure sense of attachment and containment. The distress behind symptoms of problematic behaviour can be articulated, understood and changed.



What this means in practice is that you will be encouraged to talk openly about your thoughts and feelings and avoid secrets. Your opinion is important and the support you are able to offer others, particularly in groups, is valued. There is also an expectation that you will try and keep yourself safe. If problems do occur, we ask for a willingness to talk about what went wrong and what could be different in future.

The Group Programme

Much of the therapy you receive will take place in various groups, and you will be expected to attend them all. They are designed to offer a variety of ways in which you can express yourself, and to explore how to think about yourself and your life. Sharing this with others allows you to explore how you are affected by relationships, how to use the support of others better, and how to break out of the world of secrecy that so often surrounds mental illness. Each group is facilitated by one or more member(s) of the staff team.

Certain groups (Start of the Week/Review of the Week) involve everyone on the unit, staff and patients alike. These groups are designed to be a place where people should feel free to speak out on their own behalf or for others. We strive to make them feel a safe group, which will help people use their stay well. They are for communicating information about what is going on in the unit and the wider world; to discuss problems of living together; and to think about the relationships between the different people in the community. Incidents and conflicts can be discussed and dealt with, and achievements noticed and celebrated. Events from home or elsewhere which impact upon people can be made known. Feelings, and the effects they have on people's behaviours, can be discussed.

Therapy comes from your committed participation in the programme. While the staff set the overall structure of the Naomi programme, we expect you to contribute to keeping treatment safe and therapeutic, both by acting responsibly yourself during activities, and by helping others think about the effect of their behaviour when participating in (or not participating in) any activities that are set.

The weekly programme consists of compulsory and optional groups. The compulsory groups are flexible to suit your problems and needs – to be determined by your team.

Compulsory Groups

Start of the Week
Core CBT Skills Training
Drama Therapy
Transition Planning
Assertiveness
Advanced CBT
Distress Tolerance
Body Image

Psychotherapy
Healthy Living
Review of the Week
Shop and Cook

Optional Groups

Relaxation
Gym
Secret Garden
Yoga
Swimming
Pottery
Creative Expression
Chaplain's visit



The Naomi Unit Group Programme

MONDAY	08.15 - 08.25	08.30 - 09.30	09.00 – 09.30 am Handover 09.45 – 10.15 am Start of the Week 11.00 am – 12.00 noon Drama 11.15 am – 11.45 am Mindfulness	12.30 - 1.30	2.25 – 3.25 pm Reflective Practice 3.30 – 4.30 pm Activities Group 3.30 – 5.00 pm Core CBT	5.30 - 6.10	6.00 – 7.30 pm Family Therapy 6.30 – 7.00 pm End of the Day
TUESDAY		B R E A K F A S T	08.45 am – 12.45 pm MDT 09.30 am – 12.30 pm Practice Nurse 11.00 am – 12.00 noon Chaplain's Visit	L U N C H	1.30 – 3.00 pm Swimming 2.00 – 3.00 pm Business/Nurses Meetings 2.15 – 2.45 pm Distress Tolerance 3.00 – 4.30 pm Pottery 4.00 – 4.30 pm Relaxation	E V E N I N G	6.30 – 7.00 pm End of the Day
WEDNESDAY	Y O G A	P O S T	08.30 – 09.15 am Referrals Meeting 08.30 am – 12.30 pm G.P. 09.45 – 10.45 am Psychotherapy 11.30 am – 12.30 pm CPA Review	I N C L. P O S T	1.00 – 2.00 pm CPA Review 2.00 – 3.00 pm Staff Training 2.15 – 3.00 pm Core Body Knowledge 3.30 – 5.30 pm Trip with Les	M E A L	6.30 – 7.00 pm End of the Day
THURSDAY		M E A L	09.30 – 11.00 am Horse Riding 10.00 – 11.00 am Expressive Art 11.00 am – 12.30 pm Advanced CBT	S U P P O R T	2.00 – 3.00 pm Case Management 2.00 – 3.00 pm Transition Planning 3.15 – 5.15 pm Trip with Les	M E A L	6.30 – 7.00 pm End of the Day
FRIDAY		S U P P O R T	08.00 – 09.00 am Collaborative Meeting 09.00 – 09.30 am Handover 10.30 am – 2.00 pm Shop & Cook (3 wks out of 4) 11.00 am – 12 noon Healthy Living - Every 4 th week		2.00 – 3.00 pm Case Management 3.00 – 3.45 pm Review of the week		6.30 – 7.00 pm End of the Day
SATURDAY AND SUNDAY : Meals, Yoga and End of the Day							



Care Programme Approach

The Care Programme Approach was introduced by the Department of Health in 1991 to ensure that users of mental health services (and their carers where relevant) receive comprehensive well coordinated care.

CPA is a collaborative process. The main elements that you need to be aware of, and we ask for your co-operation with, are:

- On admission, and sometimes before, we will make a comprehensive assessment of your needs. This assessment will inform the writing of a care plan in which we will agree with you what your treatment will include. You may have more than one care plan. The overall summary of your treatment is described as a recovery and well being plan. You should be involved in agreeing your care plans and will be given copies. Your consent is usually indicated by a signature.
- Your care will be regularly reviewed. The multidisciplinary team meet weekly with you to do this. If you are in treatment for more than six weeks you will have a more comprehensive CPA review involving family members and external professionals involved in your care. You will be consulted about who should be invited to these meetings. Occasionally it may be necessary to bring forward or have an emergency review.
- All patients admitted to The Retreat will have a care coordinator who will keep in close contact with the person receiving care and all those delivering it. We will tell you who your care co-ordinator is.
- Prior to discharge we will discuss with you a discharge and relapse prevention plan. With your agreement we will send these to people who will continue to be involved in your recovery. We have an obligation of care to ensure that we communicate any ongoing medication or risk issues to your GP and local services.

The Multidisciplinary Team

This is the name given to the team who will work with you. They come from a range of professions and bring a broad range of perspectives and expertise. Below are overviews of the roles of professionals included in the MDT.

Clinical Service Manager (RMN)

The Clinical Service Manager (CSM) has Head of Departmental responsibility for the Specialist Adult Services which is the title given jointly to the Naomi, Acorn and Hannah Mills units.

Responsibilities include managing the budget and being line manager for many of the senior staff. The CSM also has wider organisational responsibilities for quality improvement. The present role is largely managerial, but with a clinical background. The CSM retains a strong interest in the welfare of the two communities, attending both community and staff meetings.



Clinical Team Leader (RMN)

The Clinical Team Leader has responsibility to ensure you receive the highest quality of care and treatment within a safe therapeutic environment.

The Clinical Team Leader works closely with the MDT and will attend and facilitate groups. Please feel free to talk with the CTL about any comments or concerns that you may have.

Deputy Clinical Team Leader (RMN)

It is the Deputy Clinical Team Leader's responsibility to assist the Clinical Team Leader with all aspects of care and treatment delivered to you by the Naomi Team. The deputy Clinical Team Leader focuses on working collaboratively with you in order to provide high quality care and facilitate recovery.

Consultant Psychiatrist

The Consultant Psychiatrist is part of the Multidisciplinary team (MDT) for Naomi unit and is involved in accepting referrals, assessing people for admission and liaising with referring teams. The Psychiatrist regularly sees all of the patients on Naomi to assess their mental state and make recommendations about medication. The Psychiatrist is also a trained psychotherapist and sees some of the patients for therapy as well as running therapy groups. She is also part of a small team of staff within the Naomi staff group to make up the family therapy team. If a patient is detained under the Mental Health Act on Naomi then the Psychiatrist acts as their Responsible Medical Officer

Clinical Psychologist

The Clinical Psychologist on Naomi has a number of different roles within the team, including coordinating research on the unit and supervising a number of the team. The Psychologist undertakes assessments for people who have been referred to the service, sees a number of individuals for therapy within a CBT framework, and is also trained in other therapeutic models including DBT (Dialectical Behavioural Therapy) and CAT (Cognitive Analytic Therapy). There are several trained therapists within the team so you may not always see the Clinical Psychologist for individual therapy, but will be allocated to a therapist most suitable for you on your arrival.

Clinical Nurse Specialist

The Clinical Nurse Specialist on Naomi is involved in seeing patients individually as their therapist for cognitive-behavioural psychotherapy. The Clinical Nurse Specialist can also often be found in several of the groups taking place on the unit. In addition, the Clinical Nurse Specialist is involved in supervising nurses and assisting them in their training and development requirements.



Within the hospital the Clinical Nurse Specialist works to facilitate evidence based practice standards, policy, guidelines and research and contributes to the strategic direction of Naomi and the organisation.

Dietitian

The role of the Dietitian is to interpret and communicate the science of nutrition to enable you to make the necessary changes to your dietary intake to restore a healthy body weight. The Dietitian will work with you towards achieving a balanced diet that meets your individual nutritional requirements, in order to prevent any nutrition-related problems and achieve a weight that is normal for you.

Registered Mental Health Nurse

The role of the RMN on Naomi is to take charge of the unit, coordinate the shift, and support patients, junior staff and bank staff. Responsibilities include administering medication, admitting and discharging patients, assessing risk, formulating care plans, and carrying out any other administrative tasks required to ensure the smooth and safe running of the unit. With other MDT members the RMN facilitates unit rounds, Care Programme Approach meetings, and the Group Programme. Some RMNs are also trained to act as Site Coordinator for the whole of The Retreat.

Occupational Therapist

The Occupational Therapist works as a member of the multidisciplinary team. The role of the Occupational therapist involves using meaningful activity to enable individuals to achieve a positive balance and structure that increases independence and supports recovery and wellbeing.

Physiotherapist

The Physiotherapist works with the team to treat orthopaedic conditions that co-exist alongside mental health problems. This can include: devising appropriate physical activities to enhance mood, agreeing appropriate activity levels, educating patients about physical conditions that result from their illnesses, devising strategies for patients to ground them selves and manage self-defeating behaviours, supporting patients to take normal healthy exercise and promoting the use of relaxation

Physiotherapy Technical Instructor

The Physiotherapy Technical Instructor works under the supervision of the Physiotherapists to help you with your physical health needs. This may happen in groups or on a one to one basis.



Social Worker

The Social Worker works as part of the MDT, contributing to your Recovery and Well-being plan, under the Care Programme Approach. You can discuss with the Social Worker any issues around childcare, family support, housing and financial needs, access to benefits, support on discharge, or your rights under various legislation, for example the Mental Health Act. You can ask the nursing staff to make a referral and the Social Worker will then contact you to arrange a meeting.

Drama Therapist

Drama and movement therapy involves the structured development of movement, mime, improvisation, drama narrative, script work and role play, in order to bring insight, learning and change. If you are interested in working with the therapist, please speak to your Named Nurse.

GP and Practice Nurse

Twice a week we have a visit by a GP and a Practice Nurse who deal with any physical related issues.

Assistant Psychologist

The Assistant Psychologist's role is to work with you and as part of the MDT under the supervision of the Clinical Psychologist. The role includes assessing an individual's progress and the overall approach of the unit through outcome assessment. Additionally, the Assistant Psychologist is involved in conducting a variety of research projects on the unit and also works as a Support Worker.

Support Worker

A Support Worker is a crucial and essential part of the Naomi nursing team. The role is to support other healthcare professionals within the team, and the Support Worker plays a valuable part in delivering patient care.



1.4 How We Manage Risk

Naomi Code of Conduct

We recognise that for a community to be comfortable and safe there is a need for rules and boundaries. These are based on common sense and for the common good of the community. Staff and patients need to be informed of what these are and the consequences of any transgressions.

Being part of a safe and happy community imposes certain responsibilities upon us all. Taking these responsibilities on involves us behaving in a positive and supportive manner to those around us. People like to both work and stay here because of the efforts made to create a safe environment in which to recover. So that we can work effectively as a community, staff and patients should:

- Speak calmly, without raised voices wherever possible.
- Listen respectfully to others opinions.
- Recognise that some people struggle in silence and remember that everyone has their own individual needs
- Take responsibility for your own recovery
- Keep in mind that although everyone is struggling your needs for recovery should be your priority
- Be able to apologise sincerely and be prepared to make whatever amends are necessary, when things go wrong.
- Recognise that this may not be the right time or place for recovery, but that this does not mean you have failed.

Rules and Boundaries

Alcohol and Illegal Drugs

We adhere to The Retreat's policy on drugs and alcohol. There is a 'No Alcohol or Illicit Drugs' policy on the unit. Drinking in a harmful way is considered a self-defeating behaviour (See below). Drinking on leave is discouraged. Anyone returning to the unit intoxicated will be asked to remove themselves from public areas, and to complete a chain analysis and present the summary thereof to the community (once sober). Individual therapy will be suspended other than supporting the individual to complete a chain analysis. If this happens more than once the fund holders and community team will be made aware. Depending on the circumstances the options will either be a two week commitment period or discharge back to the community.

Illegal drug taking is not tolerated on Naomi under any circumstances and will result in the police and fund holders being informed.



Self-defeating behaviour

A self-defeating behaviour is a dangerous behaviour that may help you escape from, or cope with difficult thoughts and feelings in the short term, but is dangerous to your mental and physical health.

Self-defeating behaviours (such as self-harm, abuse of drugs/alcohol, refusal to eat, excessive bingeing) are not to be discussed in secret between patients except to support each other to bring the struggles to the attention of the group. While we recognise that self-defeating behaviours have been part of most of your lives prior to admission, you are expected to actively work towards extinguishing these behaviours and replacing them with healthy coping strategies.

Self-defeating behaviours are serious and need to be addressed. We find that analysing your actions, thoughts and feelings leading up to the episode is a helpful way to learn what went wrong and what could have been done differently. Therefore, following an incident of SDB, patients will be asked to complete a chain analysis. This is not a punishment but a helpful tool to support your self-discovery. Anyone who has not completed a chain analysis before will receive support to do so.

Following any serious episodes of self-harm it is important that the staff team don't reinforce negative behaviours by the giving of extra time. It is also important that understanding what went wrong and what needs to change becomes the focus of your attention. For these reasons following a serious episode of self-harm we may cancel all individual therapy until a chain analysis is completed and shared with the wider community.

Impulsive departures

The central therapy programme runs from Monday to Friday. You are expected to attend the whole programme unless you have a specific agreement with the group. Leaving the unit at other times must also be planned and discussed with the community and staff team.

Impulsive departures make the work of the group feel unsafe. This is how we will respond:

- If you leave the unit in distress staff will not normally follow you, as this tends to encourage leaving the unit as a way to seek help in distress.
- Staff may make an exception to this if they believe there is an immediate risk to life. At such times The Retreat Missing Persons Procedure will be followed.
- If you do leave the unit in distress you should make contact and return to the unit as soon as possible. You must let us know if you make a decision not to return.
- When you return to the unit a member of staff will see you briefly and ask you to complete a behaviour chain analysis as a way to look at what happened and to find more effective ways to cope in future. All incidents of this type will be treated sympathetically and as a learning opportunity.



Overnight leave should be requested through the MDT meeting. You should inform the community as far in advance as possible, to avoid impulsive departures and anxiety on the part of others. Please note that we need at least 3 days warning to be sure of arranging leave medication.

Violence and aggressive behaviour

We cannot tolerate violence of any sort on the unit. Violence to others will lead to discharge at the earliest possible moment. Physical or verbal threats to patients, staff or others will be treated very seriously, and will normally lead to you being asked to take time out from the programme; your return will depend upon you finding ways to stop the threats. In extreme circumstances where violence is threatened or occurs, or the threat of self-harm is severe, you could be restrained. Police may be called to help deal with a dangerous situation. Our aim is to safely contain things until we can work through it together.

Respect for property

If you cause damage to Naomi unit property or that of a fellow patient, you will be asked to pay for its replacement or repair. Please do not take property that does not belong to you.

Driving

People resident on the unit should not drive. If we have any indication that someone is driving at a time when they are physically too unwell to do so safely, or under the influence of drugs or alcohol, we will inform the police.

People who suffer any sort of psychological disturbance should inform the DVLA, who will decide if you are fit to drive. There are guidelines issued by the DVLA which give an idea of the likely decision, but they do treat individual cases with sympathy. We are obliged to inform them if we have doubts about a person's fitness to drive. We will discuss with you situations where we think this may be.

Child protection

We are obliged to inform the social services department if we have reason to believe children may be at risk of abuse by an identified person, or of harm in other ways. If you think you know of children who are at risk, you are probably also aware of why this should be stopped. We will discuss with you any situation where we think this may be relevant, and will not tell anyone without you being told first. We will not tell anyone outside the unit about anything you tell us without your knowledge. We will not tell members of your family, the police or other agencies anything you don't want them to know except in the situations above where we have a legal duty to do so. We would normally work with you even in those situations to get your agreement as to how and when information is given out.



Emergency community meeting

Where there is a high level of concern amongst staff or patients regarding an incident that has occurred or may occur, three or more patients or the person in charge of the unit may call for an emergency community meeting. This is an opportunity to use the combined resources of the group to problem-solve an issue or reduce conflict.



1.5 Other Issues

Confidentiality

While the group must be able to discuss anything which happens in the unit, it is important to remember that the work of the group is confidential. We want people to feel safe to talk about experiences which they may have kept secret elsewhere. Do not pass on anything you learn about people's lives to others outside the programme.

The staff team need to share information we have about you among ourselves, and must talk with the Team who referred you to the Programme to ensure they can carry out their part of your care. We work to ensure that we only share the information necessary for your best treatment.

We try to involve families and carers as much as possible, but we will not talk to them without your knowledge. There may be reasons why we should not talk to or involve particular people: please make sure we know if this is the case. If there is a life-endangering crisis, we will inform your next of kin unless there are clear written directions to the contrary.

Visiting Policy

Visitors are allowed on the unit, but we ask that you are considerate of other patients' needs, and respect the fact that all visits are at the discretion of the staff team. If the staff have any concerns about someone visiting, they should explain this clearly to the patient.

Children are only allowed to visit the unit on agreement with the nurse in charge on that shift. If staff have any concerns about a child visiting, then they should explain this clearly to the patient.

The Retreat has a Family Room which can be booked for when carers, friends or family visit. We ask that visitors do not go into a patient's room without consulting with staff.

Proposed visiting hours: 9.30 am until 9.30 pm. However, we request that visits do not disrupt your therapeutic programme, or your need for time and individual space to unwind from the day.

You are responsible for your carers, family members and friends when they do visit the unit. Disruptive visitors will be asked to leave.

Audit and research

The Naomi programme is unique and innovative. We are committed to a programme of audit and research to establish in what way and for what type of problems it is most useful. You will be asked during your stay to fill out questionnaires which we use for these purposes. These will be made anonymous, and the data used to help us obtain this information. While not filling out questionnaires will not affect your treatment, we



would like you to help us with this to ensure the programme continues to operate, and to improve. You would be asked separately if we wanted you to be involved in any research.

Bedroom access and belongings

All patients have the right to personal space and privacy. In order to meet this need, the following process is implemented:

- All bedrooms are fitted with a Yale lock.
- Individual patients will have access to appropriate keys at all times, unless it is deemed unsafe for the patient at a particular time.
- All patients are encouraged to take responsibility for the safe keeping of their own key.
- Staff will always knock and wait for your response before entering your room.
- While we will do everything we can to ensure the safety of your belongings The Retreat can not take responsibility for any items which are not handed in.
- When you leave please take all your belongings with you. Anything left behind will be kept in storage for a maximum of two months then disposed of or given to charity.

Please note further information about The Retreat and York can be found in the Personal Information file, which will presented to you on admission.

Appendix 1

The Eating Disorders Programme

This information is about our Eating Disorders Programme, which is a treatment programme designed to help people overcome and recover from eating disorders. The main goal of the programme is to help you give up reliance on disordered eating and the preoccupations that go with it; to do this you will need to understand enough about why you use the behaviours and thoughts to learn how to cope with your problems in a different way. This means that your stay with us will not be spent only dealing with eating: the really important work is to recognise and deal with the reasons why you have the disorder in the first place.

You will not complete your recovery during your stay. Our goal is to help you reach a point where you can leave the unit and continue your work in the community, while managing a safe and stable eating pattern, and avoiding other types of self-damaging behaviours. We will ensure that appropriate plans for your continued work are made and agreed with you before you leave.

What are Eating Disorders?

Eating Disorders are conditions in which people have ideas about food and eating which give rise to potentially dangerous behaviours. Women are affected ten times more frequently than men: for this reason, the person with an eating disorder is referred to as 'she' in this handbook.

The behaviours of a person with an eating disorder focus the attention of herself and of those around her on weight and body shape. Family and Carers become increasingly preoccupied by the dangers the behaviours cause. Anorexia Nervosa is the commonest psychiatric cause of death in young women: it's no surprise people get worried.

In the background to the eating disorder will be experiences in life which have been difficult to handle. Some people are very aware of this, for others it is difficult to understand what has gone wrong. We do not believe people develop an eating disorder lightly, and our programme is intended to help you pay attention to your underlying difficulties, and to find less destructive ways to deal with them.

However, we must always start with the disorder of eating, in order to stabilise your physical and emotional state enough that you can think. As you begin to think more clearly, we will encourage you to notice your characteristic thinking style, and the ideas which drive your eating behaviours. At the first level, there will be ideas about the effects of food – usually a fear that you will lose control of your eating, or that your body will respond to food in an unusual way, so you will gain more weight than you can bear. This fear triggers further thoughts about what this would mean, for example that you



might appear out of control or greedy. You will no doubt have your own particular fears, and recognising them may help us to begin to understand the underlying problems.

You will have noticed that your life has become increasingly taken over by the thoughts and feelings about food and eating.

As a result you will have done various things to regulate food intake or activity levels – reduce food intake or avoid certain types of food completely; avoid eating at times when you think the food will have a more fattening effect; increase exercise, and exercise excessively; vomit food so your body will not absorb it; and so on. You may also use laxatives or other medications in an attempt to control your body's shape and response to food. Your life will have become increasingly taken over by the search for control over your body and your appetite.

When you are losing weight you may feel successful and in control – but for most people there will be times when they cannot keep this up and they will eat in a way that feels out of control, which is called bingeing. This may lead to more vomiting, and to attempts to get control by increasing food avoidance subsequently. Your feelings and self-image, which you have been trying to improve by these efforts, will be damaged as it becomes increasingly dominated by recent eating patterns and by weight.

Most people make valiant attempts to appear cheerful and as if there is nothing worrying them. In fact, someone with an eating disorder is often unhappy, frightened and lonely. The self-discipline needed to keep going is huge, and exhausting.

Having an eating disorder is like being in sinking sand – the more you struggle to get your eating sorted, the more you are drawn into it. To escape, you will need to let us help you, and try to let go of some of your panic and struggle. This is hard to do, as you are only struggling to try to stay in control. If you let us take over, you will be afraid things will get worse.

Although most people have a mixed pattern of disordered eating, with periods when starvation and weight loss predominate and others when bingeing and impulsive eating take over, eating disorders are usually diagnosed as belonging in one of two main types – Anorexia Nervosa and Bulimia Nervosa. You may have been given a diagnosis of one of these before you reach our unit. While diagnosis is helpful for professionals trying to think about how to help, during your stay we will try to think about you in ways which are more to do with your struggle and difficulties.

Although it is less common than bulimia overall, most of the people who need treatment in our programme suffer from a condition which is predominantly anorexic in pattern. Usually when people arrive they are at a low body weight, and the dangers arising from this are the reason admission occurs. The first priority is to achieve a safe weight, and to manage the immediate risks.

People with a bulimic presentation will usually be admitted to help break out of a phase of bingeing and other behaviours which cannot be controlled as an outpatient.



The description of the programme reflects the fact that most people on the programme are admitted at low weight. Admission to control bingeing is usually shorter, and the initial phases of treatment are not necessary.

The Eating Disorders Treatment Programme

Meal Planning and Meal Support

The Dietitian has planned a gradual reintroduction to eating in a healthy manner, and will support you in taking this on. You will meet with her each week to plan your meals for the week ahead, and will increasingly prepare this plan in advance of the meeting. You will start with a limited diet, and work up to a pattern of three full meals and between one or three snacks each day.

You will eat your meals with the other people in the programme in the dining room as soon as you are deemed physically able to do so. You will be given the meal that has been planned, and will eat it in company with the others. Meals are supervised with staff available for support. The level of support and supervision you receive will depend on your stage in treatment. As a general rule it is hoped you will require less supervision the further you progress in treatment. However whatever stage of treatment you are at you should feel able to ask for support if you need it.

The expectation that you will make every effort to finish your meal within 40 minutes. Patients on the programme will remain together at the dining table until everyone has finished their meal.

Every effort is made to make meal times as relaxed and sociable as possible, while ensuring that people are sticking to their agreed eating plan.

After each meal, the whole group will leave the dining room together, and have a 20-minute 'Post-meal Support' group with two members of staff. This is an opportunity to give and seek help and reassurance, and to discuss difficulties which have emerged. It is also a time to note when people have managed well and are coping differently from before. All patients should attend Post-meal Support. Patients are expected to:

- Sit on chairs.
- Be on time.
- Not hide behind furniture/cushions etc.
- Not bring distracting items into the group.
- Switch off mobile phones.
- Give space to speak and to listen respectfully to everyone else.
- Not say: "I'm OK" or "I am fine" as a means of deflecting attention.



- Remain responsive and attentive at all times. Those in crisis, who are struggling, will be helped to reconnect. If this is not possible during the group then they will be supported after the group.
- Use this time to reflect on daily personal progress, goals, group participation and integration.
- Not walk out of groups.

Snacks are eaten either with support from staff or, in time, without support. There is no group after snacks.

Shopping and Cooking

One group is devoted to practicing shopping and cooking, with others on the programme. This is for many a particularly difficult experience, but is essential for a full recovery. The Occupational Therapist will facilitate this group with the Dietitian, and will help you understand and deal with what makes these basic tasks so difficult.

Weight Gain

We do not set you a 'target weight' on admission. Most people only find this a burden, and we aim to help you gradually get used to the weight gain that will follow improved eating. We would like you to allow your weight to rise to the level at which it settles – your 'set weight', which is the weight your body is designed to be. At this level you are least likely to be troubled by intense hunger, which would be a problem if you stop your weight gain at a lower point, or excessive fullness which would be the case at a higher weight. We cannot predict precisely your set weight, but it tends to be at the lower end of the 'normal' range, when your body mass index (BMI) will be around 20.

During your stay you will hear people talking about Body Mass Index, or BMI.

This is a standard way to think about weight and height, and is calculated by dividing your weight in kilograms by your height in meters squared (kg/m²).

The range of 'normal' BMI is generally put between about 19 and 25.

What you must do and what you can negotiate

Eating disorders are dangerous: they kill people. We think our first task is to ensure people are safe and well when they leave the unit. Because this involves doing things you have learned to avoid – eating regularly, allowing your weight to be stable at a level where your body will function normally, being well and calm enough to take decisions about your life – your instinct may be to resist some of what we ask you to do.

Eating to a plan which will allow you a physical recovery is a 'non-negotiable' element of the programme. We will discuss your difficulties with it, and do reasonable things to



make it less difficult, but you are here to recover, and that must include being physically safe. You will be expected to eat.

People with eating disorders usually dread the idea that people might know they feel hunger, like any food and want to eat. This 'anorexic thinking' will make it very difficult for you to make a decision to eat. We will take this problem away by asking the Dietitian to plan your eating for the week, and involve you in doing this increasingly through your stay. You will be expected to eat to the plan, in the dining room. You will be asked to remain at the table until you have finished the food on your plate. This is a group programme, and there is evidence to indicate that offering others support and prompting them to eat to their plan will help your own recovery. You will be expected to stay at the table until everyone on the programme has finished her food. If you leave the table, you will be brought back.

You will be weighed weekly, on Tuesday morning. We will keep a record of your weight and of your Body Mass Index, which allows us to follow your physical recovery.

Some other things are not negotiable, either because they make your recovery impossible, or because they make it impossible for the programme to operate. People are expected to avoid self-harm of any sort while they are with us. Any behaviour which is dangerous to yourself or to others is not allowed, and would be likely to lead to your discharge from the programme. We do not allow alcohol or illegal drugs on the unit, and we will report any illegal activity to the police.

You will be expected to take part in individual meetings with staff and the group programme, which is where the therapy happens. We do not believe you are with us just to gain weight, so we hope you will want to engage in the therapy available.

We have guidelines about physical activity which you will be expected to keep to. They reflect our concern to look after your physical safety.

You will be expected and encouraged to discuss and make decisions about the way you use your time outside the therapy. Increasingly this will be an important part of your treatment as you progress towards leaving. Getting used to making decisions about your life which are not just about food and body shape will, we hope, be a welcome development.

Catering Guidelines

These Catering Guidelines are designed to give you information on what is expected during your stay at The Retreat, in order for you to meet your individual dietary requirements and be able to manage eating in a normal way. You will have the opportunity to discuss these guidelines with the Dietitian. You will be required to both plan your meals and keep a food diary at all times, including any meals you are planning/having away from the unit.



Meals will be provided as follows:

Breakfast

Breakfast is available from the unit and will comprise of the following:

- Cereal (full bowl with a cupful of milk) +
- 2 toast (wholemeal or white) +
- 2 butter/margarine pats +
- Jam/marmalade if desired.

Lunch

Lunch is provided from the hospital kitchens. You can make your own choice from the menu, but will be encouraged to take a variety of the different foods available. These will be discussed with the Dietitian. You will be expected to choose one cooked meal per day, varying throughout the week.

You will be expected to choose:

- A protein food eg meat, fish, egg or vegetarian main dish.
- A starchy food eg potato (any kind), pasta, rice or bread.

This will be served with vegetables if a cooked meal is chosen or salad if it is a snack meal.

There will be a choice of dessert from either:

- Pudding & Custard / sauce / ice cream (a minimum of three times a week)
- Milk Pudding

On the occasion when it is a roast dinner, potatoes can be ordered as ½ mash and ½ roast.

Evening Meal

Again, the hospital kitchens will provide this and you can make your own choice from the menu, to be discussed with the Dietitian. You will be expected to select from:

- A protein food
- A starchy food
- Vegetables / salad
- Dessert

Supper

You may choose from the snack list.



Snacks

These will be added at an appropriate time in the programme, as negotiated with the Dietitian. Snacks are to be chosen from the snack list.

Snack meals, sandwiches and salads

This type of meal can be chosen at either lunch or evening meal, but should be limited to once per day and not requested at both mealtimes.

When choosing a snack meal ie a sandwich and side salad or a jacket potato with a filling and salad, the salad must be accompanied by one of the following:

- Pasta salad
- Coleslaw
- Potato salad
- Crisps

Rationale

This will allow you to challenge a variety of different foods, rather than becoming dependent on lettuce, tomatoes and cucumber.

You must choose a minimum of three salad items, which will then be served by staff.

Meal Options

The following dishes are available as double portions to have with no additional carbohydrate or protein:

- Cheese, tomato and mushroom welsh rarebit
- Spinach and red pepper lasagne verdi
- Pasta lentil bake
- Macaroni cheese
- Tuna, tomato & courgette pasta
- Cottage squeaky pie
- Spaghetti bolognaise
- Fisherman's pie
- Vegetable lasagne
- Pasta tuna bake
- Shepherd's pie
- Vegetarian pizza



Rationale

The above dishes have an adequate carbohydrate and protein content, which with the addition of vegetables or salad allow a balanced meal. All other pasta/potato dishes are inadequate in their carbohydrate or protein.

The following dishes are available as double portions to have with no additional carbohydrate, but require the addition of grated cheese as there is insufficient protein:

- Capsicum and chickpea cous cous
- Vegetable fusilli
- Italian style peppers

Dislikes

The dislikes are individual genuine dislikes and not categories of food or main meals. You are allowed 3 dislikes. If a food appears on the menu, which has not been specified as a dislike and is part of a meal, then either the whole meal must be eaten or a different choice selected. (This is most likely to occur with foods such as Yorkshire puddings, stuffing, dumplings etc). If the specified food is a dislike eg stuffing, a different food choice should be made.

Rationale

It is difficult to determine what is a genuine dislike and what is an anorexic behaviour. By limiting the amount of dislikes, you will be encouraged to try foods that you would have previously avoided, thus increasing the variety of foods consumed.

Condiments

- Any individual difficulties in this area should be discussed with nursing team.
- 1 sachet of salt, pepper or vinegar is considered a portion.
- No more than 2 types of these condiments may be used at any one meal time.
- 1-2 sachets of sauce is considered to be a portion, but if 2 different sauces are chosen, only 1 sachet of each can be used.
- No more than 2 different sauces may be used at any one meal time.
- If a dish already contains sauce eg cauliflower cheese, this will count as a sauce portion.
- 1 dessert spoon of pickle may be added to salad or cold meat.
- Marmite and other condiments not mentioned may only be added when agreed with the Dietitian.

Rationale

This reflects what is normal for most people and what is expected when eating out.



Dining Room Boundaries

- The cutlery provided should be used to eat the meals.
- Puddings/desserts should be eaten with a dessert spoon. A teaspoon should only be used when the dessert is in a small pot eg yoghurt.
- Sandwiches should be eaten with hands, not with a knife and fork.
- Food should be eaten on the one plate that it has been served on and not several different ones.
- The table should be left set as it is, not moved around.
- Everyone is to attend meals and snacks on time.
- All patients on the eating disorders programme are to leave the dining room together (which includes no-one going to the toilet at mealtimes).
- All patients are to support one another throughout the meal and in post-meal support.

Rationale

This reflects what is normal for most people and what is expected when eating out. It also allows peer support for those patients who are struggling.

Self-catering/Meals out

- All meals that you want to self-cater or eat away from The Retreat, including home leave, will need to be agreed in the multidisciplinary team meeting.
- All meals, including self-catered meals, are to be eaten in the dining room unless an individual is catering a specific meal with a member of staff eg in the Occupational Therapy kitchen or in your own home.
- If it is agreed that an individual is able to begin practising meals outside of the unit, this is to occur only once a week; 48 hours notice is required and the practice meal is to be planned and discussed with a staff member before the meal out.
- If you are self-catering, you will still be required to attend post-meal support unless you are away from The Retreat or you are with a member of staff.
- Nearer to discharge, you will increasingly be able to practice eating away from the unit and so some of these catering guidelines will not apply to you. However, any changes will need to be agreed in the multidisciplinary team meeting.

Rationale

This promotes a balance between allowing you to practice taking some responsibility for meals, but also allows staff to identify individuals who are struggling and offer support.



Diet Food

- No diet, reduced fat, slimming foods should be brought onto the unit. This includes diet drinks eg diet coke.
- Cottage cheese is only allowed once a week.
- All-bran and other diet cereals are not allowed on the unit.
- No other food, except fruit, should be eaten outside of agreed menu plans. The quantity of fruit eaten should be discussed with the Dietitian.

2 portions of vegetables should be chosen at a meal. If one of the vegetables available is a dislike from the individual's choice of 3 dislikes, then a double portion of the other vegetable option is to be taken.

Rationale

This prevents you from becoming dependent on diet foods and allows you to understand that these foods are not required in a balanced, healthy diet.

Stages of Therapy

Recovery from an eating disorder is not just a matter of gaining weight. People develop eating disorders in response to their experiences, and become very used to being preoccupied by their thoughts about food, weight and shape. During recovery, it is necessary to make the physical and psychological adjustment to living once more at a 'normal' body weight, and to attend to underlying psychological difficulties. In addition, it is necessary to find new and less self-defeating ways to handle the demands of life.

We think of recovery as following a broad path, which might be thought of as consisting of a series of stages. These stages are not rigid, and people may move backwards and forwards between them, but they are helpful in trying to focus your mind on the central tasks of recovery as you follow your path. The focus to begin with is on physical safety and establishing a safe and stable eating pattern. The focus will shift towards the underlying psychological difficulties as you progress through the programme.

Admission Stage

Central tasks:

- Orientation and familiarisation with the programme
- Motivation and Commitment to joining the programme
- Assessment of Physical Health

Staff will:

- Meet you for Assessment; show you round the unit; describe the programme; give you this Personal Information File



- At the time of admission, gather information from you about you and your eating problems
- Work with you on motivation to accept treatment
- Do a physical assessment

Stage 1 (BMI <15)

Central Tasks:

- Establish a safe and reliable eating pattern
- Get used to routines of the unit
- Initiate and tolerate weight gain, and BMI as guideline
- Extinguish 'compensatory behaviours' (vomiting, purging, exercise, etc.)
- Commit to physical recovery as step towards full recovery
- Engage with group and other therapies

Staff will:

- Help you with eating at the 'support table' and joining after-meal support
- Start you working with the Dietitian
- Keep a regular check on your physical state
- Help you develop strategies to self-soothe and manage distress
- Give you support and reassurance that recovery is recognised to be a complex process

Stage 2 (BMI 15 – 16)

Central Tasks:

- Accept weight gain as necessary for recovery
- Improve confidence with food
- Shift attention to emotional and psychological issues
- Recognise and identify feeling states, and link to behavioural impulses
- Identify psychological and other factors leading to an eating disorder
- Focus on psychological therapy

Staff will:

- Help you with a gradual move off the support table



- Start thinking about choice and preferences
- Work with you on exercise, fitness and health, and developing functional activity
- Start Body Image work
- Help you increase your confidence with emotion regulation and distress tolerance

Stage 3 (BMI 16 – 18.5)

May involve move to day patient attendance

Central Tasks:

- Develop self-confidence with eating and food management
- Focus on psychological and emotional work
- Address relationships
- Begin to use new skills outside the unit

Staff will:

- Start you in the 'Shop and Cook' group
- Help you plan eating out, and time away from the unit
- Plan with you to manage public transport, shops and other settings
- Start embodiment work
- Offer Family Therapy if it is appropriate

Stage 4 (BMI > 18.5)

Central Tasks:

- Accept 'set-point' weight
- Manage food with confidence
- Recognise psychological background to an eating disorder
- Prepare for Discharge

Staff will:

- Arrange with you to eat in a range of settings, and learn to manage food with confidence
- Work on an 'emergency' eating strategy, risk prediction, and relapse prevention
- Help you make plans for work, leisure and life activities; focus on choice and preferences



- Help you practice emotion regulation and distress tolerance skills
- Sort out discharge plans including continuing therapy

Stage Zero (0) - risk management

For times when risk makes engagement with therapy impossible and the patient effectively returns to a state prior to Stage 1.

Central Tasks:

- Assess risk – suicide; dangerously low weight; failure to manage safe eating; other possibly life-threatening behaviours
- Contain and manage risk
- Resume recovery path

Staff will:

- Focus on risk assessment.
- Continue physical monitoring
- Maintain observation and support
- Ensure you have adequate nutrition
- Consider assessment for using the Mental Health Act if necessary
- Involve other agencies (eg Physicians at the General Hospital)
- Deal with the triggers for the difficulties
- Go back to motivational work
- Inform the referring team

Physical rehabilitation

Learning how to be active and to exercise in a balanced and safe way is an important part of recovery. During your stay we will try, with the help of our physiotherapist, to help you recognise the dangers of over-exercise, and to develop a plan for safe physical activity.

An overview of the priorities of each stage of rehabilitation is described here using BMI as a guideline, as it reflects your physiological recovery. We do recognise that other factors will need to be taken into account in agreeing individual programmes.



BMI <13

Priority: physiological stabilisation.

At this point you are expected to rest in the unit or in bed when you are not in groups or at meals. The focus is on establishing an effective pattern of eating and drinking, and on medical monitoring. This means a wheelchair is used indoors, for example to get to the dining room. Time outside is limited to sitting on a bench immediately outside the unit.

BMI 13 – 15

Priority: function

There is a gradual increase in functional activity and a decrease in wheelchair use indoors. At BMI 14 you can be accompanied outside in a wheelchair for 20 minutes daily.

BMI >15

Priority: physical activity which emphasises things other than stamina and strength – eg balance, body awareness, coordination, position sense and posture.

At BMI 15 you can go out unaccompanied for up to 20 minutes, and go out in a car if there is no more than 20 minutes walking involved. This would need to be fitted in between meals and snacks. At BMI 16 you can go out for up to an hour unaccompanied.

In-house Tai Chi or Yoga are available at this stage onwards dependent on the availability of an instructor.

BMI >17

Priority: recreational activity, eg walking, swimming, cycling, gardening, dancing. Building links to the community.

The emphasis is on doing physical things that have a meaning, not just exercising to burn energy or lose weight. By the time you are discharged, we hope you will have a clear idea of how to incorporate exercise and activity into your lifestyle in a way which is safe and life-enhancing, and which you can continue independently.

Medical Management

The management of the physical risks of your eating disorder is clearly an important element of our work, especially in the early stages of treatment. We work to a standard protocol which helps us make safe decisions, and we monitor your physical health as



you progress. If we need to, we can call on the help of medical specialists from York Hospital.

We do not use nasogastric feeding in this treatment programme, and would try hard to prevent the need to do so from arising. It could be used if a person is dangerously undernourished, and not able or willing to eat adequately. We expect that assertive and calm handling of the difficulties that emerge during treatment will help to avoid this situation.

In the rare event that nasogastric feeding cannot be avoided, we would arrange for this to be done in a medical ward, in a collaborative effort shared between us and the medical team.

The Mental Health Act

The Mental Health Act (1983) does give psychiatric teams the powers, under extreme circumstances, to compel someone to stay in treatment for Anorexia Nervosa even if the person does not want to. This is because at a low weight you may be unable to make a competent judgement about your best interests, and this competence would improve if you were better nourished. We would try to avoid using the Mental Health Act, but would be prepared to do so if it is necessary to save your life or prevent further serious harm to you. In this situation you would be told what is happening, and we would be sure you had access to Advocacy and to legal advice. You could appeal against your detention, and the means to do this would be explained.

Detention would be maintained for the shortest possible time, and we would work hard to regain a collaborative approach to your problems.

Summary

We really want this treatment programme to be useful to you and to others. This will only be the case if everyone, staff and patients alike, are doing everything they can to make it work. Recovering from an eating disorder is difficult, and needs patience, determination and attention to detail.

If you have any queries, require further information or wish to visit please contact the Naomi unit on 01904 412551 ext 2903.





ISSUE VERSION: ng/1003

Heslington Road York YO10 5BN t: 01904 412551 f: 01904 430828
e: info@theretreatyork.org.uk w: www.theretreatyork.org.uk

Registered office: The Retreat York Heslington Road York YO10 5BN
Registered in England and Wales No. 4325622 A Registered Charity No. 1089826



INVESTOR IN PEOPLE