PROSPERITY HOUSING GROUP

Prospering Lives For The Good Of The Community

# Personalisation, Prevention, Recovery Supported Living Service For Adults with Mental Health Needs

We Bridge The Move From a Residential or Hospital Setting To Supported Living For Adults With Mental Health Needs

# WELCOME

Prosperity Housing Group (PHG) is a CQC registered Supported Living Services for adults, aged 18–65 years old who have a diagnosed mental health condition, learning disabilities and autism and those with dual diagnosis; who require care and housing support, but do not need to be in inpatient care. At Prosperity Housing Group all service users have separate tenancy agreements and service user care agreements. We recognise that people living with mental health conditions can find it challenging to live alone, to manage day to day tasks and often, experience difficulty in finding and keeping a home.

We provide safe and effective care and support for people in a shared housing communal setting with their own tenancy agreements, to enable them to develop life skills and independence, as an important part of their recovery; along with access to services that enable those with mental health conditions to live as independently as possible. Our service provides support for people who are experiencing an escalation in their mental health to either avoid hospitalisation or those who are being discharged from hospital. We provide a planned pathway to a more independent lifestyle.

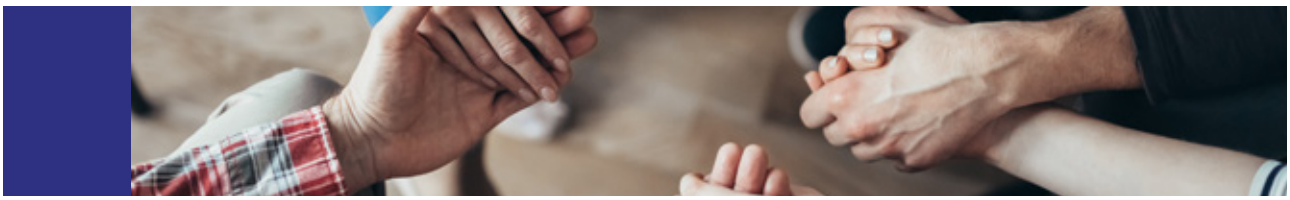
Our ambition is to empower service users with long-term complex conditions to receive specialist care in a supported therapeutic home environment. We also encourage self- management and independence by preventing crisis escalation, improving access to other services, accelerating treatment provision, and providing effective care planning.

# OUR PROVISION

We provide bespoke packages of care, giving our customers the time and space they need to recover. We use a mix of evidence-based and supportive therapies, together with our Prosperity Pathway to recovery. This powerful combination provides a positive journey to recovery for each individual service user. PHG offers a sensitive environment that enables men and women to take control of their own lives. This may then help them live independently and appropriately in the community. PHG prides itself on being diverse and accepts all adults who have mental health conditions and learning disabilities from various religious, cultural, ethnic and sexual orientation backgrounds.

## We Believe In The Modern Collaborative Model to Recovery

- The Long term orientation to care
- Relapse prevention
- A holistic approach to health and wellbeing
- Social model based on individual needs
- Reintegration into society and social roles
- Local rehabilitation and improved quality
- Promote social interaction and engagement
- Establishing stable relationships in a safe community to positively reinforce the individual's commitment to change



# PERSON CENTRED CARE AND SHARED DECISION MAKING

- Receive a personalised model of Supported Living to support the move on process to independent living in the service users own home or less supported accommodation.
- Develop new skills that prepare our service users to live independently.
- Become more engaged in health promoting lifestyle activities, such as taking part in exercise, eating healthier foods, managing stress levels and maintaining better relationships with health professionals.
- Engage in education and/or training and employment opportunities.

# OUR FOCUS

- We work alongside the service user to identify and eliminate barriers that result in extended stays in hospital, with the aim of preventing admission/readmission into inpatient treatment.
- Promote integrated discharge planning which involves collaboration with hospital services, GPs, public health nurses and other professionals.
- Adopt a service users centred approach to discharge and a smooth transition into our Supported Living Service.
- Work towards the reduction of lengthy hospital stays and a prevention of readmission so that service users do not remain in inpatient care longer than necessary.
- Minimise the risk of harm to service users and others through effective risk assessment and risk management.
- Ensure the best network of health, social care and informal support is in place for our Service Users so they receive the appropriate support they need within the community.
- Adopt a strengths based approach focusing on the positive attributes of a person.
- Work with community outreach services to support people to become more confident, participating in community related activities and maintaining family contacts.

# WHO WE SUPPORT

- Men and Women aged between eighteen (18) and sixty five (65).
- Adults who are entitled to section 117 after-care who are under what is known as the Care Programme Approach (CPA), continuing care and informal patients.
- Have complex mental disorders as the primary support need, with comorbid difficulties such as but not limited to Attachment Disorder, Atypical Depression, Obsessive Compulsive Disorder, Bipolar Disorder, Personality Disorder, Depression, Schizophrenia,Eating Disorders and a range of other disorders
- A learning disability and/or autism who have a mental health condition such as severe anxiety, depression. Or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
- Supported Accommodation for Young People: 16+ Children Looked After and 18+ Care Leavers
- 2:1/ 3:1 DOLs provision for high support need young person
- Men and women involved with the criminal justice system and or leaving prisons, with mental health conditions which are linked to offending or seriously irresponsible behaviour.
- A history of long-term hospitalisation, a number of admissions to hospital or at risk of becoming institutionalised.
- Currently residing in a time limited service for people with mental health support needs.
- Medication support needs, promoting the safe and effective use of medicines and ensuring that suitable and high quality care is provided to service users.
- Financial support needs, paying bills, shopping, budgeting, money management and accessing benefits including direct payments and personal budgets.
- Activities of daily living support needs.
- The individual agrees to continuing a programme of rehabilitation within a Supported Living setting.
- Each person must have a named care coordinator from a Community Mental Health Team or Outreach Team and written care plan under CPA.

# OUR UNIQUE THERAPEUTIC PROGRAMME

## The Prosperity Pathway Framework

Is a model that focuses on social and emotional capabilities that are of value to our service users demonstrating their link to outcomes such as educational attainment, employment, healthy relationships and independence in the community.

The Framework outlines a step by step approach to measuring these capabilities in practice.This Framework will help to address the key challenges and impact on the lives of our service users. We focus on reducing negative outcomes and sustained personal, social and emotional development, which evidence shows is fundamental to current and future wellbeing and success. Each service user identifies key areas in their lives where they require development and staff support them to set goals in these areas. These goals will be reviewed every 6-12 weeks depending on what is outlined in the care plans. The setting of goals ensures the treatment and support the service users receive is specific, measurable and focussed on the service users working towards independence.

Key areas include managing mental health, managing physical health, self love and care, living skills, healthy relationships, creating and maintaining boundaries, education, employment, responsibility, identity, self respect and self esteem.

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## Key outcomes include:

- **Personal and social development:** through which our service users develop social and emotional capabilities, including determination, self-control, persistence and self-motivation.
- **Social and emotional capabilities:** soft skills or non-cognitive skills, communication, creativity, self confidence, managing feelings, problem solving, leadership skills, resilience and self esteem.
- **Developing social, communication, and team working skills:** the ability to learn from experience, control behaviours, and make good choices. Developing the self-esteem, resilience, and motivation to persist towards goals and overcome setbacks.
- **Educational development and achievement/ career success:** Participation in training, literacy and numeracy, community courses, and activities, taking advice on services to improve education, budgeting and tenancy support.
- **Being Healthy:** Psycho-education, dietetic education, meal planning and preparation, self regulating and behavioural skills and changing thought patterns.
- **Positive relationships:** Those which can also be measured and valued by other people, accessing public services, local communities, and family networks. Having positive relationships, involvement in meaningful, enjoyable activities.

The skills required to achieve these goals will be developed and nurtured during one to one and key worker sessions. We also work with external services and organisations who are able to provide further support such as therapy with the overall aims being rehabilitation and the prevention of deterioration.

## Person Centred Approaches

- The use of assistive technology
- Non restrictive practice
- Personalised key working sessions
- Bespoke environments
- Self advocacy and inclusion in support planning
- Individualised support plan and narratives.

We provide a person centred, caring and professional service to all our service users. The service is tailored to the needs of each individual; hence we can adapt and personalise our care and support service to meet the needs and wishes of each client.

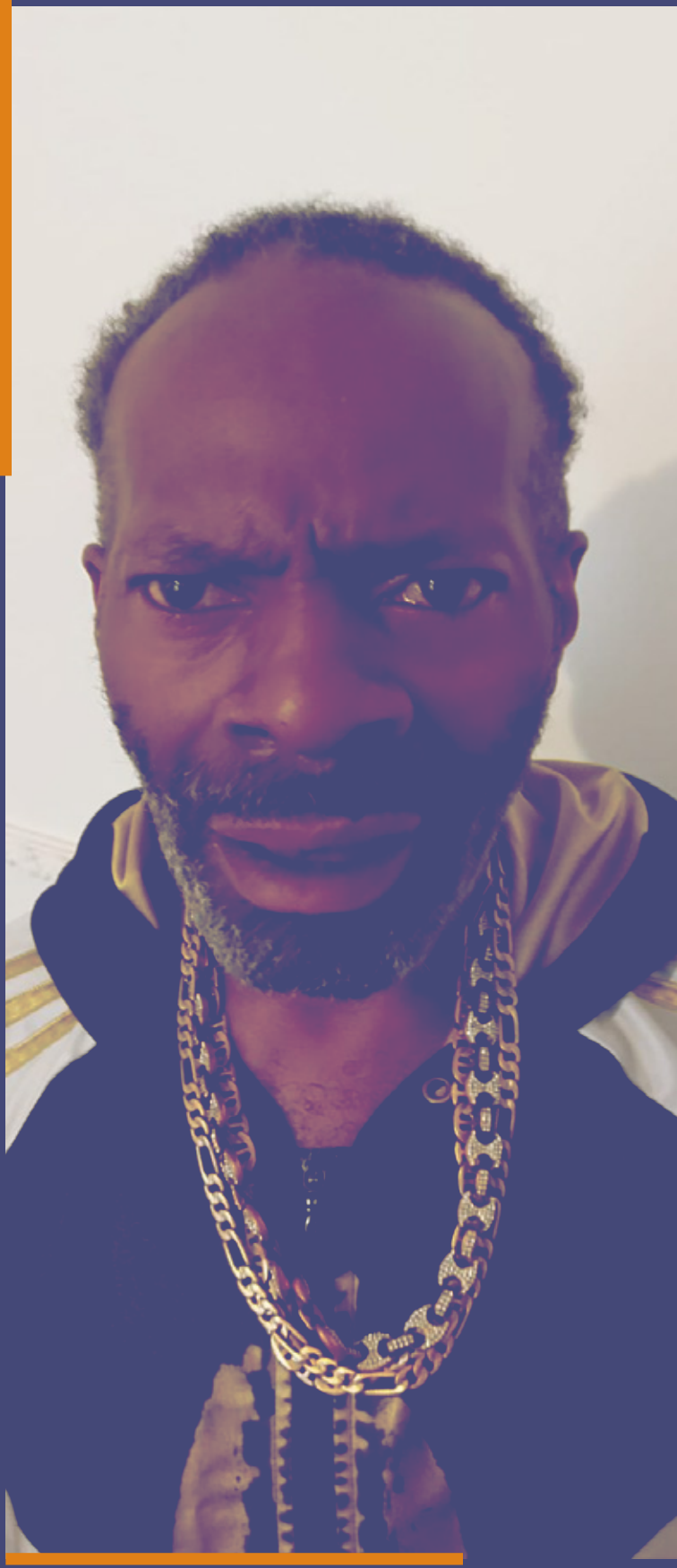
# SERVICE USER CASE STUDIES

## Pam

Before moving to PHG she had not left her home in over 12 months, had not completed personal care for several months and was living on sandwiches, soup and microwave meals. She would not change her clothing and would spend weeks in the same items of clothing. She was unable to manage her own mental health and would not take prescribed medication.

She now accesses the community daily to purchase food and other personal items such as toiletries, clothing and personal items for her room. She will also access the community with staff for activities such as going to the hairdressers fortnightly for a wash, cut and style and will regularly go for food and drink in local pubs and coffee shops and loves nothing more than a good pamper session and manicure from the staff. She will shower and change her clothing daily and wear appropriate clothing for each activity, and regularly attends appointments to support with her mental health. She has had a video call and letters with her son who's taken into care.

# Donovan



Before moving to Paula's house he was in debt and spent his money on drugs, alcohol and takeaways and would often go several weeks without finances. DL is now able to follow an agreed budget plan to ensure he has money to buy food, to prepare fresh meals daily. He has recently purchased a mobile phone so he is able to communicate daily with family members and he budgets to top up his phone as and when he needs to. He has purchased new clothes and items for his bedroom and was able to buy gifts for his family for Christmas.

Since DL has agreed to his budget plan he has access to money whenever he needs it and does not run out of food or tobacco. He takes pride in cooking his Caribbean food. He is managing his home environment well and brought himself carpet.

# Mark

Mark arrived to our service in December 2022 from a secure mental health hospital. He had been a resident their for a year and as a result his independent living skills were limited. He came to Paula's house as a transition over fears he would try to abscond as soon as he was discharged from hospital and due to specific behaviours that could result in harm to Mark and other and the community this was a concern.

Mark settled well into the service straight away and immediately developed trusting relationships with staff and his fellow peers at the home. His independent living skills soon improved significantly with encouragement and support from staff and is now preparing most of his own meals again. Mark also enjoys accessing the community with staff safely. He will attend the local pub for a game of pool and to the local café for his breakfast. Mark understands he needs to listen to the staff when in the community to remain safe and always pays attention to what they say.

When Mark first moved into the service there were frequent episodes of Absconsion due to wanting to go to the pub to have an alcoholic drink. These incidents have reduced significantly since the staff have worked with Mark to understand they he able to have a drink but it must be done in moderation and staff are happy to support him to the pub whenever he wishes to go and have a game of pool with him or something to eat.

Mark attended a trip to Blackpool with the other service users and staff and had a great time, he listened to staff and was able to maintain his safety, he communicated what he wanted to do whilst on the trip and was supported do them so Mark felt no requirement to abscond.

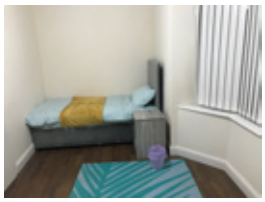
Mark engages well with staff in all areas of his care and will speak to staff if he is upset so issues can be resolved.

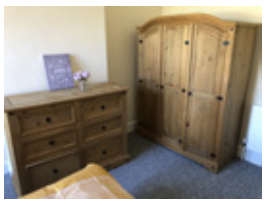
With support with budgeting Mark is now able to manage his finances more effectively and has access to a bank card which he can use in the community, he also has access to an agreed daily cash amount for Mark to spend on whatever he chooses.

> RECOVERY IS NOT ABOUT A CURE, **IT'S ABOUT HOPE AND GIVING MEANING TO THE DISTRESS AND CHAOS THAT CAUSES MENTAL HEALTH.**

## Accommodation

Our Supported Living Service recognises that prospective tenants should have the opportunity to choose a home, which suits their needs. All homes are single sex with a mixture of ensuite and shared bathrooms in the Havering and surrounding areas . All are close to local transport links and local amenities. Our evidence based framework is a planned pathway to increase independence, self management of their mental, physical health and well being. Our aim is to support their recovery in the community to sustain their own tenancies. Each home is newly decorated, well equipped and the resources are continually reviewed and expanded to maintain a high standard. Each room is thoughtfully decorated and furnished and this includes a wardrobe, chest of draws, bed and chair. There is a communal dining room providing a comfortable environment for that important interaction around mealtimes. There is a main lounge and garden area for relaxing and socialising. The Supported Living Service provides a homely environment in order to challenge institutionalisation whilst promoting supportive structures and routines for our service users to live a high quality Life.





### To facilitate that choice we do the following:

Each service user has their own 'tenancy support package', which is tailored to meet their individual needs

- Each customer has an individual Assured Shorthold Tenancy
- Comprehensive assessment by a Mental Health Nurse
- Interventions that take into account the personal goals of the customer
- Person centred care which allows service users to measure their own progress with the support of their key workers and staff
- Relapse prevention
- Immediate care following inpatient treatment or relapse in the community

### Discharge To Access Beds

We offer intensive, short-term support to help manage a mental health crisis within our homes (rather than in a hospital).

- Overnight accommodation
- 2-5 day accommodation
- A small number of beds
- Home-like environment

Referrals are to be made by The Local Crisis Team

You can call us on **01708 908028** or
email **havering@prosperityhousinggroup.co.uk**

# OUR CAPABILITIES

## Intervention and Recovery

Prosperity Housing Group offers a sensitive environment that enables service users to readdress issues pertinent to their specific needs and focuses on recovery, so that they can successfully reintegrate into the community.

## Thorough Care Planning

A highly detailed care planning system is operated based on a thorough pre placement assessment. As much information as possible is gathered to ensure we understand why the placement is being proposed. Care planning is to be arranged as soon the transition process begins.

## The Team Approach

It is vital that all teams function well together. The concept of team incorporates the mental health teams, social workers, support workers, dieticians, family members and carers. Each service users will have a key worker who is responsible for coordinating their care and with whom they can build a firm professional relationship.

To access our Supported Living Service simply **contact our central enquiries team or your local service directly 01708 908028** or email **havering@prosperityhousinggroup.co.uk** . They will be able to provide information on your options and arrange a convenient appointment for you.

# VISIT US

We encourage social workers, carers, individuals and families to visit our Supported Living Service following the assessment if we have an available placement. This will allow you to meet the manager and care staff, you will be able to have an informal chat and look around and get a feel for if the placement would be right for the individual. If the outcome of the assessment is that the service can meet the needs of the potential service user, they will then be invited to visit the property. This will give them the opportunity to look around, meet other service users in the property and ask questions or seek clarification about anything they are unsure of.

If the potential service user likes the service, there is an appropriate vacancy for them and funding for their placement has been approved, a transition plan is then agreed with the individual and others involved in their care. This can include both day and overnight visits to help the tenant settle into their new home. If there are no concerns from the tenant or the service during this transition period, an admission date into the tenancy is then agreed.

In the case of emergency admission requests, an initial assessment will be completed within 2 working days of referral. If the service can offer a suitable placement, and funding is confirmed, The Supported Living Service will inform the new service user of all-key aspects, procedures and routines of the property within two days of admission. Prior to admission, a review plan will be agreed with the potential tenant and their care team and contingency plan confirmed as to what actions will be taken if the placement becomes unsustainable. The placement will be formally reviewed in the sixth week and a decision made on whether support can be continued.

# FUNDING PLACEMENTS

Once the assessment and initial visit is complete and it's agreed that the placement will meet the individual's care needs, we will provide a costing to the commissioning authority to be reviewed by the funding panel. If agreed, the placement is confirmed.

Each local authority has their own eligibility criteria, based on the national criteria outlined in the Care Act. They Complete a Care Needs Assessment (CNA) to discuss your care and support needs and help you maintain your well-being and independence. The decision is based on the results of the assessment.

The local authority confirms how it will meet your needs in a Care and Support Plan, which sets out what services will be provided and when they will be provided.

# PHILOSOPHY OF CARE

It is a belief of the organisation and staff working at Prosperity Housing Group that change is always possible, and that behaviour is within the control of the individual. Each individual makes choices although not always with conscious awareness of themselves or of others. Any change in behaviour, thinking or feeling becomes the basis for wider changes to follow.

All people are therefore valued, are of value and are not written off or labelled because of their behaviour. We value diversity and seek to enlighten those we work with to see this value also. It is essential that the environment we create is a safe environment that promotes change, and that part of this is physical safety, therefore, we are not tolerant of dangerous or threatening behaviour. It is confronted and worked on and we expect the full support of referring agencies with this.

We recognise that all of our service users are individuals, and that suitable approaches and models may be different for each customer based on their strengths, interests and characteristics. We also understand that approaches need to develop over time as each individual grows and develops (both physically and emotionally). This may be due to their emotional state, level of understanding, chronological age or even an approach that captures their imagination helping them to engage. The care staff at Prosperity Housing Group will work towards positively developing individual qualities, which will give our service users an opportunity for personal growth and development.

# HOW TO MAKE A REFERRAL

## Referrals may be made through:

- The individual's Social Services Department management team or, if relevant, their local Health Authority
- Contact Us directly by calling our office **01708 908028 or email us at havering@prosperityhousinggroup.co.uk**

**www.prosperityhousinggroup.co.uk**

*This leaflet can be translated into other languages, large print and Braille or recorded on to an audio CD. Please contact us for details.*