Sturdee Specialist Mental Health Rehabilitation Hospital

Supporting women with complex needs through rehabilitation and on-site semi-independent living

About Sturdee

Sturdee is a specialist female Level 2 mental health rehabilitation service for women aged 18 and over. The service comprises 22 inpatient beds across two wards and nine on-site semi-independent apartments, providing a structured pathway from high-support rehabilitation towards greater independence and community living. Sturdee supports women whose clinical, behavioural and relational needs may challenge conventional inpatient or community services.

The pathway includes:

Foxton Ward – a high-support rehabilitation environment for women requiring greater structure, relational security and intensive multidisciplinary support.

Rutland Ward – a step-down rehabilitation environment supporting the development of independence, community access and everyday living skills.

Aylestone Apartments – nine on-site semi-independent apartments enabling women to test and strengthen their independence while retaining access to the support of the Sturdee team.

A Pathway Built Around the Individual

Our approach combines clinical expertise, psychological understanding and consistent therapeutic relationships.

Enquiries & Referrals:
T: 0330 236 8231
E: referrals@ihcm.co.uk

We work with each woman to understand the factors underlying her presentation, build trust, manage risk safely and support meaningful progress at a pace that reflects her needs and recovery goals.

The Hope Recovery Model is embedded throughout the service, focusing on individual strengths, hope and the development of a meaningful life beyond hospital.

The Sturdee Recovery Pathway

Sturdee provides an integrated pathway from high-support rehabilitation through to on-site semi-independent living. This continuity allows women to progress without unnecessary changes of provider or clinical team and supports carefully planned transitions towards less restrictive settings.

We recognise that recovery is rarely linear. The pathway is therefore flexible, allowing the level of structure and support to increase or reduce in response to changing clinical need, risk and progress.

1. Understanding the Person

- Comprehensive multidisciplinary assessment
- Psychological formulation
- Assessment of mental and physical health needs
- Trauma and attachment-informed understanding
- Review of risk history, previous placements and patterns of breakdown
- Collaborative recovery planning and goal setting
- Early identification of potential barriers to discharge
- Engagement with families, commissioners and existing clinical teams

2. Stabilisation and Relational Security

- Development of consistent therapeutic relationships
- Emotion regulation and distress-tolerance skills
- Relational and environmental security
- Trauma-informed care
- Positive and proportionate risk management
- Support to understand and reduce behaviours that place the person or others at risk
- Development of engagement, confidence and trust
- Meaningful daily structure and occupation

3. Active Rehabilitation

- Psychology-led and formulation-based interventions
- Development of independent living skills
- Occupational rehabilitation
- Community access and positive risk-taking
- Medication review and support with self-management
- Physical health and wellbeing
- Education, vocational and volunteering opportunities
- Family and relationship work
- Building resilience and relapse-prevention skills

Psychological interventions are determined by individual formulation and clinical need. They may include DBT-informed work, CBT, EMDR, Schema Therapy and other trauma-informed approaches.

4. Step-down and Semi-independent Living

- Planned progression from Foxton to Rutland, where appropriate
- Access to the on-site Aylestone Apartments
- Increasing responsibility for daily routines and personal wellbeing
- Development of budgeting, shopping, cooking and household skills
- Gradual reduction in direct staff support
- Increased community access and use of local resources
- Testing independence while clinical and practical support remains available

5. Transition to the Community

- Discharge planning from the point of admission
- Partnership with commissioners and community mental health teams
- Identification of appropriate accommodation and ongoing support
- Graduated transition and planned periods of leave
- Clear relapse, risk-management and crisis plans
- Support to establish meaningful community connections
- Continuity and handover arrangements designed to reduce the risk of placement breakdown

Our Clinical Approach

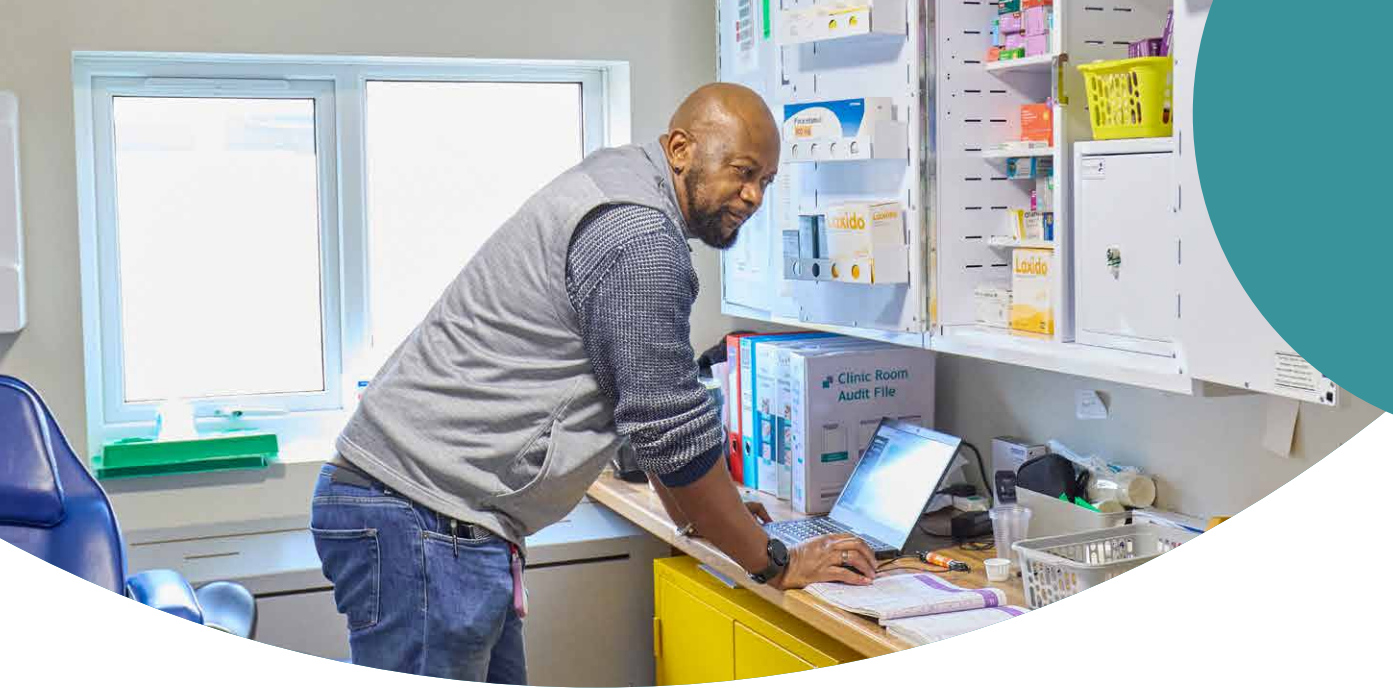
Sturdee is designed for women who require a service able to look beyond diagnosis and presenting behaviour to understand the individual, her history and the reasons previous pathways may not have succeeded. We are particularly able to consider women whose needs do not fit neatly within conventional service models and who may benefit from an individually designed package, an adapted environment or enhanced wraparound support.
Care is grounded in:

- Least-restrictive practice
- Trauma-informed and psychologically informed care
- Co-production and shared decision-making
- Relational security
- Positive and proportionate risk management
- Recovery-focused rehabilitation
- Active discharge planning
- Partnership with families, commissioners and community teams

Who We Support

Sturdee supports women aged 18 and over with complex mental health, behavioural and relational needs who require a structured and specialist rehabilitation pathway. This includes women whose needs may require a more individualised approach, particularly where previous placements or care pathways have been unable to support sustained progress.

The service supports women with diagnoses including schizophrenia and other psychotic disorders; bipolar affective disorder and complex emotional needs associated with personality disorder diagnoses. Women may also have co-occurring needs relating to trauma, emotional dysregulation or autism.



We welcome discussions about women:

- Stepping down from low or medium secure services who no longer require secure care;
- Considered for secure care whose needs may be safely managed within a specialist non-secure rehabilitation environment;
- Requiring a higher level of support than a conventional open rehabilitation service may provide;
- Moving from acute, picu or other rehabilitation services;
- With forensic histories or complex patterns of risk requiring positive and proportionate risk management;
- Experiencing repeated placement breakdowns, readmissions or stalled pathways;
- With extended inpatient stays who would benefit from a renewed focus on active rehabilitation; and
- Requiring a discharge to assess or care, recovery and further development pathway.

Each referral is considered individually. We work with the referrer, commissioner, existing clinical team and, wherever possible, the woman herself to determine whether Sturdee can safely meet her needs and support meaningful progression.

Bespoke and Responsive Packages of Care

For women with particularly complex needs, Sturdee can develop an individual package of care based on clinical presentation, risk, sensory needs, functional abilities and recovery goals.
Following multidisciplinary assessment and discussion with the commissioner, this may include:

- Individually tailored staffing arrangements;
- Enhanced multidisciplinary and therapeutic support;
- Personalised routines and rehabilitation programmes;
- Environmental or sensory adaptations;
- Structured relational and behavioural support;
- Additional support during admission, transition or periods of increased need;
- Phased progression between ward-based care and semi independent living; and
- Coordinated input from external specialists and community services.

Each package has clear outcomes and regular reviews, with the level of enhanced support adjusted as needs change and progress is made.

Why Sturdee?

- A complete on-site pathway from high-support rehabilitation to semi-independent living.
- Continuity of clinical relationships throughout the rehabilitation pathway.
- Specialist experience in supporting women with complex needs and risk histories.
- An alternative for some women who require enhanced support but do not need the restrictions of secure care.
- Flexible levels of support that can respond to changing needs.
- Bespoke care packages where standard service models have not been successful.
- Active rehabilitation and discharge planning from admission.
- Close partnership with commissioners, families and community teams.
- A clear focus on sustainable progress, greater independence and successful transition into the community.

Admissions and Referrals

On admission, safety and immediate needs are assessed and treatment started. Following this, there is a full MDT meeting where a full assessment is completed, and care and treatment discussed in consultation with the patient. Discharge planning starts at the point of admission.

The Central Referrals Team coordinates enquiries,
information gathering, assessment and funding discussions and keeps referrers informed throughout the process.

Central Referrals Team T: **0330 236 8231** E: **referrals@ihcm.co.uk**

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