Gala Resource Centre

A review of services provided by the Gala Resource Centre to inform future planning

1. Introduction

The Gala Resource Centre (GRC) is a partnership service jointly funded by Scottish Borders Council (SBC) and NHS Borders (NHSB), offering building-based day service support to adults aged 18 and over with mental health challenges. It was originally established to meet the care and support needs of people with longer term, severe and enduring mental ill health (such as schizophrenia, bi-polar disorders) following the closure of Dingleton Hospital, offering a more community-focused model of delivery.

GRC is located within Galashiels and provides centre and community-based leisure, interest and skills-based courses indoors and outdoors, where individuals can access support to regain and develop their existing skills, strengths and abilities. GRC does not offer an accessible service to those living out with central Borders. Many of those accessing GRC for support over this time reported positive experiences and benefits, but evidence of impact was not routinely gathered.

An independent evaluation of GRC carried out by Figure8 Consultancy (2017), made recommendations for improvement. These recommendations were not implemented and GRC continued to evolve operationally in response to changes in staff and referrals being directed to them for support.

GRC resources (building and staff) are owned by Scottish Borders Council and NHS Borders yet are not linked in strategically to Joint Mental Health Services. As it is not a commissioned service there is no contract with agreed service specification, routine monitoring, or oversight. GRC has not routinely been included in broader transformation work across adult Mental Health Services. The tables below lay out the staffing details and costs of the service as it currently is across both the NHS and SBC.

NHS Borders Component:

	Budget	**Funded (WTE/Hours)**	**Current (WTE/Hours)**
Band 5 Nursing	£39209	1 / 37.5	0 / 0
Band 6 Nursing	£12495 (£1398 from MH Innovation fund)	0.2 / 7.5	0.2 / 7.5
Band 7 Nursing	£33726	0.8 / 30 (0.41 of which is fixed term)	0.8 / 30
TOTAL	£85430	1.78 / 51.38	1 / 37.5

Scottish Borders Council component:

Annual Budget		Current (WTE/Hours)
£146,026	Grade 7 Day Centre Officers	3.85 / 144.63
	Grade 4 Peer Practitioners	0.32 / 12
	TOTAL	1 / 37.5

Add annual building maintenance costs (excludes cleaning) – approx. £5,200 (2019/20)

Total combined budget: £236,656

The onset of the COVID-19 pandemic brought with it severe restrictions on face-to-face service delivery, including for Mental Health Services. As a result, GRC was temporarily closed to allow staff to be redeployed elsewhere. Those accessing the service were either assessed as being ready for discharge or referred to alternative services for support, mainly the Local Area Co-ordinating Team (LACT) or Health in Mind.

There remains a need to address issues highlighted by the Figure8 evaluation which has been exacerbated by the transformation of Mental Health Services round about GRC. The recent closure of the Centre has presented an opportunity to carry out a review and consider longer-term plans for the service.

This review will examine the role and function of GRC, identify if there are areas of unmet mental health need, and consider if/how a revised version of the service might meet these needs. It should also explore whether recommendations previously made by Figure8 still apply.

Any possible future service model must fit with other strategic priorities, provide effective, responsive and integrated support, offer equality of access across the region, and make best use of available resources.

2. Background

In 2017, Figure8 Consultancy were commissioned to independently evaluate the GRC service. Recommendations included:

- the need for a permanent management post
- development of a clear service model
- greater IT capacity (to facilitate monitoring)
- a need for more joint working with other services
- greater emphasis on the recovery agenda.

These recommendations were not implemented. Interim managers continued in post and GRC evolved in a way that aligned more with Primary Care rather than Secondary Care Mental Health Services. Many of those accessing GRC for support over this time reported positive experiences and benefits, but evidence of impact was not routinely gathered.

Since that Figure8 (2017) report there have been several other developments in local Mental Health Services. These include the formation of the Local Area Co-ordinating Team (LACT), the Wellbeing College, a Distress Brief Intervention service, and latterly, the 'Renew' service offering psychological therapy for mild to moderate anxiety and depression. Between them, these services now offer a range of early intervention, treatment and recovery supports for mild to moderate mental health challenges.

Figure 1 below sets out the current range of mental health supports and services in the Scottish Borders using a Tiered model of care. GRC is a community-based, specialist mental health provider that offers recovery-orientated care and support at Tiers 2 and 3. However, it is presented here in Tier 3 as it currently, requires referral from a GP or health and social care professional to access the service.

JOINT MENTAL HEALTH SERVICES (Adults) PATHWAYS

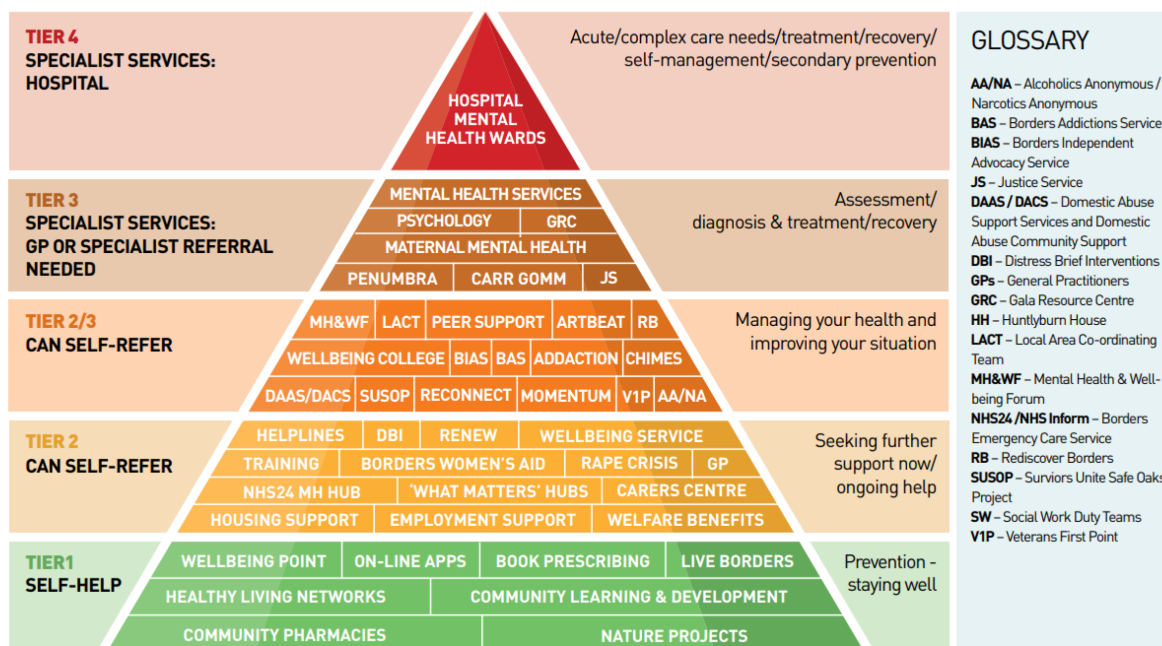

Figure 1: Joint Mental Health Services (Adults) Pathways (Scottish Borders Health and Social Care Partnership, 2019)

This shows an extract from a Mental Health information resource was created to support that work by mapping out what supports, and services are available for adults and how to access them. It is based on a 'Tiered Care' model that shows what is available for those with different levels of need, including:

- **Tier 1:** Self-help, prevention orientated services that enable people stay well
- **Tier 2:** Front line services offering urgent help when issues start to develop (accessed through self-referral)
- **Tier 2/3:** Help and support to help you managing your health (accessed through self-referral, mostly to the voluntary sector)
- **Tier 3:** Community-based care and treatment for those with more severe mental ill health (GP referral needed)
- **Tier 4:** Hospital in-patient care and treatment for those with more acute, severe or complex care needs

Support and services are grouped in two main categories - those specifically for individuals with mental health needs (including those around addiction or trauma) and some that might commonly be

used around general health and well-being. This resource can be accessed online by clicking on 'your local mental health services at: www.nhsborders.scot.nhs.uk/wellbeingpoint

There have been several developments in mental health services over recent years that have incorporated statutory and commissioned services, including.

- **LAC Team** - offers support for those with mental health issues to connect with local community resources (also offers support for those with learning disabilities and older people).
- **Health in Mind** - a voluntary sector organisation that offers a range of services including the Wellbeing College, peer support services and befriending.
- **Distress Brief Intervention service (DBI)** - offers short-term support for those presenting to GPs and other front-line services in distress.
- **'Renew'** – a new service available in primary care that offers help to those presenting with mild to moderate anxiety and depression.

In addition, there are plans for the Borders to take part in a national pilot to develop services for those with complex psychosocial needs. This could offer additional supports tailored to meet some needs not currently being addressed.

It is though also the case that some services have ceased to operate or been transformed with new service providers. These include some that previously offered supports to those with longer term mental ill health (New Horizons peer support groups and Borderline – a telephone helpline with many regular callers).

Services for adults with autistic spectrum disorders and mental health difficulties have been commissioned from an Edinburgh-based organisation (Autism Initiatives). This offers post-diagnostic support on a group basis in Edinburgh with some outreach activity in the Borders. This creates some barriers to access for those unable or unwilling to travel and has already been identified as an area for consideration with a view to improving access.

3. Review Scope

The aim of this review is to ensure that people with mental health needs in the Scottish Borders can access the right support, at the right time, in the right place – a key strategic objective in the local Mental Health Strategy.

The specific objectives were:

- To scope and analyse current service delivery
- To identify gaps and areas of unmet need
- To provide evidence-based recommendations for the development of local specialist services.

This review will be informed by:

- National and local context
- Figure8 recommendations
- GRC activity and monitoring data
- Exploration of how this sits alongside other Mental Health Services (statutory and commissioned)
- A stakeholder consultation workshop
- Focus groups for those with lived experience including some that have accessed GRC.

Stakeholders included those with lived experience of mental ill health, people who had accessed support from GRC and other sources; and staff from GRC and other statutory and third sector mental health services. This process was supported by Border Care Voice - a local, independent, voluntary sector organisation that facilitates the involvement of those with lived experience and those who support them. Project support was also provided by NHS Borders.

4. Strategic Context

NHS Borders and Scottish Borders Council came together to form a single integration board (Integration Joint Board) in 2015 with the aim of providing improved and integrated adult health and social care services that make the best use of available resources. The Scottish Borders Health & Social Care Partnership Strategic Plan (H&SCP) (2018-2021) along with the Mental Health Strategy (2017) set the details of this strategic vision. This includes a commitment to forge effective links with all its

partners in care, such as patients, staff, local communities, and disadvantaged groups, so that their needs and views are placed at the heart of the design and delivery of local health services.
In support of that aim, an independent Mental Health Needs Assessment was carried out by Figure8 Consultancy (2014). This analysed the mental health needs (excluding dementia) for adults and informed future mental health planning and service provision.

Key findings included:

- Commissioners should review the pattern of service provision and contracting to ensure that its strengths the co-ordination of care and effective partnership working and communication
- Services need to be developed to be more responsive including ensuring that waiting time targets are consistently met, having clear access criteria, being available for longer hours and ensuring that staff understand what services are available and how to appropriately refer
- Commissioners need to work with providers to look at how IT can be more effectively used to enhance mental health support
- Commissioners need to look at how third sector and peer support can be developed and more integrated into local models of service provision
- Promote empowerment and positive recovery from mental ill health.

The 'Mental Health Strategy: Scottish Borders' (Scottish Borders Health & Social Care Partnership, 2017) sets out a framework for the delivery of activities and services designed to improve the mental health and wellbeing for all ages groups in the local population. A key strategic priority clearly states that '…delivering services within an integrated care model' should look to co-locate services where possible to ensure equity across the Borders.

5. Current and Future Need

Demographic and socioeconomic factors

The Scottish Borders Health & Social Care Partnership (2015) provides background information on the Scottish Borders: A population of just over 115,000, widely dispersed across towns, villages and remote areas and with no natural centre. The Borders has a high proportion of older people placing increasing demands on care and treatment services. Those of working age are subject to a low wage economy, and deprivation is often hidden. Public transport is limited so owning a car is a necessity rather than a luxury.

Funding allocations from central government are usually informed by population size and, where relevant, the prevalence of certain diseases or issues. This does not take into account the expense of delivering services across such a widely dispersed area. Funding is also often short-term posing recurrent challenges to devise, develop and retain new and innovative services that connect to those already in place.

The Mental Health Strategy (2017) talks of mental ill health often being associated with stigma, and of people being reluctant to be seen accessing support. This is a particular issue in this rural setting where services are more visible in small communities with extensive family networks. The same applies to other 'sensitive' services such as those for addictions and sexual health.

Services are planned across five localities within the Scottish Borders (Fig 2). Together, these factors pose challenges for the Integration Joint Board in the planning and delivery of services.

Specific issues are:

Accessibility - To make services accessible you must make sure people who need those services can get to them, or the services can get to the people. Limited public transport and the costs of travel may make accessing some services difficult. Community-based services cost time and money to travel around the region, and limit how many people can be seen in a day.

Acceptability - ensuring anonymity can be difficult when people feel that everyone 'knows their business'. Making services generic and using bases that are accessed for several services can help to address this, as can making use of technology to increase flexibility.

Recruitment and retention of staff – rural areas can mean there is a limited pool of people with the required knowledge, skills and experience to do the jobs advertised, and with lower wages than might be offered in the city. Working in a demanding, isolated job out in the community can increase the stress of working in a caring role. Rigorous support and supervision arrangements are required to ensure staff feel supported and connected to their team.

Figure 2: Scottish Borders Localities (Scottish Borders Council, 2018)

COVID-19

The COVID-19 pandemic and associated restrictions on service delivery have meant that services have had to withdraw much of the face-to-face support they would normally deliver. This has increased anxieties, loneliness and isolation for many, including those who normally benefit from mental health support. It is though also the case that many services have become more resourceful, moving services on-line as well as delivering support by telephone, text and e-mail.

Whilst this has not been sufficient to meet everyone's needs, it has enabled those in more remote areas to access help that might otherwise have been more difficult. It has also helped some with social anxieties or worried about confidentiality to seek help more discreetly. As restrictions are eased, it is envisaged that recovery plans for services will include retaining some of these developments, increasing accessibility and flexibility of supports available.

Mental Health in the Scottish Borders

Extract from Scottish Borders Mental Health Needs Assessment (2014) and Scottish Borders Mental Health Strategy, 2017-

‘Evidence shows that mental illness affects 1 in 4 adults and 1 in 10 children under 15. These figures would suggest that around 23,000 adults and 1,898 children and young people living in Scottish Borders will experience mental ill health at some point in their lives.
Depression and anxiety are the most common. Antidepressants were the most commonly used drug to treat mental health problems in both Scottish Borders and Scotland, having increased year on year.

Co-occurring mental health and drug or alcohol problems are common. Over 40% of people supported by the community mental health teams (CMHT) report problem drug use or harmful drinking, and mental health problems are present in over 70% of those in touch with addictions services.

Long term physical health conditions are associated with older age and with living in deprived circumstances and are key risk factors for mental ill health.
The suicide rate for the Borders was 15 per 100,000 population, just above the rate for Scotland.
The number of psychiatric admissions and lengths of stay shows a steady decline over the last 20 years. There were 680 admissions in 1998 falling to 470 in 2020. Most hospital stays were for a period of 8-28 days. This numbered 230 people in 1998, and had fallen to 120 people by 2020.

Prescriptions for anti-psychotic medication amongst adults shows a small increase over time from just under 7 per 1,000 in 2010/11 up to almost 9 per 1,000 in 2019/20 (reflecting a similar trend for Scotland.

Such data likely reflects a reduction in capacity (less beds) rather than demand so is not a good indicator of future need. It shows a gradual shift of resources in line with national and local policy of reducing bed numbers and moving care out into the community. This is based on the premise that as hospital-based care and treatment is reduced, it will be replaced by care delivered closer to home (hence the establishment of GRC in the first place).

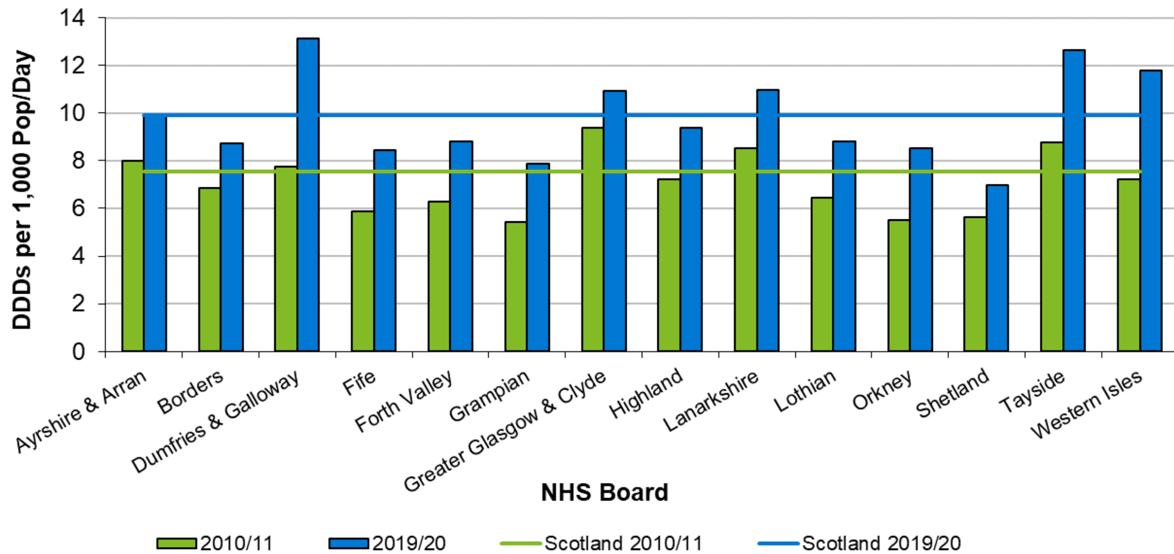

Figure 3: Drug used in psychoses and related disorders 2009/10 – 2019/20 (Public Health Scotland, 2020)

Regional profiles can also show comparisons with other areas. Scotland and Dumfries & Galloway were chosen to give national and rural contexts which showed psychiatric admissions for Borders compares well to both since 2012.

6. Current GRC Service Model

GRC was established in the 1990's as an integrated day service of NHS and SBC. It is predominantly a building-based service for the Galashiels community and caters for adults 18 and over with a primary diagnosis of mental ill health.

It originally operated as a drop in facility for people resettling into the community and worked routinely with people experiencing severe and enduring mental illness (Bi-polar, schizophrenia). In early years, the number of referrals was relatively low (10 referrals in 1999 rising to 76 in 2009). There were 381 referrals in total over a 10- year period, and the number of contacts in groups and activities averaged around 3,000 per annum. Referrals were mainly from the statutory mental health services with only 15-20% being GPs.

The Figure8 (2017) report described a model that had evolved into a more structured, daytime therapeutic resource for a wider client group, and from a wider geographical area (albeit still Galashiels focused). GRC was described as offering 'a safe place where you can access support to

regain a level of personal recovery that enables you to maintain your community presence, contribute to society, and to maximise your individual potential'.
This has been further developed over recent years with services now including a range of 1-1 and group activities (building and community based) as well as therapeutic groups around resilience and self-management.

Also, over recent months, there have been discussions between GRC, the LAC Team and Health in Mind to explore areas of possible duplication and explore the potential for joint working. Key aspects of these discussions have been ways of promoting engagement and of enhancing support.

GRC activity

Accessing data was difficult as it had not been routinely gathered. Activity data for 2019/20 shows a change in the pattern of referrals to the service in terms of gender, age, diagnosis and referral route.

- There has been an increase in younger adults (18-25), most commonly experiencing social anxieties
- There has been an increase in young woman with trauma related EUPD
- There has been an increase in those either diagnosed, or thought to be on the autistic spectrum
- The largest referrals source is now GPs, with Community Mental Health Teams the next highest referrer. Numbers referred with severe mental ill health over recent years are very low.

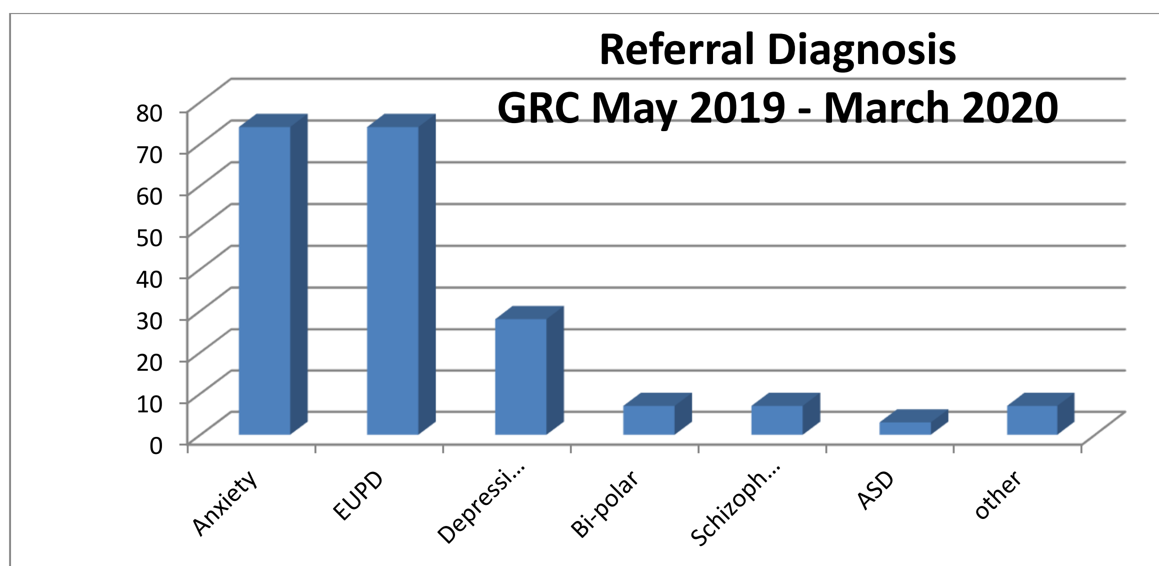

Figure 4: Referral Diagnosis May 2019 – March 2020 (NHS Presentation 2021)

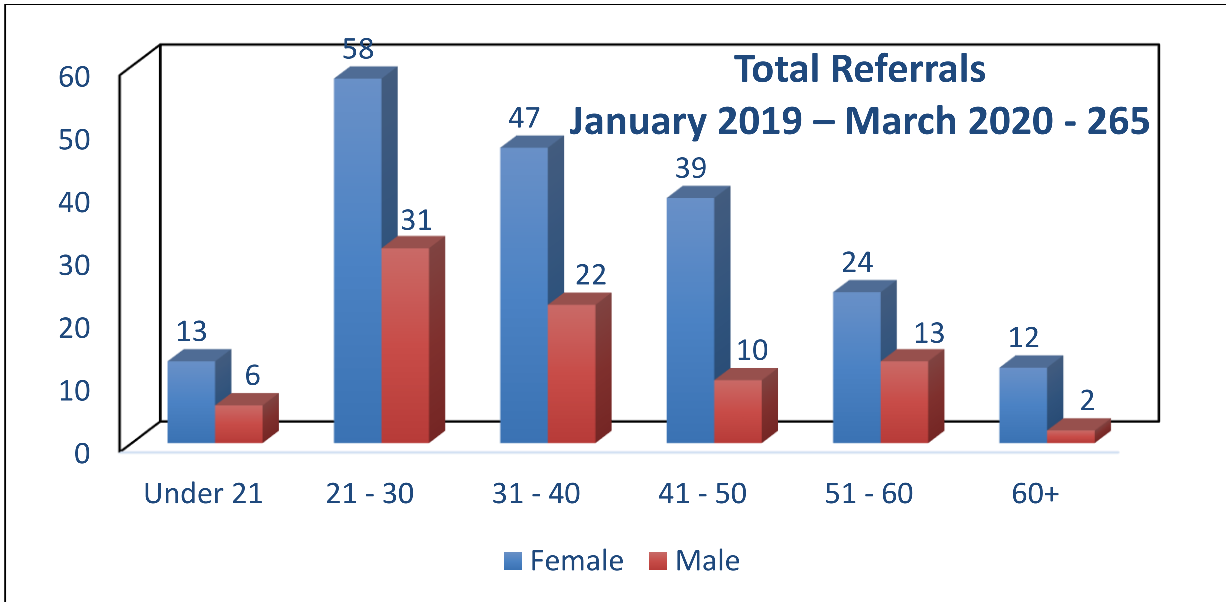

Figure 5: Total Referrals Jan 2019 – March 2020 (NHS Presentation 2021)

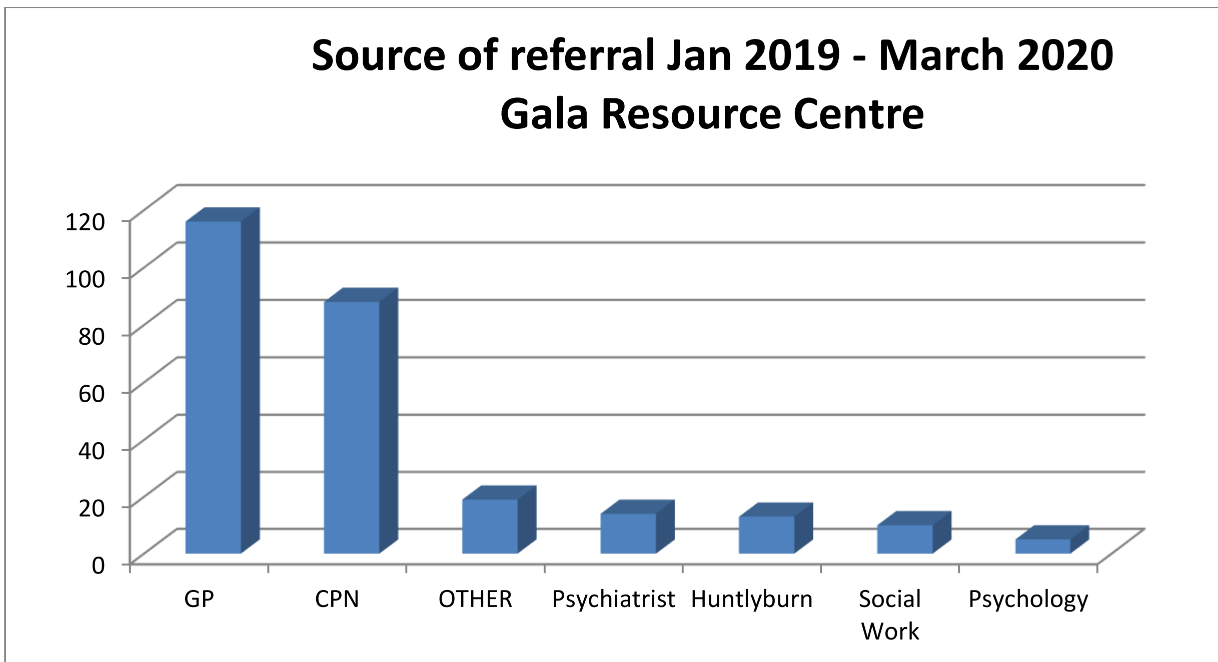

Figure 6: Source of referral Jan 2019 – March 2020 (NHS Presentation 2021)

Figure 7 below shows the type of referrals to GRC by source. EUPD forms the largest proportion (38%), followed by anxiety disorders (34%), and depression (14%). Most EUPD referrals come from the statutory mental health services (CPNs) but even those coming via their GP are likely to have first been diagnosed by mental health clinicians.

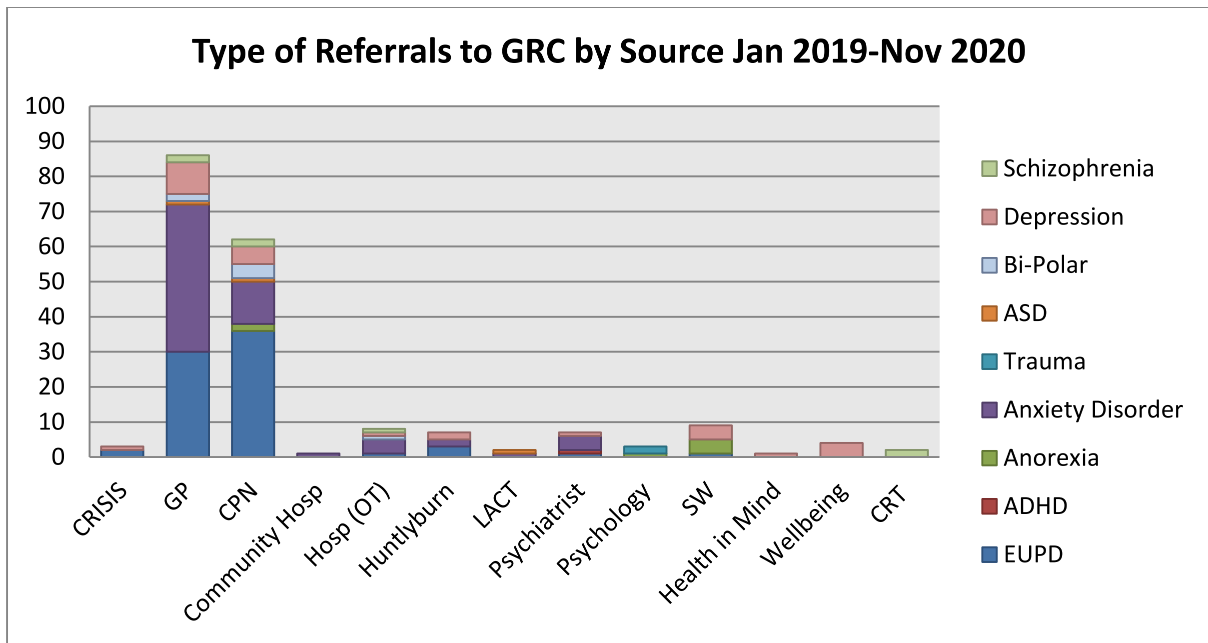

Figure 7: Type of referrals to GRC by source Jan 2019 – Nov 2020 (sourced from GRC data in NHS presentation)

Figure 8 below shows the current profile in terms of referral type, source and routes in/out of the service.

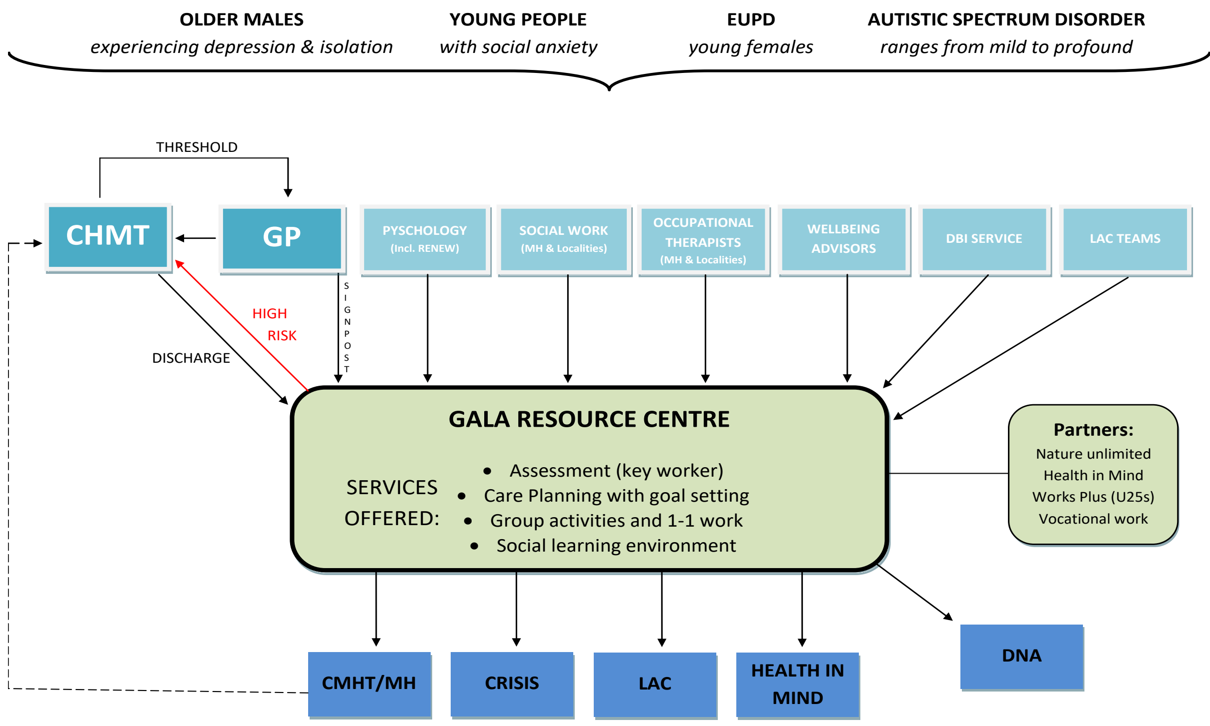

Figure 8: Referral Pathways (NHS Presentation 2021)

Challenges in GRC delivery

It is acknowledged that GRC has been operating in relative isolation from other statutory and commissioned Mental Health Services. Staff describe pathways for referral, joint working and discharge into the service as disjointed. GRC's geographical location also creates a barrier to access, placing it at odds with strategic priorities to achieve equity of access across the Scottish Borders.

Clients are discharged from Community Mental Health Teams (CMHTs) immediately after referral to GRC but their presentation can often fluctuate considerably. If they are no longer appropriate for GRC, or if they relapse, they cannot be referred back into Mental Health Services but must start again back at their GP.

7. Stakeholder Workshop

A workshop was held 11th May 2021 attended by a wide range of stakeholders. This was followed up by a number of small focus groups where people with lived experience of mental ill health were invited to share their views. Participants at these events were asked to consider four questions:

1. Who is the GRC *not* catering for?
2. How do we best meet the needs of those previously attending GRC?
3. What do we want any future service to look like/achieve?
4. How should future service provision connect to other services?

Key points raised are presented below (a summary can be found in Appendix A).

1. **Who are we *not* catering for?** Those with 'severe and enduring' mental ill health were identified as a group no longer being specifically catered for but having a high level of need. People with anxiety disorders and emotionally unstable personality disorders (EUPD) were the largest groups being referred. It was acknowledged that new services have developed to support anxiety issues such as 'Renew' and the Distress Brief Intervention service (DBI). Others noted were co-morbid and complex cases (such as co-existing long-term conditions, physical or learning disability, drug or alcohol misuse); younger adults (16-18s); autism/ADHD; and perinatal mental ill health.

2. **How do we best meet needs?** A person-centred, flexible approach that offers a range of options including psychosocial interventions (mindfulness, anxiety management, CBT, emotional

regulation), peer support, life skills development, and activities that promote health and wellbeing, connectedness and employability.

3. **What should future services look like?** Locality-based support (to reduce geographical inequalities); hub & spoke model; blended of face-to-face and digital; flexible, not time limited); multi-disciplinary (include OT, social and practical support); activities adapted for people with severe and enduring mental ill-health.

4. **How should it connect to other services?** Improved integration with the Wellbeing College and other services and more clearly defined treatment pathways; close working with CMHTs, working in partnership with locality-based community resources; staff aware of and understand how services connect with each other; multi-disciplinary working; empowerment – equal relationships between staff/those using the services.

Together with GRC activity data, two main areas of need were identified as requiring additional examination:

- Those with severe mental ill health (for whom GRC was originally designed to support); and
- Those with EUPD (for whom there are limited, dedicated services within adult mental health services).

The adult Mental Health Services were invited to consider how the needs of these two groups might best be met, and two further Focus Groups were planned for those with lived or living experience of EUPD.

8. Severe Mental Illness

One proposal was put forward around the current 'Space to Grow' garden allotment based at Huntlyburn. The project allows patients and staff to participate in Social Therapeutic Horticultural (STH), be active outdoors and engage/explore/absorb the natural environment. The proposal looks at the expansion of the service through redesign with additional funding.

The Adult CMHT services submitted two proposals for addressing the needs of people with people with severe mental illness.

One was from the Community Rehabilitation Team: *Connecting People and Physical Health Improvement and Support Team (PHIST).* This is a community-based model of care delivered by a multi-disciplinary, locality-based team. It would offer interventions that addressed the physical health, wellbeing and rehabilitation needs of people with severe mental illness (initially those currently being supported by the Community Rehabilitation Team, then rolled out to all adults with severe mental illness. It is thought there are approximately 100 people currently on the team's caseload who meet those criteria.

A second proposal was submitted by the Psychology Department which focused on developing a programme of dedicated psychological therapy (individual and group) together with Occupational Therapy and a range of therapeutic activities.

9. EUPD

Views of people with lived experience:

Three on-line focus groups were held with four people with lived experience of mental ill health, some of whom had consulted peers who wished to contribute their views. Two of the Focus Groups focused explicitly on Emotionally Unstable Personality Disorder (EUPD). The full notes can be found in Appendix B. A common theme was recognition that EUPD was often accompanied by a background of trauma, anxiety and self-harm leading to frequent presentations for help.

Experiences accessing supports

Although the focus for discussion was on GRC services, participants chose to share examples of having accessed support from various sources including GRC, GP and adult Mental Health Services.

Overall, the GRC was described as being a 'safe, secure and relaxing space', and staff praised for being sensitive, patient and welcoming. Helpful interventions in managing anxiety and depression included mindfulness, talking with others, café, crafts, walking and other outside/gardening activities.

Other examples of seeking help suggested fewer positive experiences that could have been improved with a more a compassionate and informed response.

How do we best meet needs?

- GRC type service that everyone who needs it can access
- Opportunities to connect with others in a non-threatening way (e.g. group and outdoor activities)
- Good information about their condition and opportunities to discuss what this means for them
- Education and self-management (managing emotions)
- Safe space/safety planning (when in crisis, suicidal thoughts, and self-harming)
- Peer support/buddy (sponsor type role) – someone who knows them who they can 'check in' with
- Long-term, flexible support when needed (not short-term programmes)
- Mindfulness (that is open to people with mental health challenges)
- Making sure staff have the necessary training and support to do this difficult job (supporting those with EUPD)
- Help to access appointments/sessions when anxious.

What should future services look like?

- Blended delivery of face-to-face, on-line, social media group/peer support
- Like GRC but available across the Borders on different days (a building is lockable and helps to feel safe and secure)
- 'Social prescribing' - support to find out about and access other resources in local communities (LAC and HiM do this)
- Open-ended as and when needed, not time-limited programmes.

Views of Adult Community Mental Health Teams (CMHTs)

Adult Mental Health Services represent medical, nursing, psychology and Occupational Therapists. CMHTs started development of a Care Pathway for people with Personality Disorders in 2019. This is awaiting completion, having been delayed by the COVID-19 pandemic, but will include sections on assessment, treatment and in-patient care (see Appendix C).

The CMHT were invited to submit their views on perceived gaps in community supports for people with EUPD. These include:

- Early intervention-access to therapeutic, goal orientated support, accessible via primary care and supporting joint work with community-based resources. This could provide therapeutic input at first point of need, reduce the need for referral to secondary services, and help address education and employment issues
- Transition from acute or secondary services. Often there is a gap between receiving inpatient or intensive secondary services to only accessing 3rd sector/community service, education or work. Having a goal focused approach that clearly sets out the individual's aims, is activity/therapeutically focussed and supports smooth transitions would be beneficial.

Potential solutions included:

- Moving away from a crisis or maintenance model to a more recovery focused, multi-disciplinary approach
- A person-centred, evidence-based approach that enables self-management
- Activity groups and vocational rehabilitation that support remaining, returning or starting work (good for health and wellbeing)
- The GRC Occupational Therapist (O.T) had offered a 'stepping stone to work' through work assessment, resilience skill courses (such as Mindfulness) and the opportunity to develop work skills through supported volunteer opportunities
- Physical spaces offering therapeutic environments to support people
- Joint working with third sector and community-based resources working collaboratively.

10. Summary

Background:

GRC was originally intended to provide essential support for people with severe and enduring mental ill health as part of a transition from hospital to community-based care. Mental Health Services have continued to develop over time, enhancing the type and range of supports on offer, but GRC has not been an integral part of that process. These developments have tended to focus on the shorter-term needs associated with emotional distress, anxiety, depression, loneliness and isolation. Those with longer-term support needs have not received the same level of attention.

Independent evaluation of GRC in 2017 recommended areas for improvement around structure, management and ethos of the Centre. These recommendations did not translate into any changes for

the staffing, approach or oversight of the service. Difficulties in accessing good monitoring data, together with feedback from stakeholders, suggests that the same issues still exist.

Gaps in services and unmet need:

Over recent years, GRC has evolved to meet the needs of those people now being referred for help – predominantly those experiencing anxiety and depression (for which there are now a range of community-based services in place), and those diagnosed as having an EUPD (for which there are no dedicated, community-based services). These supports have been well-received and beneficial for those accessing them, but a disconnect with other services has resulted in fragmented care, gaps in support, and a revolving door between services. This is leading to repeated presentations at front-line services and referrals into secondary mental health care.

Stakeholders are agreed that attention must now focus on the needs of those with longer term mental health needs: restoring support for those with severe and enduring mental ill health, and those with a diagnosis of EUPD (increasingly being referred to CMHTs and the GRC for support over recent years).

How these needs might be addressed:

The Community Rehabilitation Team and Psychology Department have both submitted proposals for providing enhanced support for those with severe mental illness (attached in Appendix C). These would create a stronger, multi-disciplinary focus on recovery and support people to improve physical health and wellbeing outcomes, living as well as possible with their condition in their local communities. This would benefit around 100 people currently on the Community Rehabilitation Team's caseload at any given time, and more if it was subsequently rolled out to others in need of such support.

For those with EUPD, there is also a degree of consensus on ways in which people might best be supported in the community. This includes:

- Opportunities to connect: Group and 1-1 activities (therapeutic, social and outdoors) previously provided by GRC but made more widely available across the Borders
- Information and advice: Help to understand what EUPD is and what it means for them; what supports are available and how to access them; developing resilience and self-management skills
- 1-1, group and peer support, especially at times of crisis that can be accessed at times of need and in the long-term and (not short programmes)

- Blended delivery (face-to-face and on-line, text etc) to facilitate access (geographically and practically)
- Collaborative working across sectors and agencies that avoids unnecessary referral/re-referral to the CMHTs, provides responsive care when needed, and supports broader family, social and employability goals
- Staff that are trained and supported to offer a compassionate response.

In terms of numbers, approximately 80 people were referred to GRC in 2019/20, but it is also featuring in referrals to other services that support those in distress such as the DBI service.

11. Recommendations

The primary recommendation of this review is to engage in an Options Appraisal process with our stakeholders to consider the proposals that will provide a cost-efficient service that addresses the unmet need of those in the community.

Some of the suggestions for strengthening care and support, particularly for those with EUPD, go beyond the realms of GRC and are thus not directly 'in scope' for this review.

a) GRC resources should now prioritise meeting the needs of two key groups:
   - Those with 'severe and enduring' mental ill health; and
   - EUPD

b) Various proposals have been submitted for those with severe mental ill health which would re-establish and improve upon services historically provided. These need further examination to consider the best option for taking this forward.

c) Further work needs to be done to work up a specific proposal for those with EUPD that would help to address the emerging needs of this group and reduce re-referrals into secondary Mental Health Services. This should include information and support post diagnosis; longer-term support via 1-1, group and peer support (to learn self-management; manage crisis and build resilience); opportunities to connect with others (social and creative activities). These opportunities should link with existing services and supports in the community.

d) Services should be locality-based to ensure equality of access across the region and delivered in a blended style of face-to-face and on-line to facilitate contact. The involvement of support workers, peer support and/or carers could also help to address barrier to attendance and engagement.

e) The building currently housing GRC could be assessed for its potential as a local 'hub' that facilitates a multi-agency programme of support (this would likely necessitate an assessment of suitability and refurbishment). Alternatively, the building could be handed back to the Council for alternative use.

Findings in this review have wider implications for adult Mental Health Services that suggest a need for further discussion. This could contribute to the further development of care pathways, support collaborative working across statutory and commissioned services, create opportunities for inter-agency staff support and development, and avoid unnecessary referrals and re-referrals into secondary care.

Once these developments have been agreed, there is a need to raise the profile of information resources on what services are in place, who offers what service, and how to access them.

12. References

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Appendix A – Stakeholder Workshop Feedback

Going forward how do we best meet the needs for those who were previously attending GRC?

Service Users

- Person Centred and not time limited
- Skill Building and Confidence Building
- Different methods of access- blend of face to face and digital
- Clear pathways so patients have a positive journey

Services

- Services that are more joined up/ work in conjunction with CMHTs
- Pleases for opportunity for peer support such as cafe, kitchen or garden
- Partnership working with services like open door cafe, Bowhill and the wellbeing collage
- Building based services to support patients feel safe
- Streamlined anxiety disorder pathways
- Hub and spoke model to cater for people outside of central area
- Services that facilitate patient's ability to engage with local services
- Clear referral pathways into the right services – single point of referral or self-referral – clear for GP's to follow
- Clear therapeutic routes such as – mindfulness, anxiety management, emotional regulation, communication and social skills
- Clearly defined patient treatment pathways that consider how the services link in and smother transition between services
- Develop services for severe and enduring, complex cases
- Stepping stones to support patient's recovery journey
- Consider services for 16+ to support CAMHS
- DBI/ Renew are short term need to support those not captured by CMHT
- Offer goal based therapy based on individual needs

What do we want any future service to look like/ achieve?

Supports people with severe and enduring MH problems

Offers access to Peer support

Employability locality based approach

Borders wide service- More locality based services not just a central building- everything we do must widen equity

Hub & Spoke- have a base but also have a travelling service

Adapted wellbeing courses for people with severe and enduring MH issues

Time limit as allows people to be goal focused but then peer support group that could have a looser timescale

Stepping stone to other community groups

Fills the gaps we have in other services

Sufficient OT/ Support/ Volunteers/ CBT Resource

Move away from set timescales – long term support for long term conditions that is flexible based on people's current need

Focus more on social and practical support as opposed to psychology

More fluidity with 16-18 as gender identity is becoming more prominent

Occupational Therapy could be utilised to support autism gap

Clearly defined pathways between services

Close links with Wellbeing College

Tailored to individual recovery journeys – supports employment

Goal focused can sometimes be overwhelming also focus on acceptance and believing in themselves

Drop the PD role but make sure it sits within an alternative service

Use of walking groups/ cycling groups/ music therapy / art activities / gardening/ cooking skills

Considers physical health and physical activity

Peer support and peer led sessions

Promotes health and wellbeing skills and creative skills

Continues to build on the benefits felt with going online over the past year but is a blend of services to recognise health inequalities

Consider use of alternative venues not restricted to NHSB & SBC

Avoid duplication with LAC- more about recovery community- focus on peer to peer support

How should the future service provision connect with other services?

Need for therapy for the future

Links with Public Health to support physical health

Develop a core set of courses in conjunction with the wellbeing service- consider joint service

Communication- build an effective communication route

Maybe a one stop shop a hub of services operating out of one building

Ensure consistent language is used across all services

Work as equal partners supporting each other, working together to build solutions

Multidisciplinary working to support seamless access to multiple services- develop a system of support

Discharge plans- established who is involved in developing and updating ensuring person centred

Educate staff about how services can connect in and out

Link with post diagnostic support – would same model work? If focused less on clinical then would free up time for other areas

Post diagnostic support in conjunction with CMHT so that people aren't discharged

Appendix B - EUPD Focus Group responses

Experiences accessing support

One person described having received a diagnosis of EUPD and told they were being discharged (with no follow up and no information) all within a 20-minute phone call. The discharge was based on them having been assessed as 'high functioning' because they were 'able to hold down a job' (they had in fact been on long-term sick leave for 7 months). This took place before the development of the current Care Pathway for Personality Disorders* (updated Dec 2021).

Most spoke positively of their experiences accessing support at the GRC, describing it as being 'safe, secure and relaxing'. Staff were praised for being sensitive, patient and welcoming. One person felt it to be 'dingy, unwelcoming 'not homely'. Interventions regarded as helpful in managing anxiety and depression included mindfulness, talking with others, café, crafts, walking and other outside/gardening activities.

Following the recent closure of GRC, two people had been referred to the LAC Team for support. Both had received leaflets; advice and a telephone call every 6-8 weeks to check on how they were. One was offered access to walking activities, but the other was not, but both would have found it of value. They felt was insufficient to meet their needs but understood that out with Covid restrictions they would normally have been offered more regular and face-to-face help.

One person described having gone to their GP several times with problems of anxiety and self-harm, but not being offered any help to address these issues other than being told the only option was to reduce their medication. It was acknowledged that there are other sources of support that could have been suggested.

Another described an incident where they arrived for an appointment with their CPN but were too anxious to leave their car and were now a few minutes late. They telephoned staff to let them know they were outside and ask for a few minutes extra. This was turned down, the appointment was cancelled, and the person discharged because of failure to keep their appointment. The very problem they had been referred for (anxiety) had stopped them attending. They suggested that if staff had come out to offer reassurance it could have helped them to access support and avoided wasting the appointment.

How do we best meet needs?

GRC type service that everyone who needs it can access

Opportunities to connect with others in a non-threatening way (e.g. activities)

Good information about their condition and opportunities to discuss what this means for them.

Education and self-management (managing emotions)

Safe space/safety planning (when in crisis, suicidal thoughts and self-harming)

Peer support/buddy (sponsor type role) – someone who knows them who they can 'check in' with

Long-term, flexible support when needed (not short-term programmes)

Mindfulness (that is open to people with mental health challenges)

Making sure staff have the necessary training and support to do this difficult job (supporting those with EUPD)

Help to access appointments/sessions when anxious

What should future services look like?

Blended delivery of face-to-face, on-line, social media group/peer support
Like GRC but available across the Borders on different days (a building is lockable and helps to feel safe and secure).
Creative activities, walking and gardening e.g. the 'Space to Grow' at Huntlyburn.
The use of 'social prescribing' was discussed where people are helped to find out about and access (LAC and HiM do this) other resources in their local communities that would help improve mental health and well-being and connectedness.
Open-ended as and when needed, not time-limited programmes

Appendix C: Care Pathways for Personality Disorders

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