ARBD Southside Response
Housing Support Service

2/2
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Glasgow
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Type of inspection:
Unannounced

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Service provided by:
Scottish Action For Mental Health

Service provider number:
SP2003000180

Service no:
CS2006136878

About the service

ARBD Southside Response provides housing support and care at home for people living with alcohol-related brain damage (ARBD) across the city. The provider is Scottish Action for Mental Health.

The service currently provides structured support to 28 people living with ARBD to help them maintain their tenancies and become more socially included in their communities. Referrals are made through the ARBD Glasgow team and GCC/HSCP commissioning team.
ARBD Southside Response follows a harm reduction approach working towards abstinence. Its stated aims are:
• To provide support within individuals own homes to high quality to enable the individual to remain in their own home.
• To provide support to individuals to develop the necessary practical, social and emotional coping and communication skills in order to sustain and enjoy life.
• To deliver support in a kind, compassionate and respectful way.

About the inspection

This was an unannounced inspection which took place between 09 and 12 May 2025. The inspection was carried out by one inspector from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service we:

- spoke with five people using the service
- spoke with four staff and management
- observed practice and daily life
- reviewed documents including personal plans
- spoke with one visiting professional.

Key messages

- Support was delivered by a committed and flexible staff team.
- People's lives were improved as support focused on promoting health, wellbeing and independent living skills.
- People were encouraged to be involved in their community and access activities that were of meaning and beneficial to them.
- Personal planning required to be improved to reflect identified needs, outcomes and progress made.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	4 - Good
How good is our staff team?	4 - Good
How well is our care and support planned?	3 - Adequate

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 4 - Good

We made an evaluation of good for this key question, as several important strengths taken together clearly outweighed areas for improvement. Whilst some improvements were needed, strengths had a positive impact on people's experiences.

Quality Indicator 1.3 People's health and wellbeing benefits from their care and support

Most people using the service lived with a diagnosis of Alcohol Related Brain Damage (ARBD) and were supported in their own home to manage their tenancy, or within hostels or sheltered housing. People were supported to remain or become abstinent from alcohol or to reduce the harm from continued alcohol use. The service supported people who may previously have not fully engaged with services.

Feedback from people using the service was positive. Comments included "they are all great, have a great deal of empathy and are very reliable" and "I know when they are coming to see me, it helps me structure my day".
A flexible and proactive approach from the staff team resulted in people feeling valued and engaged in support. Staff spoke positively and were knowledgeable about the people they supported. People supported had positive relationships with staff and expressed that they trusted them. Some individuals shared this had contributed to their recovery. People supported felt the service had helped them gain more control of their lives. One person highlighted that their ARBD had caused poor memory but with staff help managed bills, attended appointments and was able to engage in recovery community activities. This increased their chances of remaining abstinent and living well within their community.

Staffing resources had impacted on scheduled supports. The service strived to offer support to those most in need and to be consistent in their approach. Senior staff delivered some face-to-face support to limit the impact of this. However, this meant that oversight functions and the ability to forward plan proved challenging as the daily schedule changed frequently.
People were encouraged to utilise recognised recovery tools and strategies such as white boards, memory clocks and calendars. People confirmed they felt they worked in partnership with the staff and one person shared that staff often take the lead from him regarding his support. This helped people to feel empowered.

Staff worked hard to ensure people felt part of the community in which they lived.
They identified local resources and people were supported with shopping, attending local amenities and improving their confidence getting around in their community. Staff also offered walking and cycling activities to encourage a healthy lifestyle.
Exploring further education, voluntary opportunities as well as engaging with recovery community activities was encouraged.
One person shared "having the support has meant that I use them as my social circle, I go out to the community for coffee, visit places of interest including galleries and museums. I have also benefitted from going to the opticians and getting my eyesight sorted."
Some people continued to use alcohol. The service remained committed to supporting them using a harm reduction approach. Support was flexible and adjusted to when people were most responsive and better able to engage. This ensured support was person centred and people felt valued and appreciative.

People living with ARBD can experience a range of health issues. People were encouraged to attend to their health needs by arranging appointments with external medical services.

Appointments were recorded on whiteboards and support made available to attend. A committed staff team knew people well and were able to recognise and respond to changes in people's physical and mental wellbeing. The service supported hospital admissions and discharges and made appropriate referrals to external agencies. Social work colleagues were alerted when there were concerns about people's ability to manage independently. This ensured appropriate multi agency discussions took place and additional support put in place. This helped to keep people as safe and as well as possible.
Medication was generally managed by individuals but where needed people received telephone prompts or a greater level of assistance if required. This helped to support people to take medication as prescribed.
The manager was involved in the city wide ARBD "Pathways" meetings where each individuals' current needs, circumstances and potential move on plans were discussed. This helped to ensure the most suitable support and future options was available to people.

How good is our staff team? 4 - Good

We made an evaluation of good for this key question, as several important strengths taken together clearly outweighed areas for improvement. Whilst some improvements were needed, strengths had a positive impact on people's experiences.

Quality Indicator 3.3 Staffing arrangements are right and staff work well together

People supported gave positive feedback about the staff team, highlighting a compassionate, professional approach to supporting them to meet their identified outcomes. Comments confirmed people felt comfortable with staff .
The service had experienced significant staff changes. This resulted in a level of inexperience within the staff team with some people working in social care for the first time. People were recruited according to best practice recruitment guidance and confirmed an induction programme had assisted in preparing them to deliver face to face support to people. An ongoing mix of training opportunities including shadowing more experienced staff supported their developing practice.
Staff had opportunities to share concerns and ideas through regular team meetings and supervisions. A weekly catch up meeting had been introduced following feedback. This ensured staff had a regular forum to discuss risk and raise concerns about individuals who may be relapsing or having difficulties. This allowed management to evaluate and adjust support to meet peoples changing needs. It also helped staff feel supported by the management team and less isolated.

Staffing challenges had impacted on staff having access to scheduled office time with senior staff. The management team acknowledged this and planned to explore alternative mentoring opportunities. This would support individual staff development and ensure improved consistency in personal planning and use of organisational recovery tools. We have made a related requirement in Key Question 5 of this report.
Despite resource challenges the staff team remained committed and endeavoured to deliver compassionate, professional support.

How well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate. An evaluation of adequate applies where there are some strengths, but these just outweigh weaknesses. While the strengths had a positive impact, key areas need to improve.

Quality Indicator 5.1 Assessment and personal planning reflects people's outcomes and wishes

Personal plans help to direct staff about people's support needs and their choices and wishes. Some personal plans were written in a person-centred way and involved those using the service. "All About Me" documents provided information to allow staff to get to know people and their past experiences.
Staff were confident completing daily recordings. These were largely person centred and evidenced meaningful conversations. However, records did not consistently reflect peoples identified goals or outcomes.
The electronic support planning system (ACP) provided a framework to evaluate risk and support people to live safely and well by developing individual safety plans and risk management plans where appropriate. Some plans had not been regularly reviewed. This meant we could not be confident they reflected everyone's current situation.
The electronic personal planning system included the organisation's generic recovery tool to support people to achieve personal outcomes, "My Plan, My Way". People should be involved in a regular review of their support outcomes and identifying meaningful goals to shape their support. However, some individuals personal outcomes and goals had not been reviewed regularly. Additional mentoring and learning opportunities for staff would support the development of an improved approach to support planning. The provider had plans in place to review and improve support planning. (See requirement 1)

Requirements

1. By 06 October 2025, the provider must ensure service users' health, safety and social needs are evidenced through effective personal planning.
To do this the provider must at a minimum ensure:
a) Personal plans are consistently evaluated, reflect risk reduction measures and support people to achieve their personal outcomes in accordance with the organisations recovery framework.
b) Training and mentoring opportunities are available to support staff to develop personal planning skills.
This is to comply with Regulation 5 (1)(b) of Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011, SSI 2011/210.

This is to ensure care and support is consistent with the Health and Social Care Standards (HSCS) which state that: "My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices" (HSCS 1.15) and "Any treatment or intervention that I experience is safe and effective" (HSCS 1.24).

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Detailed evaluations

How well do we support people's wellbeing?	4 - Good
1.3 People's health and wellbeing benefits from their care and support	4 - Good

How good is our staff team?	4 - Good
3.3 Staffing arrangements are right and staff work well together	4 - Good

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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