



# Self-directed support and mental health

## Paper 1 Background



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# Introduction

## About Self-directed support in Scotland

The Scottish Parliament has passed a new law on social care support, the Social Care (Self-directed support) (Scotland) Act 2013. The Act comes into effect on 1 April 2014.

The Act gives people more choice in how their social care is delivered, empowering people to decide how much ongoing control and responsibility they want over their own support arrangements. In practice this means:

- People can focus on the outcomes they want - what they want to achieve and what a good life means for them.
- The care and other support they get is planned to help them achieve these outcomes.
- There are more flexible ways of organising the support, to make it easier for people to get the combination of support they need.
- People choose the way they organise their support, as well as choosing the support.

Overall, this approach is known as Self-directed support (SDS).

## About Getting There

Getting There is one of the capacity building projects which is funded by the Scottish Government to support the implementation of Self-directed support (SDS) in Scotland. The project is supporting smaller voluntary organisations that deliver services and are led by the people who use those services as they get ready for the introduction of SDS. It is based at Outside the Box.

## About this work

One of the gaps that the people involved in Getting There identified was that there is relatively little experience of people with mental health problems in Scotland using Direct Payments or other forms of Self-directed support. Similar arrangements have been in place for a few years already in England, and the learning from there could be useful to people in Scotland.

The Getting There project asked the National Development Team for Inclusion (NDTi) to bring together existing evidence and practice on Self-directed support for people with mental health problems. The overall aim is to share with people in Scotland an idea of how SDS can work in practice for people with mental health problems, based on what has happened before.

This paper looks at the background to SDS and how it works for people with mental health problems. It is one of 3 papers, which overall describe what we are learning about how SDS can be made to work for people with mental health problems. The other two papers are:

- Evidence on how SDS works and the impact it has for people and their quality of life.
- Practice around SDS, including ways to overcome the barriers that can limit the ways people with mental health problems use and benefit from SDS.

**To download copies of any of these papers please visit the Outside the Box website: <http://www.otbds.org/gettingthere/>**

**For more information about this work, please contact us**

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Note: this work has mainly drawn on practice from England, where personalisation and Self-directed support has been in operation in earnest since 2009, with much activity before then.

# What is Personalisation and Self-directed support?

Self-directed support (SDS) is one of the key ways in which the personalisation of social care services comes to life.

Personalisation is an overarching philosophy which fundamentally reshapes the relationship between people and public services, including in social care and health.

Personalisation means all of the following:

- Someone has the right to shape and determine the way they lead their life.
- Meeting the needs of individuals in ways that work best for them and that are self-directed.
- Giving people as much choice and control over their lives as they want, regardless of where they receive their support.
- Promoting good mental health and maintenance.
- People are supported to live independently, stay healthy and recover quickly.
- People are able to access universal services such as transport, leisure and education, housing, health and opportunities for employment, regardless of age or disability.
- People are recognised, respected and empowered as individual citizens, family members and members of their communities and can participate as active and equal citizens.
- A person's human rights, dignity and autonomy are respected.
- The needs and aspirations of whole communities are addressed to ensure everyone has access to the right information, advice and advocacy to make good decisions about the support they need.
- Looking at the whole system of support people receive, including prevention and early intervention.

Coproduction must be an underpinning principle to support the development and delivery of personalised approaches. Coproduction can be described as a way of working whereby citizens and decision makers, or people who use services, family carers and service providers work together to create a decision or service which works for them all. The approach is value driven and built on the principle that those who use a service are best placed to help design it.

Although the implementation of personalisation and its constituent parts (including SDS) will be affected by funding cuts, it is important to recognise that personalisation brings challenges regardless of the financial context. Similarly, cuts in social care budgets bring challenges regardless of the model of social care.

## Self-directed support

Self-directed support (SDS) is not the same as personalisation: it is a way in which personalisation is achieved.

SDS is for people who have been assessed as needing help from social care services, and who would like to choose how the way in which their care and support is delivered. It focuses on outcomes people want to achieve, not just the inputs and outputs of what support people get. It's also important to remember that people don't just make one choice and that's it: they can choose different options, depending on their circumstances or whatever their preference is at different times.

There are 4 ways in which someone in Scotland will be able to exercise Self-directed support:

- A Direct Payment (Option 1) is when you get the money and you organise the support yourself.
- An Individual Service Fund (Option 2) is when you can spread and move around the resources between different services in the same way as a Direct Payment, but the council organises it all and handles the financial side.
- The Council can organise the care for you (Option 3). They have arrangements with a small number of care providers to deliver support to anyone in the area who needs it.
- You can have a combination of any of the above (Option 4).

There are similar arrangements in place in other parts of the United Kingdom and other countries.

A self-directed approach doesn't mean that people are left on their own to do things. They should have access to whatever support is needed to self-direct their support.

People with mental health problems have tended to be the last to be offered the possibility of using Self-directed support, especially Direct Payments. In England, for example, the option of offering Direct Payments has been gradually expanded to different client groups over time, as follows:

- For disabled adults between 18-65 in April 1997.
- For older people (aged 65 and over) in 2000.
- For carers, parents of disabled children and for 16 and 17 year olds (young adults) in 2001.

In all places there are some people who are currently remain excluded from receiving Direct Payments, for example people who are under court orders that require them to have treatment or services due to alcohol or drug problems are not allowed direct payments.

# Specific differences for Self-directed support in mental health

The introduction of personalisation and Self-directed support raises a number of opportunities and challenges for everyone.

However, there are some specific differences that arise for SDS in mental health, which are outlined below. More detail and practical ways these issues have been overcome are highlighted in the Practice Section.

## Fluctuating conditions and involuntary users of services

Personalisation and Self-directed support has had much success for people with learning disabilities and physical/sensory impairments, for example. However, it has been harder to personalise services for individuals whose support needs fluctuate or who may, at times, be involuntary users of services such as people with mental health problems.

The flexibility of Self-directed support, however, has been identified as a distinct advantage for people with fluctuating conditions and/or changing circumstances. SDS means people can tailor services and supports to suit them, at times and in ways they feel would be most helpful. For example, receiving a Direct Payment to manage a person's own support needs also means they can easily arrange if they need a greater amount of support at any time, without having to rely on relatively inflexible "crisis" or emergency social service provision or go into hospital. Furthermore, there is evidence to show that people with mental health problems can be supported to identify risks and to develop advance statements to ensure that there are advance directives or a crisis plan in place for themselves should they become unable to decisions, which can guide the people around them at these times.

## Eligibility and capacity

Eligibility for funded mental health services provided through social care can create difficulties. Since local councils commonly provide services only to people with critical or substantial social care needs people with more basic level mental health problems are unable to access the funded social care support necessary for recovery and prevention of ill health and social exclusion.

Similarly, perception of people's capacity is a major issue in Self-directed support for people with mental health problems. People with mental health problems can be seen by frontline mental health staff as not having the capacity to self-direct or manage their support, and so resulting in a reluctance to promote self-directed support. Policy statements are very clear on this point: someone should be assumed to have capacity unless there is reason to think otherwise. Furthermore, there are a range of decision-making points in setting up and managing Self-directed support, so if someone lacks the capacity to make a particular decision their ability to make decisions on other matters should still be assumed.

Throughout, the person's views should be sought. There are also a variety of ways in which people can arrange for proxy-decision making, for example by a carer, user-controlled trust, advocate or circle of support.

## Staff and sources of support

The range of staff involved in mental health services is also noticeably different than for other client groups. Where most literature on Self-directed support refers to “social workers”, the integration of mental health services means care coordinators are responsible for assessing health and social care needs. In practice, this means that mental health practitioners (such as Mental Health Nurses) are as likely to support someone to access Self-directed support as social workers.

Furthermore, it is vital to ensure people who act as advocates or carers for people with mental health problems are aware of and involved in the Self-directed support process, should the person being supported wish this to be the case. Similarly, though the majority of people with mental health problems are able to self-direct their support themselves, many also welcome opportunities for peer support.

## Self-directed support and people in touch with secondary mental health services

In England, there is a dedicated framework for assessing people in touch with secondary mental health services (called the Care Programme Approach, CPA). It should provide ‘access, through a single process, to the support and resources of both health and social care’. However, mental health practitioners often report that incorporating Direct Payments into the CPA involves considerably more additional paperwork, and so can be a deterrent. Similarly, it was reported that the procedures for accessing Direct Payments are different for mental health service users than other service user groups. This is a consequence of the ways in which mental health has been integrated across social care and health in England.

This is less likely to be an issue in Scotland, although lessons on not overlaying additional paperwork and bureaucracy are useful.

## Service structure

Structurally, the different forms that integration in mental health can take create some difficulties that are relevant to Self-directed support and its mechanisms. Such problems can include:

- Integrated provider trusts, where local councils set up a formal partnership arrangement with a local mental health trust to deliver their mental health social care responsibilities: Under the management of integrated NHS Trusts, mental health may not feature as strongly in local council implementation of Self-directed support.
- Separating out resources and services into health and social care, or extracting ‘social’ care resources from jointly funded provision. This can also mean there is cost shunting between different budgets.
- Increased demand: because the opportunity of Self-directed support or Direct Payments is more attractive to some users than receiving services.

- Outcomes indivisible into 'health or 'social' care. This can also lead to problems concerning use of Direct Payments for social/personal care but not health care, since Direct Payments can only currently be used for social/personal care and not health care.
- Different accounting arrangements.

However, evidence from the piloting of personalised approaches in England reflected people's views that not including NHS resources was a "missed opportunity" and that personalisation that is focused only in social care "can't work" alone.

A practical way that such issues have been overcome in many places is through multiagency groups that have all relevant stakeholders involved. Such groups typically adopt a strategic approach, set out to develop new ways of working and do so through fostering partnerships, creative thinking and collaborative problem-solving. They usually involve:

- People eligible to use mental health services.
- Service user groups, carers' groups, black and minority ethnic groups and advocacy groups.
- Mental health commissioners.
- The local council's direct payment scheme.
- Direct payment support services.
- Mental health trust/s.
- The voluntary and community sector.

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