Self-Directed Support in Mental Health: Capacity Building for Third Sector Providers

Summary Findings

April 2013
The Mental Health Foundation (MHF) is the leading UK research and development, policy and service improvement charity working in mental health, learning disabilities and dementia. The Foundation undertakes research, develops services, designs training, influences policy and campaigns to raise public awareness throughout the UK with offices in England, Scotland and Wales.

MHF are committed to reducing the suffering caused by mental ill health and to help everyone lead mentally healthier lives. The Foundation helps people to survive, recover from and prevent mental health problems, working across all age ranges and all aspects of mental health.

MHF works across the UK and internationally, with a wide variety of partners including the voluntary sector, businesses, local authorities, health boards, national bodies and networks. This breadth means that we are ideally placed to bring a vision of the ‘bigger picture’ of wellbeing to inform everything we do.

Mental Health Foundation
18 Walker Street, Edinburgh EH3 7LP
Telephone: 0131 243 3800
Website: www.mentalhealth.org.uk

MHF and the Scottish Mental Health Cooperative are grateful for the frank contributions made by participants at the regional events.

This report was prepared by Chris O’Sullivan with John Ithell and Chris White

Design by Lewis Brown

Contact:
Chris O’Sullivan
Policy and Development Manager, Mental Health Foundation
cosullivan@mentalhealth.org.uk

Contents
5 Introduction
5 Process
8 Mental Health and Self-Directed Support
13 Choice and Control
20 Information and Engagement
24 Process and Systems
30 Conclusions
31 Next Steps
33 Appendix 1: Regional Event Summary
34 Appendix 2: Summary of Action Planning Event, March 2013
INTRODUCTION

Introduction

Mental Health Foundation and the Scottish Mental Health Cooperative have been jointly funded under the Scottish Government Self-Directed Support Strategy Provider Capacity Strand to support local third sector service providers to prepare for and engage with self-directed support.

The Provider Capacity Building strand is part of the ten-year Self-Directed Support Strategy which the Scottish Government launched in 2010. The Social Care (Self-Directed Support) Act 2012 was passed during the course of the first year of the project. It is expected that Guidance for this legislation is due in draft form in March 2013 ahead of expected implementation of the Act in Spring 2014. During the course of the project thus far we have developed links with other initiatives in the field, most notably the PilotLight Programme being led by IRISS, and CCPS Providers and Personalisation, both of which are useful points of reference for providers.

The first year of the project scoped challenges and opportunities for capacity building in SDS for mental health. We have undertaken this through a launch event and ten regional meetings involving providers, service users and local authorities, with other stakeholder groups. In addition to raising capacity in themselves, the findings from the sessions presented in summary here were presented in March 2013 at an open event at which participants considered the findings, and defined potential avenues for development for the subsequent two years of the project.

In addition to the learning the sessions have given for providers, participants gave contributions which will be of interest to other organisations and stakeholders outwith the project, and these are highlighted here.

Process

A series of regional events were held across Scotland in Winter 2012. These were drawn together principally by members of the Scottish Mental Health Cooperative working with the project team and with other local providers and service user groups. The project set out to establish two tracks of events, for service users and providers separately. In most cases the events that went forward were joint events planned to include both perspectives equally. Event content was planned following input from a launch event in August 2012, attended by a range of stakeholders. Events held are summarised in Appendix 1. Across the ten events, around 350 participants took part in discussions.

Across ten regional events there was a range of discussion, with points that were consistent across multiple sessions, and key concerns raised locally in a fewer number of sessions.

- In general, we found that awareness of self-directed support was lower amongst service users than amongst providers. This had an impact on the extent to which detailed discussion of potential ways of using services could be discussed. Where awareness was higher, and where self-directed support in other impairment groups was better understood, service users and providers had concerns about SDS in practice in mental health.

- Providers were largely aware of the introduction of self-directed support, and had started to consider what that would mean for them. In areas of advanced implementation providers were already aware of the process and the consequences, and were engaging with local authorities and other providers and stakeholders to develop awareness and systems. In other areas where implementation was in the preparatory stages, providers were keen to engage and assist where possible.
Participants highlighted things that providers could do, but additionally made points that could be taken forward by other stakeholders including policy makers, advocacy organisations, user led organisations, and the wider mental health sector.

Two key areas of focus for capacity development emerged in the regional sessions:

- The first area of focus was in terms of preparing to support the cohort of people with clear support needs. These people likely already use services and have social care input, meet eligibility criteria and should be allocated an individual budget and then have the choice of the four options. It was clear that there needed to be a genuine choice for people in terms of what services might meet their outcomes and how they might be organised or combined and that third sector providers had a key role in achieving these outcomes. Importantly as many of these people already use and trust providers, there was also a sense that people in this group would welcome support from existing providers in the transition to self-directed support.

- The second area of focus was the extent to which self-directed support would reach people who have some social care needs, in the context of a range of health needs. This population was identified as being more likely to get a low value individual budget, or to not qualify for an individual budget. These people might lose access to services they already used under SDS, if they were asked to contribute under charging policies, or if the value of their individual budgets was insufficient to meet the cost of the services.

This group could still have support needs arising from a mental health impairment that are currently met or partially met by health services or traditionally funded voluntary services, and would be likely to be signposted following a social work assessment for SDS. In addition, this group would also include people who were interested in accessing preventive services, or directing aspects of their healthcare, but whose social care needs in terms of eligibility criteria were less clear than their clinical needs in the health context.

Throughout the key findings presented below we have sought to draw out key statements, with summaries of discussion, followed by suggested implications that providers may draw from these points.
Health and Social Care

Providers should be aware of SDS and the development of health and social care integration in Scotland. Third sector providers are often funded by both health boards and local authorities and can link the agendas effectively.

Self-Directed Support should be a natural fit with recovery, but recovery itself is still growing and isn’t a static concept

Third sector providers were at the forefront of developing and promoting person centred, recovery oriented mental health services, and they continue to innovate and develop tools and approaches to support emerging service models such as peer support.

- Recovery should have a strong affinity with self-directed support. A principal component of the recovery movement is that a person should be supported to find what works for them, with the aim of living a meaningful life. This includes identifying and using a range of support, including services where needed to manage the symptoms of mental ill health, or minimise their impact on life.
- The development of self-management and recovery tools for individuals and for services, and linked efforts to change culture and embed recovery outcomes in services may provide some interesting learning for self-directed support. WRAP and other self-management tools were suggested as ways to assist people with framing outcomes in SDS.
- Mental health problems can be persistent impairments that result in substantial disability and clear need for social care support. For this group of people, recovery often means living a good life with substantial support from social care and health services. This group has been very hard to access with direct payments, but could, participants felt, flourish with self-directed support if supported to do so.
- Self-directed support might indeed be a useful tool for people who found recovery challenging, in the sense that health service models of recovery can be oriented on ‘returning to function’ when some people are likely to find that impossible.
- Some participants felt that self-directed support might be a useful way of promoting a recovery ethos in dementia, or highly complex mental health problems where conventional notions of ‘getting better and getting a job’ were less helpful.
- Many people using the services provided by third sector providers fall between these two extremes, with periods of good functioning, and periods of very poor functioning. A person might require very little support one month, and extremely intensive support the next and their level of need for care services may vary. For this group self-directed support presents a challenge. Participants were concerned that assessment and review systems may not be sensitive or accessible enough to plan for fluctuating needs.
Third sector providers have been at the forefront of developing recovery oriented services. Providers should examine the potential for using recovery tools and personal recovery planning tools like WRAP to assist people with framing outcomes in SDS.

Providers already offer personalised services to many people. They should be confident that though systems change, much of the ethos behind SDS is already mainstreamed in the mental health third sector, which means providers have knowledge and expertise local authorities can benefit from.

Welfare reform is terrifying service users, who are moving away from assessments and fearful of charging policies

At most sessions, participants raised concerns about the extent to which the introduction of self-directed support corresponded to local authority budget restriction and welfare reform.

At every session, the point was emphasised that self-directed support was not directly connected to the welfare reform process. Although this is true, there are touch points between welfare reform and SDS which were highlighted by participants and which may provide challenges for providers and local authorities during the implementation phase.

The parallel implementation of self-directed support and the introduction of simultaneous welfare reform and reduction in welfare spend has led to a set of circumstances where disabled people feel that they are exposed to multiple, intensive assessments, which have the potential to drastically change their lives. It was a consistent message in these meetings that service users were reticent to take part in assessment, because they were bruised by assessments such as the work capability test or DLA renewals, or fearful of them.

For people with mental health problems these effects can be magnified by the nature of the impairment with fear leading to anticipated discrimination, and media reports intensifying self-stigma to the point that participants felt that many people who might qualify for SDS would not put themselves forward for assessment.

Providers are very familiar with the impact welfare reform is having on people’s mental health and willingness to engage with services. They should continue to gather this information and bring this to the attention of local authorities and to Government.

Providers could look at the pre-assessment preparation for SDS, potentially working with service user organisations and other partners to enable those who could benefit from SDS to see the assessment process as distinct from welfare related assessment.

Guilt and Self-Stigma affect people’s ability to advocate for their needs, or feel deserving of services

“I’d feel guilty with this kind of package, like I was taking money from a real disabled person”

Self-stigma is a term used to describe the internalisation of negative stereotypes about people with mental health problems. Self-stigma was a theme in five of the regional sessions. Service users had disproportionate concerns about their competence to make choices or manage or influence the use of funds. In some cases, people reported that this had been reinforced by professionals who should have been better informed.

Key points included:

- Service users felt that ‘people like them’ would not be able to manage direct payments or employ staff.
- Service users expressed concern that the assessment process would be bound to reduce their support package because they had mental health problems.

- Service users found it hard to frame outcomes beyond clinical/medical activities. Some expressed the view that they were grateful to be given what they got, and did not want to ask for other things in case what they had would be jeopardised.
- Service users expressed concern about the extent to which they could spend personal budgets on ‘leisure’ activities, especially where there was concern about the legality of things like bingo, which was an important social activity but technically counted as gambling.
- Service users had concerns about their ability to manage budgets, especially where financial mismanagement had been a problem in the past. Several spoke of ‘paralysis’ due to a fear of being judged to have spent money wrongly.
- In one session, people wondered if imaginative or creative uses of budgets might be picked up on by local media or the tabloid press, or used politically in election campaigns.
- Service users were concerned that the assessment process was likely to be so intensive, or extended that they wouldn’t be able to get through the whole process and therefore would not apply.
- Service users expressed concern about contacting social work in relation to their mental health, due to their previous contact with social work having been related to children and families services, addiction or criminal justice. Several service users told us they categorically would not engage with social work, even if that is the only way they could access services.

Providers are supportive of local and national anti-stigma programmes, and have engaged wholeheartedly in their activities for decades. As anti-stigma work in Scotland develops over the coming years, providers can continue to work on this.

Self-stigma is a critical area for empowerment in mental health. There are opportunities for providers to support service users and user organisations to develop peer led services in SDS and to support the sharing of stories of SDS in practice through initiatives such as the Narrative Project.

One area of emerging interest in anti-stigma and discrimination work is discrimination in services. Providers may be interested in working on SDS implementation as an area of interest in the field, working with service users and providers to ensure all staff are aware of mental health needs, and monitoring for and addressing any concerns raised in regard to assessment or implementation of SDS. Anecdotally we heard at sessions that service users had been told SDS wasn’t for people like them, when it is clear that though SDS can be challenging in mental health, it can be done.
Choice and Control

Some of the most interesting and useful discussions at the regional events centred on the nature of choice, culture and control in mental health. The introduction of self-directed support for social care in mental health was very challenging on a number of fronts.

Practically and culturally choice is challenging in mental health, and this was a recurrent theme at the regional sessions. There were discussions about extent to which people felt able to make choices about their support packages, and discussions about the development of choices in service provision in mental health and the way in which people accessed those.

People were excited by the prospect of using SDS, but still concerned about practical implementation

Service users and providers were both excited by the principles of choice and control that self-directed support could bring. Most could see the potential for self-directed support to enable imaginative solutions to peoples support needs.

This could include peer led services for instance, the flexibility to return to the guiding principles upon which many third sector mental health service providers were founded.

The idea of people moving from being ‘service users’ to ‘service commissioners’ was discussed, and was seen as both exciting, and challenging. People liked the idea, but were concerned that it might be difficult. At the same time providers recognised the culture change that would be needed to get to this.

Most people who took part in the discussion sessions welcomed the introduction of the four options for SDS, and could see where they fitted with mental health. There was a general feeling that the options that weren’t direct payments made the possibility of greater control short of directly managing budgets more real. That said there was real concern about what choice would mean in practice on the ground.

At several events we heard from staff who had previously worked in England in services or in statutory roles, where the potential for personalisation of support to include a measure of choice over health as well as social care services had enabled people with mental health impairments to engage more fully with personalisation.

This had, they felt, enabled people with a high level of ‘health’ need but ‘low’ social care needs to exercise choice. This was in contrast to perceptions of SDS in mental health in Scotland, where narrow eligibility criteria might be difficult for a person assessed as having similarly low social care needs to access an individual budget and direct their support in the future, even if the relatively small amount of support they currently receive is of very high value to them.

With the potential for charging policies and their interaction with welfare reforms and what appeared to be restrictions on the use of funds several sessions questioned whether self-directed support in mental health would achieve outcomes for service users or just be ‘another passing structural process.’

Provider organisations should be aware of SDS implementation in their areas of operation, at all levels from governing body to operational staff. It can be hard for provider organisations to make staff available to participate in training and awareness activities, but governing bodies and senior staff should be aware of what SDS implementation could mean for organisational development, strategic planning, risk management, and operational effectiveness.

As well as being aware of implications of SDS at a strategic level, governing bodies and senior staff should ensure that they keep staff at all levels aware of development, and involved in development activities to ensure staff are engaged.
Choice is threatening for people with mental health problems, and change makes it harder still

“Fear of change can be paralysing, and there will be a lot of change in next few years. Even if we choose to 'stay the same' by asking Council to choose, there will still be change in services, and that is scary.”

Choice itself, whilst liberating and empowering to some people, can also be challenging to some people with mental health impairments. During the course of this project, service users related concerns about change in general, and specific concerns about self-directed support and being ‘forced’ to choose an option for delivery of their social care.

“How do I know what to pick and who should provide it? I find making decisions difficult in the first place. I want to be involved but I don't know if I want to make decisions.”

This is not to say however that there are opportunities for people to develop new, imaginative ways to support their mental health needs using self-directed support. In several sessions, even service users who had previously never heard of self-directed support were interested in the potential it might have to help them to tailor services that they received.

“Sometimes you need a support that will tell you/cajole you into action. This might be hard with an employee, because they'd want to please you and might not push as hard. If I told them to leave me alone, they might, and then miss a crisis. On the other hand it might be easier to accept being pushed if it was by a person you could choose, someone you trusted.”

“One of the things that has stressed me out is having my support worker change. It would be good if I could arrange overlap cover for when people need to move on or go on holiday so I could get used to more people.”

Providers have a role to play in assisting service users and carers of what their options are, including the option that they can choose to have a provider or the local authority direct their support. Many service users look to support workers for advice and input and it is important that provider staff are able to give good information.

Providers can individually and collectively collect information and personal stories and use these to guide their own service development and capacity, and inform policy makers and local government.

As well as outcomes, people needed to hear about what they might be able to buy, so as to set their expectations appropriately

In every session, there were discussions about what people might wish to purchase using a support package. Local authorities were clear that self-directed support could be used for all types of service provision to meet the needs of individuals, provided it was care related, legal, and did not bring the local authority into disrepute. Local authority representatives encouraged service users and providers to be as imaginative as possible in considering ways to reach outcomes.

This approach was welcomed as it does open up opportunities for providers to return to their roots and explore creative ways to deliver support and facilitate recovery and reablement. This emphasised the importance of engaging with service users now and opening up dialogue about support arrangements in relation to desired outcomes, testing ideas with service users.

Service users expressed concern about the extent to which they could spend personal budgets on ‘leisure’ activities, especially where there was concern about the legality of things like bingo, which was an important social activity but technically counted as gambling. It was likely that SDS could be used to support a person to attend bingo, as long as they purchased their cards and entry fee from their own resources.

One important concern was raised by Clubhouse staff and members, who were unsure as to where Clubhouse fitted into the framework of self-directed support. Clubhouse is an evidence based and globally respected service model, delivering co-designed and jointly delivered personal outcomes, but some people felt that it was hard to fit Clubhouse into the framework of the four options for SDS. This had, some felt, implications for social work funded Clubhouses.

Whilst there was some confusion between what ‘care’ was, and what a health service was most people who wanted to have an element of control over their services would choose to purchase control and consistency in provision, or services delivered flexibly in a way that suited their needs. Over and above this, service users expressed interest in using a personal budgets to purchase respite (either as a carer or service user), and to participate more fully in community life.

As more examples of SDS in mental health become available, providers can supply examples of their own work, and those from other services. Providers should remember that many people choose to work in the third sector because they want to be creative, and they should encourage staff to think laterally about how outcomes might be achieved.

Providers want to work with local authorities to develop a market for SDS services

Most of the regional sessions envisaged a scenario where third sector providers will be able to offer services to individuals alongside private sector providers, arm's length services from local authorities, social enterprises and community organisations from outside the care sector from which a person might use as an outcome in their plan. In most of the events there was discussion about the way such a market would develop in practice in each local area.

“I worry that SDS may end up being a list of providers from which I'm told to pick. Mental health problems can mean that too much choice is very stressful. I need to know that that SDS is a choice, but that one of the options can be 'let someone else decide for me.”

Most sessions highlighted the critical role local authorities play in establishing a market for self-directed support, in the sense that they provide the capital, regulate the demand on the market, and regulate the conditions under which the market operates.

There was universal agreement that developing markets would take time, and that providers wanted to be part of the process. Several regional meetings pointed to there being a period between start of SDS implementation and providers being geared up to offer competitive services in an open ‘market’.

Providers were interested to know what 'bridging' support local authorities might make available to support their transition to offering SDS choices when the guidance and local structures are in place.

Providers were very keen to understand the role that the private sector will seek to take in SDS for mental health both in terms of understanding business models and competition, and in terms of modelling business practice in a market environment new to many third sector organisations.

For those with clear needs and an individual budget, choice will be open, but might be challenging

For those people allocated an individual budget it was clear that that there needed to be a genuine choice for people in terms of SDS option and in terms of what services might meet their outcomes and how they might be organised or combined.

Service users in this group said in sessions that they don't necessarily want to shop around for services when their needs are being met well by existing providers. This in itself has implications in terms of driving a conventional 'market' which is often sustained by advertising and 'marketing' of services.

Some concern was raised at sessions about the type of marketing that could and should be used to 'attract' service users to particular services, and several sessions discussed concerns about direct marketing of services via leafleting or house calls, which had been seen in older people's services.

"Current services can sometimes encourage dependency. If they rely on me being a customer this could get worse.”

Concern was raised in some groups about the size of the market, and therefore the demand for services. There was some concern expressed also that the numbers of people 'qualifying' for
individual budgets might drop compared with the numbers currently receiving a lot of support in the current systems, and that the value of individual budgets for SDS might be lower than the equivalent current value.

If the number of individual budgets and the value of these were to drop, provider staff had real concerns about the level of choice that might be offered in the market in terms of both operational sustainability of provider organisations, and their ability to provide services at the cost required.

Providers were very keen to explore opportunities for collaboration with other providers. By and large, provider staff who attended recognised that competition is a fact of life in a marketplace, as well as in a ‘managed market’ with tendered services. Most saw opportunities for formal and informal discussions about service offer and structures at a local and strategic level.

Examples of shared activities in Fife with the Barony Housing pilot for shared systems and paperwork, Falkirk with Carr Gomm and Penumbra collaborating on a voucher scheme for respite care, and GAMH and Health in Mind adopting Penumbra’s iROC outcomes measurement framework were all discussed as positive examples.

Most local authority representatives at the regional events were keen to engage with providers individually and collectively to assist them with market development, and to learn from their experiences.

Providers need to recognise that SDS will in some cases mean that they need to move away from some of the service models they have used in recent years. Equally, there are also opportunities to develop and promote new services, or return to service models that weren’t fundable previously.

Providers, local authorities and service users have an opportunity to work together to use pooled individual SDS budgets to commission, design or retain services that otherwise would not be possible.

People likely to be assessed as having low support needs wanted to use SDS to access preventive or less intensive services they otherwise could not access.

At all of the regional events, there were discussions about the extent to which self-directed support reach people who have some social care needs, in the context of a range of health needs. This population was identified as being more likely to get a low value individual support would reach people who have some social care needs, in the context of a range of mental health problems. Some of these service users had multiple impairments, and met the eligibility because of the combined effect of these, and not purely on mental health grounds.

• At several events service users who used self-directed support discussed the ways that they used individual budgets to support their mental health and wellbeing to prevent medication problems. Some of these service users had multiple impairments, and met the eligibility because of the combined effect of these, and not purely on mental health grounds.

• Service users were excited by hearing examples of people being supported to go to college courses and sports clubs, or being supported to have chickens, or a dog, but there was real concern that these activities would only be available to those with substantial or critical needs.

• Some participants questioned whether the challenge people with less urgent needs faced in engaging in community activities like this were related to discrimination, self-stigma and anticipated discrimination, and if so whether it was the role of social care budgets to address this.

• Service users pointed to the value of group sessions and drop-in services as being important to them, reflecting that SDS seemed to be very focused on individual services rather than group activities.

• Several service users expressed interest in using an SDS budget to access group activities outside services (such as a community knitting group or night class) as part of their recovery, but then were concerned that if they were well enough to do that they probably wouldn’t be entitled to enough of an individual budget to pay for support to do that, notwithstanding any contribution they might already make.

At most of the regional events provider and service users felt that they need more clarity about how local authorities would support services for those with small value individual budgets, or those who were assessed as having needs that did not qualify them for social care. It is unlikely that directly funded services for this group will cease even though budgets may fall. There is therefore space for innovation in this area too.

Some providers also recognised that there may be an opportunity to offer preventative and low value mental health support to people with other impairments who have individual budgets and outcomes relating to improved confidence, self-esteem, social skills and coping.

Technology provides opportunities for new service, but not for everyone.

Technology was widely seen as a means of improving access and choice, as well as information, and certainly was raised by service users and providers as a means of reaching people. Equally, participants were keen to stress that not everyone wants to use the internet, or has access to the web. Whilst service users use of new technology may be inconsistent, several groups felt that staff and providers should be able to access information and e-learning to help them to gain understanding.

A critical point made in several sessions was that technology cannot become the only, default way of gaining information or completing forms. Anxiety was expressed that web portals were becoming the default way of passing information on official matters, and that many older service users had no skills or access to technology. Service users and providers raised the example of the new Personal Independence Payment (PIP), which has an entirely online application process that people found challenging.

Technology would be crucial in delivering choice in SDS. In Falkirk and Glasgow Penumbra have used tablet computers to assist people in scheduling appointments with support staff. As well as being used for this, service users had the opportunity of gaining internet skills by using the tablet devices to access the internet. Service users from Falkirk are now set to assist those in Glasgow with getting used to using the tablets, providing peer support, recognising that they themselves found the technology challenging at the start.

Assistive technology may enable people to prioritise face to face services when they really need them. In Renfrewshire service users had requested late night visits to administer medication, a visit which would be expensive to offer compared to the cost of a visit in office hours. If a support worker could leave the medication in a locked box that opened in the evening, the service user would not have to pay the added cost of the late night visit. Similarly, personal video conferencing tools like Skype or FaceTime might enable virtual visits for people in rural communities.

Providers have started to use technology to streamline record keeping and enable staff to share quickly. Richmond Fellowship in Fife for instance were using tablet devices for support staff to update service user files quickly, and to manage their diaries in the community, enabling more appointments to be scheduled, and a range of staff to engage with service users.

In some areas of Scotland geography and weather limit choice.

“Services will be forced into providing the cheapest possible services. If you don’t live in a town you are going to get left out. If I get assessed as needing 2 hours home support who is going to drive 45 minutes each way to provide it, especially in winter.”

Several meetings in small or rural areas such as Highland, South Lanarkshire and Perth highlighted the challenges with market development in difficult market sectors, such as low volume areas or remote and rural environments.

In some areas, such as Highland this was in terms of the options available in terms of providers who could cover remote localities, and the challenges with transport people face. In other areas, such as in Glasgow and surrounding areas there was concern about sector boundaries between CHPs, local authorities and localities, and the ease with which people are able to access services outwith boundaries in which traditional services were accessed and into which NHS services still fit.
Weather was also highlighted a challenge to delivery, especially given that poor weather can also be a factor in fluctuating mental health.

Participants pointed to the fact that stigma and self-stigma meant it may be harder to engage community members as assets in a support package when a person with mental health problems may not want to disclose, or may be actively or tacitly discriminated against in a community.

Providers who operate in remote areas will already engage with local authorities and health boards in those areas to address concerns posed by geography and weather. It may be desirable for providers to link up more systematically to share experiences of addressing these challenges.

Community Asset Mapping projects such as ALISS and IRISS projects may assist people to access community resources locally. Micro-provision may also be a way for local services or hyper local services to support people distant from population centres.

Providers operating across multiple local authority areas were keen to understand how transferability of SDS packages might work when individuals either move into an area, or move across local authority boundaries within the same locality. It was not clear as to whether support would transfer, or whether a new assessment process might be required.
Information and Engagement

The top line finding in this area, consistent across the launch event and the ten regional sessions was that awareness of self-directed support amongst mental health service users was either low, or that information was inconsistent or unclear.

Service users were often not aware of SDS and did not understand the implications for how it could affect the services they were receiving at present. Service users also showed a degree of confusion regarding the extent to which choices would extend to health services under self-directed support, and the extent to which self-directed support was connected to welfare reform.

In Highland, one service user pointed to the challenges with ‘systematising’ something as complex and individual as mental health:

“The truth is that two individuals with the same mental health problem may be as different from one another as any two people can ever be. One of them may thrive on intense support and being well trained professionals. The other may require absolute independence and control to complete their journey to good mental health. It always strikes me therefore, that any attempt to systemise the provision of care, to allocate it to neat diagrams, flow-charts and logical processes are, in themselves, quite illogical!”

Natalie Thomson, a social worker from Highlands Health & Social Care Partnership presented the current structure for SDS in Highland, which is very well summarised in a leaflet ‘What is SDS’ produced in Highland and available online.

Many service users expressed anxiety about the arrival of self-directed support as the only way of accessing social care services, pointing to the nature of mental health impairments potentially making choice a challenge. This was in contrast to the intention of self-directed support as a way of empowering people to make choices and take control of their lives. Service users and providers all felt that tailored, mental health specific information was crucial for all stakeholders, to be able to raise awareness, manage expectation, and facilitate choice. Most participants saw the need for high quality independent information provision alongside a role for providers and for service user groups.

In addition, every meeting called for the development of resources that showed examples of people with mental health impairments using the four options in practice, so they could see the sort of things they might use.

There is a need for specific mental health information about SDS from a range of sources

There was discussion at every event about who should provide information about self-directed support in relation to mental health. These discussions covered basic information, advocacy in relation to choice, support for assessment preparation, and support for utilising an individual budget on a daily basis.

• In terms of basic information, it was clear that local authorities and information providers should make available good quality information that included mental health examples. Local advice centres and information providers should also be aware of the basics of self-directed support and the options as they relate to different impairment groups and the local systems and structures.

• Service users at several events made it clear that they trusted the advice of support workers or organisations that they knew well and had a trust relationship with. Many felt that they would like to get information about self-directed support from their provider.

• In every meeting participants called for the availability of case studies/examples of support packages that were mental health specific for each the four SDS options. It was suggested that guidance for implementation of the new legislation should include mental health specific worked examples.

Providers were keen to provide information, but were also mindful of the fact that they would need to balance this against ensuring that clients had the widest possible choice of service. The analogy of financial services was raised, where a bank customer can choose to be advised by a trusted bank manager, whilst being made aware that discussions with an Independent Financial Adviser might yield a wider range of options to consider. The customer can choose to purchase from their bank, or look for other options. The challenge, some felt, was that the nature of mental health impairments is often such that choice is intimidating and the status quo may seem attractive, even if it is not in the person’s best interests.

Some providers also provide information services. They should consider how best to maximise these for providing information on SDS, without appearing to create a conflict of interests.

Some providers felt that improving the awareness of support workers on the ground could enable them to better support and allievate their own anxiety about what SDS might mean for their organisations and security. This could thereby reduce ‘leaking’ of this anxiety to service users.

It was widely suggested that providing a range of examples of both process and practice using the four options for mental health related impairments would be useful in explaining self-directed support and enabling people to engage. These examples will in time come from real life case studies, but several participants suggested that guidance examples should also include examples of mental health related support packages.

The need for examples of SDS in practice was so consistent that since the regional events the project partners have linked with Penumbra and the Scottish Recovery Network to develop a joint mini-project to collect and present these stories of people’s experiences of applying for and using self-directed support in mental health.

There was no clear consensus on who could or should provide support, advice and information, although local authorities, providers and existing advice and advocacy services, and service user representative groups all had some responsibility to ensure that people were properly supported. In order to achieve this there would be resource, funding and capacity implications on existing provisions particularly in relation to advice services or advocacy services.

Participants hoped to improve the flow of accurate information within the system

Across several sessions a consistent message was that the introduction of self-directed support required both a shift in culture, and the assimilation of a huge amount of complex information by service users, providers and existing advice and advocacy services, and local authorities and their provider networks, as well as good quality information being shared within local authorities and provider networks through staff training and awareness. National initiatives such as Providers and Personalisation through CCPS were seen as an important feature of this sharing.

• Concerns were expressed that implementation of the new legislation would result in more information and systems to process. This was of particular concern where the new regulations meant that recently introduced systems for self-directed support that people were becoming acclimatising to would need to be adapted to accommodate new arrangements.

• Providers and service users both hoped to see a flow of information across the system, with information from central government passed to local authorities, and on to local authorities and their provider networks, as well as good quality information being shared within local authorities and provider networks through staff training and awareness.

• Providers and service users both hoped to see a flow of information across the system, with information from central government passed to local authorities, and on to local authorities and their provider networks, as well as good quality information being shared within local authorities and provider networks through staff training and awareness.

• Service users at several events made it clear that they trusted the advice of support workers or organisations that they knew well and had a trust relationship with. Many felt that they would like to get information about self-directed support from their provider.

• In every meeting participants called for the availability of case studies/examples of support packages that were mental health specific for each the four SDS options. It was suggested that guidance for implementation of the new legislation should include mental health specific worked examples.

Participants hoped to improve the flow of accurate information within the system

Across several sessions a consistent message was that the introduction of self-directed support required both a shift in culture, and the assimilation of a huge amount of complex information by service users, providers and existing advice and advocacy services, and local authorities and their provider networks, as well as good quality information being shared within local authorities and provider networks through staff training and awareness. National initiatives such as Providers and Personalisation through CCPS were seen as an important feature of this sharing.

• Concerns were expressed that implementation of the new legislation would result in more information and systems to process. This was of particular concern where the new regulations meant that recently introduced systems for self-directed support that people were becoming acclimatising to would need to be adapted to accommodate new arrangements.

• Providers and service users both hoped to see a flow of information across the system, with information from central government passed to local authorities, and on to local authorities and their provider networks, as well as good quality information being shared within local authorities and provider networks through staff training and awareness.

• National initiatives such as Providers and Personalisation through CCPS were seen as an important feature of this sharing.

• In mental health there was an additional need to ensure that all staff working with people with mental health impairments were able to give accurate information. This included both health and social care staff as well as service user organisations and advocacy groups. We heard anecdotally that service users had been told that direct payments wouldn’t suit them, or that there weren’t any local services for them. This then discouraged service users from pursuing their ambitions.

• Some local authority social work staff attending sessions did not have an understanding of what SDS was, and were told by colleagues present that the opportunity for training had passed. This said in other areas specific training had been delivered to local social work teams to support capacity building in staff teams. In some areas mental health is already included in SDS specifically or as part of a pan-disability approach. In other areas, SDS is being gradually introduced in different impairment groups, and it is important that as interest increases and service users start to ask about SDS that accurate information about timetables for implementation locally can be given.
The period now, between the passage of legislation and the coming into force of the law presents an opportunity for providers, local authorities and user/advocacy groups to start to put together information for interested parties. In all of the areas visited providers were keen to engage in, or continue with, dialogue with local authorities to develop and test systems.

Co-Production can really help explore outcomes and plan services

Providers and service users saw potential for SDS to provide the opportunity for the re-development of services according to the needs of service users by pooling individual budgets or collectively commissioning services. Examples of co-design processes such as a pilot in Renfrewshire for using service design approaches to redesign housing services by Loretto Housing, IRSS and Creative Frontline, and similar work by Penumbra in North East Scotland to develop shared solutions for supported housing by groups of service users were highlighted. In addition, some service user organisations saw the potential to develop peer support services either in collaboration with provider organisations or independently.

Though co-production was seen as crucial to the successful implementation of SDS, participation by those with lived experience in the regional meeting was still lower than expected. Several service user groups, notably Highland Users Group sought to distance themselves from self-directed support, and taking a role in supporting its implementation. Other service user groups were interested in engaging with the process, and keen to work with providers and local authorities on developing capacity.

Providers were keen to understand more about marketing and market research with their service users, as they look to develop their services and workforce to meet a wide range of individually defined outcomes than to meet a defined set of criteria outlined in a broad contract.

Service users present were loyal and keen to be involved, suggesting that co-production approaches with service users at a local level would provide valuable insight into the services people wanted. This kind of approach was already being implemented by Penumbra, GAMH and other providers in the West of Scotland, who have established an SDS ‘Champions Group’ to assist with the development of services, informal peer support for those using SDS and information on SDS and services for service users.
Process and Systems

The single biggest area of discussion at regional events was about the process and systems that would be in place to support the implementation of self-directed support. Most local authorities already had systems in place for direct payments, and some, such as North Lanarkshire and Glasgow are already implementing self-directed support across social care including mental health.

For the majority of local authority areas represented at the regional meetings processes and systems were now being developed. This presented a challenge in terms of provider and service users being able to consider how best to develop their capacity based on what might happen going forward, but also an opportunity in that local authorities were very keen to recognise the particular circumstances mental health impairments present and to take note of this in developing their systems.

Participants felt that transparency was critical with joint work resulting in clear agreement and focused outcomes. People need to trust the systems and processes used if SDS is to be successful in achieving the aims set. Systems need to be open and accessible so that everyone is clear about what to expect and how to engage. A degree of flexibility is anticipated in order to respond to different needs of service users and this was a key message to commissioners.

The language of SDS needs to be welcoming

Service users and providers at multiple events pointed to the use of jargon in information relating to self-directed support. There were different understandings of terms such as personalisation and self-directed support, and confusion about terms such as Resource Allocation Systems (RAS) and Self-Assessment Questionnaires (SAQs).

Some participants in areas where SDS implementation was advanced were concerned that the pace of implementation had been such that they had not been able to acclimatise to the new terminology and systems in time.

“They can’t just change the system overnight, it should be a gradual process done at a person’s own speed.”

Service users and providers were keen to see such things as ‘jargon busting’ guides to self-directed support and access to helplines and public information services.

Take-up of direct payments has been low in mental health. Participants at several events pointed to the fact that most available information on self-directed support still focused on direct payments, leading to a misunderstanding that self-directed support was just direct payments by another name.

Concerns that some people had about their ability to manage direct payments was shifted onto self-directed support because of this, with people wrongly feeling that with the introduction of SDS they would be required to take a direct payment or similar.

The regional events provided many participants with their first opportunity to consider the four options for SDS. Most people felt that the options presented a much better opportunity to tailor services for people with mental health impairments than direct payments alone.

Providers in mental health can work with service user organisations and local government to ensure that materials are welcoming and accessible.

Providers and service users feared restricted eligibility criteria might impair access to individual budgets and choice

At present, many local services are block funded by local authorities and used on a self-referral basis by service users who don’t have an existing social care package but may need to obtain an individual budget in order to continue using these services after the widespread introduction of self-directed support. Concerns were expressed at the events that only those in the most highest bands set out under eligibility criteria would automatically get an individual budget in order to continue using these services after the widespread implementation of SDS.

During the implementation of SDS people with mental health impairments will need to undergo assessments for self-directed support in order to continue to receive services, even if they subsequently choose to ask the local authority to arrange their support. Service users at several events, notably Glasgow, told us that they were poorly prepared for the assessment and did not know what to expect, which had left them less able to articulate needs.

Because many people with mental health impairments to not access social work or social care services but instead use services provided by the NHS, there is confusion in service user groups about who is eligible for self-directed support.

Preparing for assessment is key

Service users and providers were very clear that people with mental health problems were most likely to meet eligibility criteria and be assessed at times when they were very unwell, such as when in hospital.

If people are unwell but improving, and for example being discharged from hospital then they are likely to be assessed quickly, and have urgent needs. It may however be challenging to work with them to define outcomes and make choices in the first instance, and it is still unclear as to where compulsory treatment will fit in the guidance for the Act. It is likely that they will need to be re-visited as their circumstances change.

Participants felt that successful outcomes planning was likely to hinge on finding a time when people were able to express their wishes, and were able to think about the future and how they might live their lives, ideally over more than one session.

The assessment process needs to fit mental health and be adaptable to rapidly fluctuating circumstances

Social work departments are charged with assessing needs for social care services according to the eligibility criteria, and then supporting those people who are eligible for services to develop a support package using self-directed support. Across the country the process for doing this varies. In order to achieve accurate assessments of need, participants wanted to see a system that is sensitive to service user needs, but also engages with them in a meaningful and inclusive way.

There was some questions as to whether this role would continue in the future, when SDS became the norm for accessing support. Some people felt that the role was likely to change, as people came to assessment either when they were first unwell or when their circumstances changed.

Providers should work with local authorities to feedback concerns about the process of assessment and assist with developing alternatives if required. Learning from pilots such as Fife, where providers and the Council have developed systems which are transferrable and therefore consistent should be shared widely.

Groups of providers in different locations may benefit from action learning sets to assist with development of services and systems.

It is likely that at least in the initial phase of SDS implementation, that a specific role exists to support people with preparing for SDS. This might include an element of peer support, or the use of planning tools to help frame outcomes. It may also include mapping recovery goals across to care and support, and helping people to translate ‘health’ issues to life goals.

There were some questions as to whether this role would continue in the future, when SDS became the norm for accessing support. Some people felt that the role was likely to change, as people came to assessment either when they were first unwell or when their circumstances changed.

In the future, information about how eligibility criteria applied in mental health was seen a key, particularly in managing expectations so that as demand for SDS assessments increase, people are not disappointed because a certain level of health ‘need’ does not equate to a social care need in terms of assessments.

The assessment process needs to fit mental health and be adaptable to rapidly fluctuating circumstances

Social work departments are charged with assessing needs for social care services according to the eligibility criteria, and then supporting those people who are eligible for services to develop a support package using self-directed support. Across the country the process for doing this varies. In order to achieve accurate assessments of need, participants wanted to see a system that is sensitive to service user needs, but also engages with them in a meaningful and inclusive way.

There was some questions as to whether this role would continue in the future, when SDS became the norm for accessing support. Some people felt that the role was likely to change, as people came to assessment either when they were first unwell or when their circumstances changed.

In the future, information about how eligibility criteria applied in mental health was seen a key, particularly in managing expectations so that as demand for SDS assessments increase, people are not disappointed because a certain level of health ‘need’ does not equate to a social care need in terms of assessments.
Most of those we spoke to who had used SDS highlighted that achieving an individual budget had been a drawn out and difficult process. In several sessions providers and service users called for the process to be streamlined, or there would be a risk that those with mental health impairments would not be resilient enough to fight for their individual budgets either because their health worsened, or they grew confused or disillusioned with the process.

Mental health impairments fluctuate, and needs change quickly. There were concerns at most events about how quickly systems would be able to reassess and amend individual budgets, with a hope that flexibility to increase support in order for instance to avoid hospital admission.

Providers may benefit from user journey research, with groups of service users participating in research throughout their journeys towards SDS, via assessment, budget setting and living with the budgets. This may enable all parties to identify and address pinch points.

Who Should Conduct Assessment?

Each local Authority will have its own processes, but there was a generally consensus that local authorities needed to look at who should be involved in the assessment and this should not just be social work. In some areas specific professions were suggested (GP, CPN, OT) and in others support workers were also suggested.

The consensus was that the process should look at who are the best people to be involved in the assessment on a case by case basis. In some areas, there was a real interest in developing multidisciplinary assessment. In Highland health and social care are integrated, and therefore there would already be a degree of crossover. In other areas such as Falkirk and Stirling there was interest as the decision making process already included health staff. In other areas there was a clear indication that there would be no flexibility on assessment by other staff.

Many of the service users attending the events had serious concerns over increased social work involvement in the way they would access SDS. Whilst people understood that social care services were largely funded through Local Authority Social Work Services most people did not feel that they had any direct social work involvement and did not want to have direct social work involvement. Either through personal experience or stories they had heard there was a poor perception of social work involvement. This was viewed as a real threat by people and in some cases people said it would act as a deterrent and stop them from accessing an environment.

Providers can assist their service users, and service user organisations, to make representation in terms of widening assessment. Although this is well prescribed as a social work role, there may be an opportunity in the Guidance consultation on the SDS Act, or discussion around the Integrating Health And Social Care legislation to broaden this.

Providers could also work with social work to run sessions for service users about social work, and address the concerns service users may have about social work engagement.

Concerns were raised over social work capacity to assess people with mental health impairments who are not currently known to social work

Concerns were raised at most sessions about the capacity social work departments had to process a high volume of requests for assessment. If implementation of self-directed support happens rapidly, as seems likely there were concerns that waiting times for assessment might be high and that people would be vulnerable as a system whose caseload is increasing and resources are reducing tries to implement the new system.

Some participants raised concerns about social work staff knowledge of mental health. Other Than Mental Health Officers (MHOs) many participants felt that most social workers may lack any significant mental health experience other than basic training.

In addition, direct payments teams are unlikely to have substantial experience of mental health due to the low take-up of direct payments by those with mental health impairments. MHOs may be familiar with mental health and may have statutory involvement with some clients, but they may find it difficult to have additional capacity as they are already under pressure with mental Health Act work.

Creativity and imagination have long been promoted as being critical to achieving the culture change required to embed self-directed support. There were substantial concerns raised that increased workloads and reduced capacity could create circumstances that inhibited creativity and imagination, rather than promoted and developed these.

Participants were clear that they wanted to see all staff that would be promoting or taking part in the process of self-directed support accessing training and on-going professional development in this area.

Providers and service users were interested in supporting that training with lived experience, and were keen to ensure that training also extended to those authorising support packages and processing appeals.

People wanted to be able to take risks and make mistakes, within a framework of quality services

In several sessions, the themes of risk and quality were discussed. Service users and providers both emphasised that self-directed support should enable people to take risks with their lives in order to push boundaries, and also to make wrong choices and amend those without judgement.

In some areas, service users were keen to stay the same and not be pushed towards independent living outcomes. That said, several groups of service users and providers noted that the nature of support in mental health can include pushing people to do things they don’t want to do.

This was highlighted as a potential challenge in terms of SDS, as in theory a person could be offered a service that would do exactly as asked, and indeed could make money from taking money for services which weren’t provided because a service user had told a provider not to come.

Concern was raised at several sessions that people with previous experience of mismanaging their money could be at risk of overspending on direct payments they were given. Several local authority contributors felt that it would be possible to contract a package that accounted for this, making small parcels of money available at a time, or working with providers to ensure financial probity.

Service users were interested in how personal assistants employed using direct payments would be vetted. In several sessions there were concerns about the kind of access to vulnerable people that working as a PA could have. People with mental health problems often have experienced of trauma and abuse, and service users felt a level of trust with provider staff. Equally, some service users who had used direct payments or individual funds were pleased at the level of control they had over the selection of support worker.

Provider staff were interested in the formal regulation of self-directed support services, and the extent to which personalised services would be covered by the Care Quality Commission and other regulation.

Providers should consider how they would operate individual service funds in an SDS environment, and the systems that would support these. Work on financial planning for this is already underway in the sector.

Providers can work with CCPS Providers and Personalisation strand to engage with care regulators and bodies such as Disclosure Scotland to ascertain where personalised service may in future require different types of safeguarding.

Advanced Statements and Named Person roles might work in SDS

Advanced Statements are legal documents described in the Mental Health (Care and Treatment) Scotland Act (2003). They enable a person with a mental disorder to express their wishes about care and treatment, in case they become too unwell to be able to take active part in planning their care. Several discussion groups suggested that a similar ‘care advanced statement’ might enable them to express opinions about the kind of social care service they would like, and who would provide those services in the event that they aren’t able to provide their own support. This might enable people who were very unwell at the time of a social care needs assessment to express their opinions in a way that they might not be able to at the time.
A Named Person is role defined by the Mental Health (Care and Treatment) Scotland Act (2003). A person with a mental disorder can designate a Named Person to liaise with services, and to hold certain information about them and their care. One challenge with self-directed support packages that involved multiple care providers was in terms of information sharing. It was suggested that a named person role with regard to a person's self-directed support package could provide a link between providers, social work, and the person when they were less able to provide information.

Providers offering services as part of an individual service plan could pilot a named person type role. In a wider context, a group of providers in one location could work with a local authority to try such a role with packages where support was provided by multiple providers.

Providers and service users worried that local authorities would face a funding shortfall with welfare reform and a squeeze on budgets

Choice was a concern in relation to welfare reform, because of concerns about the flexibility of the system to respond to changes in financial circumstances dictated by the loss of non-means tested disability related benefits.

Service users and providers were concerned that budgets reliant on contributions from individual budget holders would be severely tested as more people became unable to make contributions and the local authority budget was required to stretch further. Providers were concerned that this, combined with budget pressures across the board would result in either reduced eligibility for individual budgets, or reduced choice for those who had individual budgets.

Service users were concerned that a need to contribute to their individual budget would mean that they would be unable to afford to participate in the activities that they would wish a support package to assist them to access. An example given by one service user was that faced with a choice of paying towards the cost of a support worker to help them go out to the cinema and not being able to afford a ticket, or being able to afford a ticket but not be able to get there, the likelihood would be that they would withdraw from the service, but not go out either.

In one session providers were concerned that they had been asked to collect contributions from service users assessed as needing to contribute to packages under the charging policy. They were concerned that this financial transaction affected the dynamic of the support relationship. In the same session the local authority confirmed that if service users did not pay their contributions, in the last resort the authority would use debt recovery processes to secure the money.

Finally, providers were also concerned that the process of implementation might affect the resource available to mental health with other impairment groups such as older people and learning disabilities being implemented first. There were some concerns that the examples of high budget, imaginative support packages might be harder to pass on budgets were already tight as mental health implementation came on-stream.

As a result providers were keen to understand the process whereby assessment and resource allocation systems monetised assessed need, and how that monetary value then translated to services, especially if services were then offered flexibly according to fluctuating needs. These concerns were picked up in the parliamentary debates on the Social Care (Self-Directed Support) Bill during its recent passage through the Scottish Parliament, and providers were very interested in how draft guidance would pick this up.

Providers can monitor the effect of budget restrictions and welfare reform on their service users, and report this back to commissioners. Providers should be careful not to assume the worst case scenario, and should look to learning across Scotland for examples of good practice in innovation.

CONCLUSIONS
Conclusions

In this final section, we present some key conclusions for capacity building in provider organisation, based on discussions in the regional meetings. As providers are at different stages of development only some of the following capacity building issues may be relevant to some organisations while all of them may be relevant to others.

Key Theme 1: Change Management Capacity

Building capacity for change is a critical concern in third sector organisations that are stretched in terms of capacity and resource.

• Preparation for change: all providers know change is coming so they should be having some form of development with their governing body and staff to prepare for whatever may develop locally.

• A staff development programme may follow from the above reflecting the needs of individuals and teams affected.

• It is acknowledged that there will be a change in the relationship between provider and service users. How this manifests itself will be different depending on the level of choice and control exercised by individuals. There will no doubt be a role for the providers in facilitating and enabling people to exercise choice and control without influencing them to settle for their service, i.e. ‘who is best to meet this need’ should be at the forefront of providers approaches in opening up the range of services on offer to meet specific needs.

• It is acknowledged that there will be changes to the structural modelling of services and in employment practices. Given the fluctuating nature of mental health there will be consequences and challenges for organisations if people adopt different buying patterns and providers will need to respond accordingly.

• It is acknowledged that the language may change but this may depend on the type of choice made by the individual and also the views of the individual. Will people still see themselves as ‘service users’ with ‘providers’ in a supportive role enabling change and embedding SDS as a part of a recovery plan or will people see themselves as ‘commissioners’ or ‘ purchasers’ of services from a ‘supplier’ to meet their particular needs?

• It is acknowledged that the manner in which many third sector providers have traditionally funded made it difficult to focus on personalised outcomes and individual needs. Providers who are now working to service level agreements that are constructed on hours calculations and specific outcomes will need to adapt to SDS whilst continuing to deliver on these outcomes. Creating the space to develop personalised systems whilst delivering on remaining contracted services will be a challenge.

• It is acknowledged that there will be an impact on systems used by organisations and this may have implications for the use of technology by staff and adopting different approaches to financial management (cash flow, invoicing, debt management etc) and business management.

• It is acknowledged that working practices may need to change with more innovation and imagination required to meet individual needs. Providers may need to go back to their roots and work with people to develop a co-production approach to service design and delivery.

• It is acknowledged that policies and procedures will need to change to reflect new ways of working, change in language and adopting new processes.

• It is acknowledged that organisations will need to ‘sell’ services and will need to develop marketing and promotion skills in selling services, including Web site development.

Key Theme 2: Connectivity

Building capacity within localities between organisations to ensure positive and productive connectivity may be required in some areas particularly in relation to the following:

• Relationships between providers and local authorities

• Relationships between providers and health boards

• Relationships between providers - national, local and private sector suppliers

• Keeping up to date with the latest developments in SDS and providing accurate and understandable information to service users

Key Theme 3: Joint Working

Building capacity within localities for more effective joint working particularly in relation to the following:

• Facilitating opportunities for providers, local authorities and service users to work together and learn in order to shape better ways of applying SDS for people to achieve desired outcomes

• Developing implementation processes including pre-assessment, assessment, named person, changing plans and measurement of outcomes. This could also cover use of technology need for advocacy or legal representation, the role of others in enabling user engagement and involvement and risk management.

• Developing the market within a locality to ensure a range of choices open to people, particularly in rural areas.

Next Steps

The findings and conclusions from the regional meetings were presented at an open discussion event in March 2013. Participants were invited to develop ideas for future capacity building activities based on these conclusions. These are summarised in Appendix II of this report.

In 2013/4 the project will develop two parallel strands of capacity building work to develop some of these ideas, and build on the conclusions of the regional meetings.

Strand One will develop strategic capacity in the local provider organisations that are members of the Scottish Mental Health Cooperative. A learning network will be developed, consisting of three action learning sets covering the areas of Workforce, Systems and Market Development. The action learning sets will consider a range of concerns and opportunities raised in the regional meetings. Selected outputs of those action learning sets will be made available to inform learning across the sector.

Strand Two will develop the co-production capacity of the Scottish Mental Health Cooperative member providers. The strand will bring together several mini-projects developed with particular providers, with the support of the project team. This is likely to include:

• Development of groups within provider organisations to assist with market research, understanding needs and outcomes, and designing services to meet those outcomes.

• Examination of one or more recovery tools, and repurposing these to assist in planning for SDS assessment.

• Lived experience led research to understand service user journeys through the SDS process, to better identify and address pinch points in provider organisations, and to highlight for other stakeholders such as local authorities where improvements could be made.

Learning from both strands will be brought together and shared with other providers and interested stakeholders at three regional ‘collider’ events in early 2014. These events will provide an opportunity to share learning across the sector, and encourage further collaboration between stakeholders.
## Appendix 1: Regional Event Summary

<table>
<thead>
<tr>
<th>Area</th>
<th>Host</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renfrewshire Service Users</td>
<td>ACUMEN, local service user organisation</td>
<td>MHF</td>
</tr>
<tr>
<td></td>
<td>Renfrewshire, East</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renfrewshire</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15 people</td>
<td></td>
</tr>
<tr>
<td>Renfrewshire Joint Event</td>
<td>RAMH, Cooperative Member</td>
<td>MHF Renfrewshire Council East Renfrewshire Council</td>
</tr>
<tr>
<td></td>
<td>Renfrewshire, East</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renfrewshire</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60 people</td>
<td></td>
</tr>
<tr>
<td>Forth Valley Joint Event</td>
<td>Action in Mind, Cooperative Member</td>
<td>MHF Falkirk Council Stirling Council (including Clacks) Two Service User Perspectives</td>
</tr>
<tr>
<td></td>
<td>Stirling, Clackmannanshire, Falkirk</td>
<td></td>
</tr>
<tr>
<td></td>
<td>56 people</td>
<td></td>
</tr>
<tr>
<td>Inverclyde Service Users</td>
<td>ACUMEN, local service user organisation</td>
<td>MHF</td>
</tr>
<tr>
<td></td>
<td>10 people</td>
<td></td>
</tr>
<tr>
<td>Glasgow Joint Event</td>
<td>GAMH, Cooperative Member</td>
<td>MHF Glasgow City Council Penumbra</td>
</tr>
<tr>
<td></td>
<td>City of Glasgow</td>
<td></td>
</tr>
<tr>
<td></td>
<td>29 people</td>
<td></td>
</tr>
<tr>
<td>Edinburgh Joint Event</td>
<td>Health in Mind, Cooperative Member</td>
<td>MHF City of Edinburgh Council Service User Perspective</td>
</tr>
<tr>
<td></td>
<td>City of Edinburgh, Midlothian</td>
<td></td>
</tr>
<tr>
<td></td>
<td>31 people</td>
<td></td>
</tr>
<tr>
<td>Inverness Joint Event</td>
<td>Birchwood Highland, Cooperative Member</td>
<td>MHF Highaland Council HUG (Highland Users Group) – 2 member perspectives</td>
</tr>
<tr>
<td></td>
<td>Highland</td>
<td></td>
</tr>
<tr>
<td></td>
<td>51 people</td>
<td></td>
</tr>
<tr>
<td>South Lanarkshire Joint Event</td>
<td>LAMH, Cooperative Member</td>
<td>MHF LAMH South Lanarkshire Council</td>
</tr>
<tr>
<td></td>
<td>South Lanarkshire</td>
<td></td>
</tr>
<tr>
<td></td>
<td>46 people</td>
<td></td>
</tr>
<tr>
<td>Fife Joint Event</td>
<td>Fife Council M</td>
<td>MHF Fife Council Service User Perspective</td>
</tr>
<tr>
<td></td>
<td>Fife</td>
<td></td>
</tr>
<tr>
<td></td>
<td>27 people</td>
<td></td>
</tr>
<tr>
<td>Perth Joint Event</td>
<td>PLUS Perth, Local Service User Organisation</td>
<td>MHF Perth and Kinross Council Cornerstone Community Care</td>
</tr>
<tr>
<td></td>
<td>Perth and Kinross</td>
<td></td>
</tr>
<tr>
<td></td>
<td>33 people</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2 – Summary of Action Planning Event
March 2013

An open discussion event was held to discuss the findings from regional events and facilitate stakeholders to use these findings to suggest future capacity building activities for implementation of self-directed support in mental health. The event was widely advertised and was open to all interested parties. It was attended by 74 people from across Scotland, and representing a range of organisations and sectors. The event was chaired by Hugh Cairns, of Lanarkshire Association for Mental Health, and the lead for the Scottish Mental Health Cooperative on this project.

In the morning the findings from the regional meetings were presented by the project team, and participants and an invited panel considered what the implications of these findings could be. The panel included those involved with the project, such as Stephen McLellan, Chief Executive of RAMH (a third sector provider of mental health service and Scottish Mental Health Cooperative member) and Chris White, the service user research lead; and external invited guests, such as Allie Cherry from NHS Lothian and James Blair from Self-Directed Support Scotland.

The second plenary session gave the opportunity for participants to hear some of the examples of activities/practice that had been presented at the regional events. Penumbra presented the iROC outcomes framework and their SDS development work. Fife Council and Claire Chue Hong, a person using SDS and a member of the Fife SDS reference group, presented on their local implementation of SDS in mental health. John Ithell from the project team summarised key concerns from providers as presented in the regional meetings.

The afternoon session was constructed to enable small discussions in table groups, first to identify the key priorities arising from the report of findings, and then to develop these into proposals for action by the project and/or other stakeholders.

The most popular ideas for development were:

- Local provider forums and/or action learning sets to enable providers to work together to develop capacity, and to develop connectedness and leadership in SDS implementation.
- Develop provider capacity to work with their service users and potential service users to offer the kinds of services people want to receive. This could include developing provider capacity for co-production, and the development of peer support in SDS.
- Developing capacity for risk enablement in providers and local authorities, so that people could try things that were important to them, and where necessary learn from mistakes.
- Development of mental health specific information about self-directed support, possibly through the provision of an independent advice organisation in each local area.
- A national awareness campaign about self-directed support, which could be through public media activities, or through an awareness raising programme amongst all relevant staff who have a role in supporting people with mental health problems.
- Baseline work on developing outcomes with people, especially the translation of an outcomes focus to mental health contexts.
- Use existing tools and methods in mental health to develop capacity for SDS. This could include adapting and repurposing existing recovery tools like WRAP for use in outcomes planning for SDS, and involving service users in doing this.
- More personal stories to bring the four options for SDS to life for service users and for the various workforce groups that have a role to play in supporting and promoting SDS.
- Development of assessment standards for SDS in mental health, to enable consistency in assessment across different areas, and to include SDS in other areas, such as health.
- Building SDS into existing pathways for referral in health and social care, paying particular attention to ensuring that people from equality groups are included.

Several of these areas are outwith the scope of the provider capacity building strand of work, but, along with the findings from the regional meetings may be of interest to other stakeholders and to Scottish Government as planning for other implementation work progresses.