actioninmind

Self-directed Support and Mental Health

PLANNING FOR SELF-DIRECTED SUPPORT SERVICES

Working in partnership

Mental Health Foundation

Scottish Mental Health Co-operative
serving locally linking nationally

The Scottish Government

Contents

1.0 Introduction

SELF-DIRECTED SUPPORT AND MENTAL HEALTH: Planning for a self-directed support service was developed and produced by Action in Mind as part of a three year project, ***Self-Directed Support in Mental Health: Capacity-building for third sector mental health service providers***. It was led by the Mental Health Foundation, in partnership with the Scottish Mental Health Co-operative, and funded by Scottish Government.

The focus of the main project was to increase knowledge and understanding of self-directed support (SDS) as it applies to mental health from both a service user and service provider perspective and to obtain a good overview of how self-directed support is being implemented across Scotland by local authorities.

The basic premise of self-directed support is that people seeking support will have greater choice and control of the planning and delivery of their care, including options for managing their own budget. This proposes new challenges, not only for local service providers but also for local authorities as they too must adjust to a personalised social care approach.

Self-directed support legislation places statutory requirements on local authorities to implement self-directed support from referral, assessment and care planning through to back office systems and processes. In addition, local authorities must oversee monitoring processes to ensure that service providers are fit for purpose and deliver in full compliance of self-directed support principles. In itself, this latter point does not or should not present major difficulties for local service providers for whom the personalisation approach is not new but rather a confirming statement of their established practice. However, local service providers may be confronted with new and challenging areas around operational management, not least assessing their financial viability and operational capability to move towards delivering self-directed support as a long term, sustainable enterprise.

This publication offers a baseline for local service providers planning the transition of services to a self-directed support model or to develop a new service altogether. It is not a definitive statement of what must be considered and included when planning for a local self-directed support service, but rather a guide to what might be considered helpful to start the process off. It reflects wide ranging consultations with commissioners, service providers and service users over the course of the three year main project, including Action Learning Sets (ALS) with member groups of the Scottish Mental Health Cooperative as a core activity in Year Two.

It is therefore with thanks to the partners, the Scottish Mental Health Cooperative and the Mental Health Foundation for providing the opportunity to develop this particular tool for local mental health service providers.

Helena Scott, Executive Director
Action in Mind

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2.0 Methodology and Acknowledgements

2.1 HOW WE DID IT

- Interviews with commissioners and mental health service providers (July 2014 – February 2015)
- Service user and carer consultation event (February 2015)
- Monitoring the transition to self-directed support of Action in Mind's Home Support Service

The latter activity evolved from a review of Action in Mind's services in September 2014 which, following feedback in January 2015, indicated that the Home Support Service would transition to self-directed support from April 2015. Although this did not in itself propose a major shift in how the service was delivered, per se, it did provide a good basis for testing organisational capabilities in relation to supply and demand, financial management and human resources.

2.2 ACKNOWLEDGEMENTS

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3.0 What is Self-directed Support?

The Social Care (Self-directed Support) (Scotland) Act 2013 came into force on 1 April 2014.

The aim of the Act is to provide people in need of social care with *greater participation and dignity* through their *direct involvement* in how the services they rely on are chosen and paid for through a process of *informed choice* (brought about by broader access to advice and information) and *greater collaboration* with Social Services and service providers they come into contact with.

Under the Act, care and support services are chosen and paid for, using one of four options chosen by the client:

Option 1 Direct Payment – clients have their funds paid directly into their bank or savings account, choose and pay for the service themselves.

Option 2 Individual Service Fund – clients can ask Social Services to hold their budget or transfer this to a service provider of their choice.

Option 3 Arranged Service – the service is chosen, commissioned and paid for by Social Services following an assessment of the client's needs.

Option 4 Combined Support – clients can use any combination of the three options to plan their support..

Regardless of which option is used, the process is overseen by Social Services and entails a formal assessment of the client's needs and financial position, an allocated budget and shared agreement of the care plan between the client and Social Services.

4.0 What Are The Implications For Local Mental Health Service Providers?

Clearly, the implications of a fully-implemented self-directed service is a revolution in the making for service providers – although, the exact level of impact is mitigated by a number of practical drawbacks in the way the Act is being implemented by local authorities across Scotland.

Some of the drawbacks and implications identified in the fieldwork suggest that the impact of self-directed support is yet to be fully felt or calculated as many interviewees acknowledged it is a 'slow burn process'. It was suggested that, in part, the self-directed support assessment process is costly in *time and resources*, aggravated by the *limited availability of social work staff* and the *reluctance of many clients to engage with the process.* The length of time, from beginning to end, of the social care assessment, including financial assessments, can vary from individual to individual and between local authorities, with 18 months given as the longest waiting time for one known client.

Some local mental health service providers expressed a *lack of clarity* about whether service users receiving self-directed support can continue to access other services provided by either the same or different provider, where these are block grant funded (service level agreement). It was also suggested that eligibility criteria is finely tuned and prioritises people described as being in 'life and limb' circumstances. In terms of mental health this may well relate to people diagnosed on the severe and enduring spectrum.

Questions abound about *mental health service users who do not meet self-directed support eligibility criteria* and what happens to them thereafter, and to what extent 'preventative spend' is being used, or not, to support these clients.

A recurring theme of local service providers is the extent to which self-directed support assessments take account of the *fluctuations of a person's mental health condition* which may require adjustments to their care plan over longer periods but without the need for re-referral.

5.0 Creating A Comprehensive Approach To Self-Directed Support

Fieldwork respondents identified a number of organisational capabilities that local service providers would require to obtain or develop if they were to be recognised, in the first instance, as an approved self-directed support provider and secondly, satisfactorily meet requirements around cost and best value as well as service user outcomes, in particular.

Four organisational capabilities were identified as follows:

5.1 MANAGING CULTURE CHANGE IN SERVICE APPROACH AND DELIVERY

i) Local service providers need to adopt a **positive approach** to self-directed support and **instil a culture of 'customer care'** that sees staff engage in a co-productive relationship with their clients.

ii) **All clients seeking social care will have to undergo assessment by Social Services** which, for mental health service users, may be a formidable barrier to seeking help. Local service providers may find themselves in a position where they may be asked to support people to the assessment stage, but this must not lead to a conflict of interest if the referral is to be progressed in the full spirit of self-directed support, particularly in relation to the client's right to choose their service provider.

iii) Local service providers, whether commissioned or operating on a 'spot purchase' basis, have always undergone reviews by their local funders i.e. the local authority. Under self-directed support, those same local service providers may well retain their 'approved provider' status and be eligible for registration on the local authority's self-directed support framework, provided they are registered with the Care Inspectorate and hold grade 4 and over.

Service providers commented that providing social care under the auspices of self-directed support did place them in a competitive environment, one which could entail a more **robust scrutiny** in relation to:

- Whether they are deemed to be fit-for-purpose?
- Whether they provide services that are value-for-money?
- How cost and quality is calculated and measured?
- How service user outcomes are measured and demonstrated?
- Whether staff are suitably qualified and trained to deliver the service?

One respondent said that there is a general lack of openness and transparency by local authorities in relation to the processes they use to scrutinise these areas, and also that service providers are not given any meaningful results which would enable them to improve their outputs and service outcomes.

iv) How local authorities review local service providers in terms of assessing their suitability to deliver self-directed support raises an important issue in relation to what might become new requirements placed before the Care Inspectorate in their implementation of self-directed support.

To date, there is no clear indication of what changes might be introduced and so for the time being the Care Inspectorate will continue to grade service providers under their current criteria, as follows:

- Quality of Care and Support;
- Quality of Environment or Information;
- Quality of Staffing;
- Quality of Management and Leadership.

Local service providers registered with the Care Inspectorate are experienced in the processes required for service inspections (now all unannounced) and have clear quality benchmarks (as above) against which to self-assess themselves, plus the quality statements framework.
For local authorities and individual clients, the grades awarded by the Care Inspectorate play an essential role in influencing the choice of a local service provider and do therefore have an important bearing on the implementation of self-directed support. This is demonstrated, in part, by stipulating that service providers must be registered with the Care Inspectorate in order to obtain 'approved provider' status. However, if there is to be consistency in assessment and regulation of quality care standards across the Care Inspectorate and local authorities, it will require both to have a shared understanding of each other's role and function as it relates to self-directed support and ensure that this is communicated to service providers.

5.2 FINANCIAL GOVERNANCE – PRICING AND COSTING, MANAGING RISK

i) Respondents indicated that service providers will need to develop ***a more rigorous process to pricing and costing services*** in order to compete effectively in a more crowded marketplace where price will be a key factor in the eyes of both commissioners and prospective clients. Careful consideration is required of the following factors, for example:

- How to cost a service that has peaks and troughs of demand;
- Setting the unit cost – what's the minimum (breakeven) charge;
- Calculating overhead cost, including staff salaries, national insurance payments and pension contributions;
- How to deal with shortfalls in budget;
- Monthly reporting on expended service hours and projections for following month.

Accurate costing is also essential to balance financial risk – most importantly the risk of clients getting into arrears with their payments, particularly under Option 1 arrangements – and how to deal with these situations. A high level of clarity in developing and implementing systems and processes is essential in assessing whether these are compliant with local authority expectations and demands.

In terms of setting charges, service providers are acutely aware that disclosing service charge rates in public information materials or on their websites is highly sensitive in commercial terms, but cost is a key consideration for individual clients considering funding options 1 or 2 (see page 5). In relation to these two options specifically, service providers have autonomy to set their own charges against criteria that they too can determine.
For example, should different charges apply to services which are provided during evenings and at weekends to those during weekdays; should there be different tariffs for different types of support required, or when two workers are required for one client? However, all self-directed support funding will already have a pre-determined costing based on the local authority's single unit cost (hourly rate) which applies to commissioned services and spot purchase of social care. In general, service providers are more likely to budget their services around the local authority's single unit cost rate which fits with Option 3 (see page 5), but it is with the knowledge and experience that there can be no slippage in expenditure against budget.

Many clients faced with making decisions about which self-directed support funding option to choose may not have had to consider the real costs of their care package before, even when they were required to make a financial contribution of their own. Now, faced with the sharp reality that care packages are measured in terms of support hours and cost, clients are re-assessing their priority needs in ways that they have not needed to before. To some extent this is already evidenced by service users reducing their care plan hours so as to avoid paying a financial contribution.

Moreover, from consultations with mental health service users, there is scepticism that self-directed support is being used to drive down costs, first and foremost, resulting in less support hours overall and, secondly that this will impact on the quality of services because it affects staff pay and conditions of service which may, in turn, result in high turnovers and lead to less skilled and experienced workers.

In relation to cost and quality, respondents indicated that:

"We need to resolve the question 'what does our service cost?' We have an understanding of the totality of our income. We have an understanding of the totality of our expenditure. I don't, however, think we know in precise terms how much it costs to deliver our service. So in response to the front end of this challenge, we need far more detailed cost accounting, project accounting and service accounting. So firstly we need to be recognised as a credible provider of care and secondly we need to understand the cost of our business – something we haven't worked out yet. We need to identify in detail the cost of all the individual components. This is an absolute prerequisite to any SDS arrangement" (Service Provider).

"The risk is with providers because if they don't get the balance between quality and cost, they are not going to fare well in the tender process. The organisations that will succeed are those that balance quality and cost on a sustainable basis and have established a customer service culture in their business plan. What we are seeing is that some of the relatively smaller organisations sometimes provide better quality. So there is not always a disadvantage to being small, provided they can build closer relationships to service-users... (Commissioner).

ii) A major shift for service providers arises from the need to develop ***new approaches to financial risk and debt recovery***, particularly in relation to individual payments for services made either by clients or the local authority.

In relation to the above, it is a requirement that clients and/or their agents must have an individualised bank account, particularly around Options 1 & 2 and produce regular statements of income and expenditure to the funder. The concerns shared by local service providers was measuring the financial risk of clients paying invoices late, or not at all and therefore running up significant arrears while continuing to use services. This presented a moral dilemma for some service providers who felt this to be a highly sensitive area and went against the ethos of the charity to withdraw service support to clients under any circumstance.

Some respondents voiced the opinion that the nature of the relationship between the client and the local service provider is invariably changing and that third sector service providers are effectively becoming debt collectors.

On this point, service providers also indicated that deployment of reserves was not a legitimate option to be used to sustain self-directed support services which may already be under-funded by local authorities because of their restricted budgets. It can be argued that clients who are required to make a financial contribution to their self-directed support service offset a proportion (however small) towards the full cost of their support of the local authority. Local service providers may also have to offset their overhead costs to clients by charging for transport or parking (particularly in rural and remote communities) in order to manage services within budget.

In short, local service providers must ensure they take full account of the need for:

- A financial risk assessment of the implementation of self-directed support, including an analysis of the projected income and expenditure (based on variable unit cost) to show a break-even position;
- An arrears policy – which puts forward ways of mitigating against client debt, including supporting clients to manage their budgets better, which is fair and reasonable and retains trust between client and service provider.

5.3 WORKFORCE PLANNING

Recruiting and training ***an adaptable workforce*** which combines contractual flexibility to accommodate for greater fluctuations in demand and desired outcomes, with the loyalty and dedication to maintain continuity of care and high standards of service, is an essential pre-requisite to competing in a self-directed support dominated marketplace.

The most important challenges identified included:

- **Creating an effective service framework and cohesive team** that adheres to shared values and principles of social care within a management structure that embraces change within a learning environment, coupled with staff training and development;
- **Delivering a workforce that is skilled, flexible and responsive** to wide-ranging client needs, capable of managing variations of individual care plan hours, including out of hours (before 9am and after 5pm) and at weekends;
- **Designing and implementing rigorous service management standards** so that services are capable of being registered with the Care Inspectorate at Grade 4 minimum; that staff are fully inducted into the service standard requirements of the Care Inspectorate and local commissioners, and that there is compliance with the underpinning principles of self-directed support;
- **Providing comprehensive staff training**, to include service user outcomes and approaches to self-directed support, those specific to mental health eg suicide prevention; reducing self-harm to more general areas covering staff health and safety, moving and handling and de-escalation courses;
- **Introducing or reviewing monitoring and evaluation systems**, providing measurements and indicators that demonstrate quality and best value, as well as cost-effectiveness.

Respondents' comments

"Training is the main cost. We are investigating customer service SVQs. The approach will need to change from 'this is what we have, this is what you'll get' to 'how can we help?, what would you like?, what can we deliver for you?' We are conscious that our existing clients may now have the power and the inclination to opt for other providers if we are not sensitive to their needs. This requires a cultural change in the way we manage the relationship"
(Service provider).

"Managers in the past have tended to be focussed on fund raising and interface with commissioners of services. Now they are becoming more customer focussed. When we first introduced customer service training five years ago, there were a lot of raised eyebrows among our front line staff, particularly in regarding service users as 'customers' at all. This has gradually changed, a shift helped by our new finance manager who worked for a commercial organisation. It is now recognised that you have to speak properly to people and to be nice when they come in. We always were – but the imperative is now more clearly defined. Staff know that they now have to meet targets and that this is essential."
(Service Provider).

5.4 MARKET RESEARCH – REACHING MULTIPLE AUDIENCES

Self-directed support has introduced an interesting development for local service providers, namely the need to promote their services to people looking for support as well as commissioners of social care. It is not uncommon for service providers to produce information materials describing their services, often giving background information about their history, key milestones in their development and service outcomes. However, self-directed support opens up an area of competition in social care unknown to many local service providers, namely that the client is now seen as a customer who has independent rights and expectations of the service they have chosen themselves but even when they have not.

The range of commissioning and funding options opened up by self-directed support means that dedicated marketing strategies may be required. These will require to be aimed at multiple audiences – clients, carers, NHS Trusts or health and social care commissioners and involve extensive market research. Unlike public procurement for social care, a key difference is how that same funding can now be administered through Direct Payment (individual budget), Individual Service Budget, Arranged Budget and Combined Support (Options 1 – 4, see page 5). These factors alone are potentially challenging for local service providers in setting up the right systems and processes, but now they are required to be skilled in marketing their services if they are to compete successfully in the open market. Moreover, developing a marketing strategy and producing content for websites and social media, as well as public access materials, is a skilled activity if it is to produce satisfactory results. Many local service providers may have neither the capacity nor the capability to develop the full scope of a professional information and marketing service without additional resources.

Some key issues to be considered include:

- **Promotional materials and marketing** – service providers may need to set aside, or generate new income, if they wish to commission new promotional materials that are customer-focussed, contain high-quality and relevant information and appropriately reach their target audience. Similarly, it is increasingly important that service providers have the knowledge and skills in multi-media formats, including digital technology, which has the benefit of high impact, low cost and extends the reach of potential clients, particularly those not currently using social care services. However, it is important that hard-copy materials are available for individuals who may be digitally excluded, either by choice or circumstance so that they are not inadvertently disadvantaged;
- **Equality Groups** – to date, there is little information about equality groups, particularly BME and faith groups, and their knowledge and understanding of self-directed support. Service providers should ensure that any information is provided in accessible formats to ensure that no-one, regardless of their equality characteristic, is excluded from receiving self-directed support information;
- **General or specific** – local mental health service providers are reflecting on what services they might provide in addition to their core activities, and to what extent they should diversify their range of service provision and to whom. Examples given included extending the range of referrals to include people with dementia or learning difficulties, as well as delivering personal care or providing home respite support;

- **Setting the charges** – invariably, clients will ask about charges for different services and service providers will be required to provide information which can then commit them, under Options 1, 2 and 4 to apply these charges fairly and consistently. In some cases, clients may ask for a breakdown of these charges, in the way that a local authority's single unit cost can be broken down to show the component costs for salaries, travel, management etc.

Respondents identified a number of key areas that need to be considered:

"My assessment of mental health services, coming in from the outside, is that they have been around for a long time and we have not been rigorous enough with them. We need to be asking more searching questions and checking more rigorously where the investment is going in terms of what is their evidence base. The Council also needs to reflect that it hasn't been as strong as it should have been in the message that it sends out to providers.

Putting it bluntly, we need to understand the reason why we should invest in this organisation. We need to get engaged with the organisation in a way that we have simply not done in the past and get them involved in a dialogue that allows us to set what they provide in a broader context of what is available elsewhere and get them re-thinking about their business and to get beyond justifying what they provide simply on the basis that this is what they have always done – like saying this was of its time in terms of a mental health service in 2000 but is it fit for purpose in terms of 2014" (Commissioner).

"About a year ago, we took on an intern, through a Council-sponsored scheme designed to get graduates into employment. This intern worked on a marketing personalisation plan. He went around the various groups that use our services and asked them about their perspective of our organisation. He used a scoring system designed to assess satisfaction levels. Some groups were more satisfied than others, there were variations according to the different areas. He then worked out a publicity approach for us, in terms of re-designing how we present ourselves through leaflets and flyers. We then got some students from the College who have done some DVDs – about three minutes each – on different aspects of what we do. People can go onto websites and smartphones and see what it is that we do" (Service provider).

"If you are talking about marketing and meeting your customers' needs, then you have to find out those needs in order to either make sure you have the right service in place, which for us is about finding out the outcomes people want, and pinpoint what is the most relevant way to communicate that service. We found that most people using our service find it very difficult to get their head around SDS and why they should be embracing SDS. Of course it is about giving them more choice. We have already paid for external consultants to come in to do research with our service users and some external people as well to find out what they want out of SDS....

"...We now know the outcomes so how do we present that in a way that people will relate to? We also know that we are going to have to change our website because it is currently targeted at organisations who would refer service users to us rather than to people who might buy the service themselves. We have money in our budget this year to re-do the website in a totally different way to which we do it now. The tension will be balancing the need to have information about our services and the outcomes we can deliver. So we are planning to do our website once we have completed all our research about outcomes and how these should be presented in a way that service users can relate to. One of the managers on this project, is working with a service user group. She's going to be getting feedback from them about the words and the language" (Service provider).

6.0 FREQUENTLY ASKED QUESTIONS

Question **How do I manage client arrears?**

Answer

When self-directed support was first canvassed five years ago, this was the most concerning question asked by service providers. To date, it has proved less of a problem then was originally anticipated because the overwhelming majority of clients assessed under the new self-directed support process have not chosen Option 1 (where they are given an individual budget, paid in instalments, and are personally responsible for managing this, including the payment of invoices and any employment add-on costs, where required).

In the field research, service providers did not have a common view as to how they would manage client arrears. Some included the possibility of client arrears into their assessment of financial risk, allocating a proportion of their financial reserves to cover the shortfall, on the grounds that, as stated above, most clients would not choose Option 1. Others took the more commercial view that they would have no option but to suspend the service, accepting that this would challenge the culture of care instilled into the organisation.

Respondents' comments

"Although we have not experienced Option 1 yet, we do encounter individuals who get, say, 12 hours of service funded by the Council and might want 15 hours, so they commit to paying us for the extra time. Our experience of this has not been good. We've had to write off £2000 of unpaid debt in the last financial year. It is not a huge sum but this is indicative of people's lack of willingness to pay and we anticipate problems in recovering unpaid debt under self-directed support. It's a horrible situation to be with somebody who definitely needs the support but we can't be charitable in these circumstances. It is time and cost limited. You are so tied down and you are so prescribed that you cannot be humanitarian in your approach. The human element of it has been eradicated because of the inflexibility" (Service provider).

"Yes, we have arrears. The arrears with regard to the charging policy are there because what has also happened is that the ones getting through SDS are being discriminated against. It is a whole new ball game if you are talking about money. People are feeling discriminated against and penalised through this process. It flies in the face of recovery. But we are very clear that the support doesn't stop. There is no way that we would leave anyone vulnerable" (Service provider).

Question **Is recruiting sessional staff the best way to manage fluctuations in demand?**

Answer

How to respond in a commercially effective way to fluctuations in demand may become a feature of a self-directed support marketplace and is a major concern for local service providers. Not least, the issue of recruiting sessional staff and determining the right type of contract which treats both employers and staff fairly.

Most of the respondents have either considered or already recruited sessional staff – but all expressed concern at the potential decline in care standards that excessive use might lead to. However, it was a matter for consideration and decision by individual service providers, first and foremost.

Respondents' comments

"We have 182 people on our payroll and 140 of full-time equivalents. Of that 140, 90 – 100 are full-time members of staff and 40 who are sessional staff. We are trying to make people contracted, because it gives them more security and control over their lives – but you do need that flexibility, with odd shifts at weekends etc. What comes with that is meeting people's demand for a living wage – £7.65 an hour, which we are also encouraged to provide by local statutory bodies...

"...But with the reduction in funding, we are not always able to pay the living wage to our sessional staff. To do so could cost us £50,000 a year. How can we achieve this? The simplest thing would be to sack everybody and re-employ them on a lower hourly rate. It would meet our financial goals but in the process you have created disharmony and discontent. You may also encounter the situation where you have a member of staff who works for a number of providers at the same time to make ends meet. People will then jump ship for an extra 10 pence an hour. We may well get to the situation where we cannot provide clients with a guarantee that they receive care from the same person or set of people at any one time. We have been okay with it so far but SDS is not going to help us continue to achieve this" (Service provider).

"We have gone through a number of cycles over the years where we have considered using more sessional staff. This has created management issues. They always move onto other jobs. Our view with SDS is we should start in a small way with the capacity we currently have. The support team that is probably going to get most work has 14 people. Some of it would be spot purchase, some of it would be SDS. We will keep an eye on the volume. We are bringing on sessional workers, but the idea would be that if the volume increases, we would bring them on a permanent basis. We don't want to work too much with sessional workers. At the end of the day, we have faith in our staff that they will deliver. We know we have a good reputation. If the volume increases, we'll bring them on as sessional staff and then seek to bring them on as permanent staff. You can't have continuity of care if people are on sessional contracts. We want people whose hearts are in the job and not just doing it because they need the money" (Service Provider).

Question **What administration systems will be most affected by self-directed support?**

Answer

Complaints policies and procedures may need to be reviewed and written from a customer perspective where they are treated as individuals with rights and responsibilities.

Regardless of whether client arrears occur, all service providers stated that they are planning or have already introduced flexible banking accounting and invoicing procedures, supported by integrated databases, to monitor and account accurately for individual payments for services made either by clients or their agents.

Respondents' comments

"We need to investigate some form of software. We have so many databases and nothing spans them all so that they can be analysed from the one place. We need to have an integrated database in place long before we go down the SDS road, and to ensure that people are familiar with it. It is going to mean that each of the service departments are able to use it effectively. Otherwise you are going to have a much bigger scope for error. Good electronic management is critical" (Service provider).

"The Council requires you to have a separate account for each person. We have been looking at which banks will accommodate this. This has not been brought into being yet but they will need that when they hand over money to us. We already have a good invoicing system because of spot purchase commissions. It has not been mindboggling or horrendous. We brought all our accounting functions in-house last year anyway" (Service Provider).

"The problem has only been isolated up until now. It doesn't amount to more than a half dozen people. It is small enough not to become a significant issue. But it could become a problem. We see 4000 clients a year. If, say 10 per cent became subject to SDS it is 400 extra invoices to issue. On what basis? Weekly or monthly? This would swamp our capacity as an organisation just to administer – our finance department is one full time worker and two part-timers. Again, some authorities do impose a charging policy and some don't. If they do, it is the service provider who has to claim it back. They back away from any responsibility. So one fear is that we don't have the capacity. The other fear is that that the big national players who have the capacity to administer the process could push the local organisations out of the picture" (Service provider).

Question **Has self-directed support proved effective in the case of people with mental health problems?**

Answer

It's too early to say for sure, but the limited experience of commissioners and service providers to date suggest that the introduction of self-directed support for people with mental health problems, in contrast with the experience of those with physical disabilities, is thwarted by a number of problems, such as:

- People with mental health problems often feel threatened by assessments operated by Social Services as they find the questions intrusive and are reluctant to open up;
- The limited availability of Social Services staff means that clients often wait for months before their assessment takes place – one of the reasons why service providers in the study called self-directed support a 'slow burn' process;
- People with mental health problems, in contrast with those with physical disabilities, are often reluctant to take on the responsibility of commissioning and paying for the services of providers themselves. Very few choose Option 1, a fact that has reassured service providers worried about client arrears but which runs counter to the spirit of choice, control and empowerment that was supposed to underpin the implementation of self-directed support.

Respondents' comments

"Our challenge is that many clients have not been known to social work and they feel very anxious about this. It introduces another layer which they see as a barrier. How long does it take? It depends on the patient's circumstances and on how much information we need to get. An average would be between 4 – 6 weeks. Sometimes, though, it can be as long as 6 – 9 months" (Commissioner).

"I am probably not close enough to it to say for certain but it is certainly several months. There is a huge backlog of people and one person said to me that they had been on the list for four months and not getting anywhere. I think that is probably pretty normal" (Service provider).

"It can take ages. We have people who started a year and half ago and are still going through the process. There are two gentlemen I am thinking of in particular who have been through the process and completed the questionnaire and from the beginning of September (2015) it will have been two years since they started – it is because the care managers are caught up in lots of other work" (Service provider).

Question **Will traditional providers be pushed out of the market by large commercial firms?**

Answer

A number of service providers expressed concern that the opening up of the market for care services that will accompany self-directed support will result in commercial providers with economies of scale pushing out smaller third sector organisations who will be unable to compete on cost.

This was not a universal view as other commissioners and third sector service providers were confident that the quality of service and culture of care offered by smaller organisations created a more even playing field.

Respondents' comments

"....What we are also seeing is an increasing willingness for small providers to combine with others in their locality to reduce administrative costs and fill gaps in services that they cannot provide themselves. Where there are synergies between organisations, we find they are sharing offices in which they share payroll and other HR functions, using shared premises to reduce costs but still retaining their own identities and unique services. Collaboration and partnership is going to be an increasing prerequisite to surviving and thriving in this new marketplace. We don't want all our eggs in one basket. We are looking for a diversity in provision that can meet a much more personalised agenda of individual needs" (Commissioner).

"Yes, private providers may enter the market and offer much cheaper services but at the end of the day, our quality and good reputation with the Council more than justifies the higher rate we offer. We are able to differentiate our services. We have information services, we have counselling we do befriending, we have the peer support service and we do the regulated services – so we draw on a great deal of expert knowledge and experience that other providers do not have. With all the preventative support we offer, we are in a good place" (Service provider).

7.0 Further Information

7.1 SELF-DIRECTED SUPPORT SCOTLAND

This is a 'one-stop shop' website run by The Scottish Government which provides information and advice about Self-directed Support for people who use social care services and for health and social care professionals.

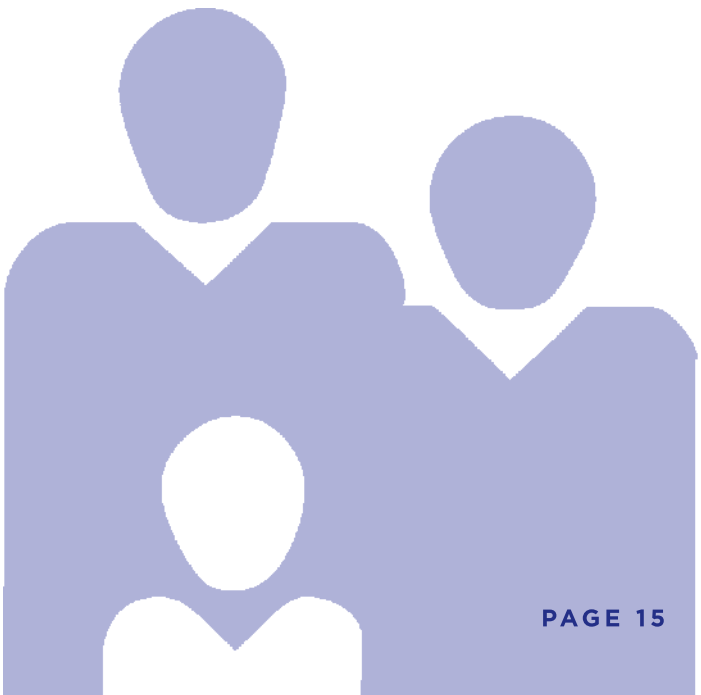
www.selfdirectedsupportscotland.org.uk

7.2 LOCAL GOVERNMENT WEBSITES

If you are looking for information on self-directed support this will be on your local authority website.

7.3 SCOTTISH MENTAL HEALTH CO-OPERATIVE

Local member organisations of the Scottish Mental Health Co-operative are based around Scotland and can offer information about self-directed support and services they offer. For more information contact, Action in Mind at **www.actioninmind.org.uk** or email; info@actioninmind.org.uk



actioninmind

changing attitudes changing lives

Our Vision

A time when people experiencing mental health difficulties or living with mental illness feel themselves accepted and valued as contributors to society.

Our mission

We help people towards better mental health and well-being to lead lives without fear of mental health stigma and discrimination.

Our Values

Dignity and Respect: Mental ill-health should not define the person nor should any person be subjected to social attitudes and behaviours that distress, offend and discriminate.

Enabling, Empowering and Supporting: We all have a right to lead lives that have meaning, purpose and self-fulfilment and to have choice and control of matters that are important to us.

Integrity, Credibility and Accountability: We will uphold the trust and belief placed in us by all our stakeholders in our role as advocates for mental health.

Unity in Action: We are stronger when we work together with people with lived experience of mental ill-health and when we work with partner organisations.

For information about self-directed support or any of our services please contact us:

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Website: **www.actioninmind.org.uk**