Radical transformation underway in social care could provide the best opportunity yet to shift the culture of mental health care towards person-centred, outcome-focused support

Mental health and self-directed support

In 1999 the government published the National Service Framework for Mental Health (NSF), kick-starting ten years of focused service development in mental health. This large-scale programme of change has been supported by an annual autumn assessment led by strategic health authorities to monitor progress in each locality covered by a local implementation team (LIT) designed to oversee delivery of the NSF.

The National Service Framework for Mental Health – Five Years On, published by the Department of Health (DH) in 2004, confirmed that significant progress was made in implementing both the NSF and the new clinical services required by The NHS Plan. The document also acknowledged that most of the achievements have been made in specialist mental health services, but that this was where the greatest problems and levels of need were to be found. However, significant problems remained in acute inpatient services, dual diagnosis, support for carers and information technology. Most importantly, the report also signalled the need to instil a major shift in emphasis and focus towards primary care mental health, social inclusion and delivering race equality. This renewed focus for development was confirmed in the 2007 follow-up DH document Mental Health – Ten Years On (2007).

Findings from the 2006 autumn assessment, published in October 2007, show that most LITs are making very good progress in crisis services, early intervention, support time and recovery workers, secure services and suicide prevention, but that progress is slow in primary care mental health, social inclusion, delivering race equality, health promotion and choice.

Opportunities and challenges

The issues of capacity and capability within mental health commissioning have been widely recognised. The 2007 DH publication Commissioning Guidance for Health and Wellbeing and recent initiatives in the NHS around world-class commissioning are attempting to address this shortfall; however, it has been apparent for some time that large mental health trusts have been acting as de facto commissioners of services. It is perhaps no surprise therefore that the most significant progress has been in specialist secondary mental health services with the additional investment and NHS Plan targets, but that progress outside this sphere, which has attracted very little additional monies up until now, in primary care and social inclusion has been poor.

With the focus of the additional investment being on the creation of new specialist community teams, it could reasonably have been assumed that this would have initiated a concurrent transformation of the form and function of what has long been seen as the central plank of local services, the community mental health team. But this has patently not been the case. This impression was confirmed in the 2007 Healthcare Commission/CSCI report, No Voice, No Choice, whose key findings suggest that many people are not involved in decisions about their care.

In addition, despite the publication by CSIP in 2006 of a suite of social inclusion guidance on direct payments, day services, vocational services and gender-specific services, progress remains pitifully slow. Furthermore, services continue to seek to understand their role in relation to people’s recovery journeys while continuing to deliver professionalised support and interventions that may not be aligned to people’s own views about their recovery.

Many of these core issues are characterised by a failure to put people at the heart of designing their own support, and are at odds with the future direction of travel for health and social care services. However, while mental health service have been unable to develop truly person-centred approaches, other public service areas have been learning from the roll-out of person-centred planning and thinking, and have begun to address the mismatch between block-commissioned services and what individuals actually want.

The future direction of travel

In December 2007 six government departments, in an unprecedented partnership with the NHS Confederation, the Society of Local Authority Chief Executives, the Commission for Social Care Inspection, the Social Care Institute for Excellence, the General Social Care Council, Skills for Care, the English Community Care Association, the National Care Association, the Association of Directors of Social Services, the Local

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Government Association and the NHS, published Putting People First. In this groundbreaking concordat, the signatory organisations outlined their shared vision and commitment to the transformation of adult social care. At the heart of this transformation is a commitment to independent living – delivered through a personalised adult social care system. The detail of the expectations upon local authorities was then outlined in a Department of Health local authority circular published in January 2008.

The personalisation agenda is about prevention, early intervention and self-directed support – and is likely to form the cornerstone of public service delivery for the future. Personalisation is about using publicly funded resources more wisely to meet the needs of individuals in ways that work for them. A personalised response allows individuals to use their allocation of resources in a way that best meets their own needs, and therefore leads to an increase in user satisfaction and improved outcomes.

More than ten years on from the Community Care (Direct Payments) Act 1996 (enacted in 1997), there are around 52,000 people in receipt of direct payments, although take-up in mental health continues, with a few notable exceptions, to be slow in many local authority areas. Barriers to take-up – plus a range of solutions – are well documented in research by the Health and Social Care Advisory Service and others. In December 2006, a solution set was published by the Department of Health in an attempt to boost direct payments take-up.

Drawing on all the direct payments experience, in 2003 the partnership organisation In Control (see www.in-control.org.uk) was launched, with the establishment of a project that aimed to help social services departments in six local authority areas to change their social care systems to increase the citizenship of disabled people. This new system was called self-directed support.

**The self-directed support system**

So how does it work? First, local authorities create a resource allocation system, which requires authorities to develop a costed, points-based system linked to a simple self-assessment questionnaire that individuals can complete themselves or with support. In many areas, the questionnaires have been developed in such a way that they include triggers for a range of other funding streams that people may be eligible for, and it is hoped that with further work a closer integration of funding streams may be achieved. The questionnaire enables the care manager or care co-ordinator to be able to tell an individual quickly how much money is available for their support. The person is then asked to develop a support plan to show how they will use the money to meet their support needs – and help should be available from a range of sources to facilitate this process. Once the person has completed the plan, the care co-ordinator reviews the plan to ensure that it meets the outcomes agreed, and that the person is spending the money in a way that is legal and keeps them healthy, safe and well. When the plan has been signed off, the person is able to get on with organising their support and living their life. As with direct payments, people are expected to keep basic financial records, which may be audited by the authority, and the outcomes are reviewed as part of the ongoing care review process.

People may choose to take the money as a direct payment, paid into a bank account for them to manage directly, or in some cases an agent may manage the money on behalf of the person. Other people may choose to ask the care co-ordinator to continue to organise services on their behalf, and some may ask authorities to transfer their resources to provider organisations, which will be required to account directly to the person for how the money has been spent.

A DH-sponsored pilot has seen 13 local authorities implementing individual budgets with people using adult social care services, but equally significant is the considerable progress made by the In Control programme. The majority of local authorities with responsibility for social care in England are now part of this initiative, with ten committed to a total transformation of their adult social care systems within the next two years.

In mental health, four of the 13 pilot sites worked to deliver individual budgets in adult and/or older people’s mental health service settings. The pilot has been subject to a large-scale evaluation (see www.ibsen.org.uk) throughout the lifetime of the project, the results of which were expected in the spring.

As with other care settings, it has been apparent from the mental health pilot sites that when people get control of the money, they generally do not buy the services that have historically been on offer locally, preferring instead to purchase support that works for them in the context of their own lives. For example, one man in Norfolk used his small allocation (about £1,000 per annum) to purchase good quality art materials, take a holiday with friends in Tunisia, join a dating agency and take some driving lessons.

But it is not just about what people have done with the money. Anecdotal evidence from individual budget recipients tells us that people value the opportunity to have real control and choice, lead the planning of support and, importantly, are able to really start to think about how they want their lives to be. Evidence from other countries seems to show similarly positive outcomes.

So far, then, it seems that personalised approaches, through self-directed support and individual budgets, may offer a real opportunity for people with mental health support needs to take control of their recovery, using their individual budgets to fund their support. However, there is significant work to do to ensure that people are able to benefit properly from the whole-system shift that will be required to bring about self-direction across all service areas, but mental health in particular.

**Rotherham – a case study**

During 2005 Rotherham local authority made considerable progress in making direct payments available to those people with mental health needs and in this respect was among the top five performing authorities in the country. On the back of this success, Sue Sumpner (project lead), working with CSIP Yorkshire and Humber, applied to become one of the first members of In Control focusing solely on mental health.
Before joining In Control in October 2005, up to 50 people in Rotherham had organised their support using a direct payment, but Sue’s team had no clear budget for this work and at this stage they were unable to influence the local commissioning of mental health services. Since joining In Control, progress has accelerated considerably and outlined below are some of the strategies they have used, the success they have enjoyed and challenges that lie ahead.

Progress to date
In the three years since 2005, Rotherham has been able to provide 201 people with the facility to organise their own support by controlling their own budget. Currently over 100 people hold an individual budget for their mental health support. A key turning point came in 2007 when, as part of the regional In Control forum, a guide was produced to convert direct payments into individual budgets. Rotherham actioned this guide without delay and has seen the following benefits:

- people now receive a budget at the point of assessment and before they make a support plan. This is a step forward from direct payments where money is allocated once a plan has been made. The consequences are that people are now able to be much more imaginative and innovative in identifying their support solutions, which are personal to them and not found in traditional services
- people are accessing support solutions within mainstream community resources which endorse the principles of self-directed support in seeking to move away from segregated, traditional services
- people are receiving their individual budgets as a one-year allocation and are better able to plan for their own needs and those of their carers.

Outcomes
Although the transfer to individual budgets is very recent, already there are very positive signs in terms of outcomes:

- people are finding that when friends, family and personal assistants plan and deliver support, their outcomes are much improved
- the longer people are in receipt of individual budgets and working to a model of self-directed support, the better their outcomes are
- people are experiencing much higher levels of independence and are commissioning their support from within mainstream community facilities
- the ‘threat’ of individual budgets is driving change in traditional services; for example, the local day centre is doing much less group work and less work at the day centre, moving to individual programmes of support in the community.

What next?
The transformation of adult social care agenda presents Rotherham and all local authorities with the challenge of scaling up this approach. Locally, 500 people in receipt of day care and/or community support have been identified as having potential to switch to individual budgets. There is also an intention to make this approach available to all new referrals and to continue to use the outcome data to inform a radically different commissioning strategy.

In mental health, there is significant work to do to address some of the foundations for self-directed support. If left unaddressed, these will undermine the entire transformation. Services need to fundamentally reconsider their role in people’s lives – and address some of the cultural and attitudinal challenges that exist within the mental health system and its workforce. In pilot areas, some staff have struggled with the transfer of power and control to people, both in relation to risk management and in believing that people have both the right and capacity to make decisions about how to use resources. In the North West, CSIP has worked with person-centred approaches specialists Helen Sanderson Associates to test out with Manchester’s early intervention service the impact of person-centred approaches in mental health settings. The evidence thus far is that person-centred thinking and practice adds significant value to new ways of working, creating the right balance between professional expertise and lived experience.

For authorities considering first steps towards individual budgets in mental health, and looking at some of the training and cultural issues, a good starting point is to revisit direct payments guidance and the solution set published by the Department of Health in 2006 (see www.directpayments.csip.org.uk), as many of the challenges for the sites implementing individual budgets in mental health have been similar to the experience of direct payments take-up.

We have already hinted at the scale of change required and do not believe this can be achieved by local

Keys to success and challenges

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<th>Successes</th>
<th>Barriers</th>
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<td>Strong project leadership</td>
<td>The culture of professionalised mental health services and the low expectations of people and families</td>
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<td>Steering group with clear action plan</td>
<td>Risk aversion</td>
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<td>Training for all staff in specialist mental health services</td>
<td>Personal assistants not seen as ‘professionals’</td>
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<td>Development of a self-assessment tool</td>
<td>Expectations that people will misspend their money</td>
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<td>Establishing a resource allocation system</td>
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A critical step forward for the local authority is that the roll-out of individual budgets is now having a direct impact on commissioning behaviour, and a number of services have been decommissioned while other contracts, particularly for support workers, have been reduced significantly.
authorities acting alone. The new monies announced for the roll-out of the Improving Access to Psychological Therapies programme present a fantastic opportunity for health and social care commissioners acting together to facilitate a radical overhaul of community-based mental health care.

One of the keys to the success of self-directed support is its rights-based approach to people designing their support and controlling their lives. No Voice, No Choice confirmed that people in mental health services very often do not see their support plan or have any involvement in its production, and while the Care Programme Approach is about to be revised again, it may well be that mental health services need to reframe their paradigm of disability to make this change a reality. The task is not just one for commissioners; organisations need to begin looking at how personalisation will change radically the way they do business in the future – because the future is personalised, and its coming to a service near you.

The views expressed in this article are those of the authors and are not necessarily representative of the views of the Care Services Improvement Partnership.

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