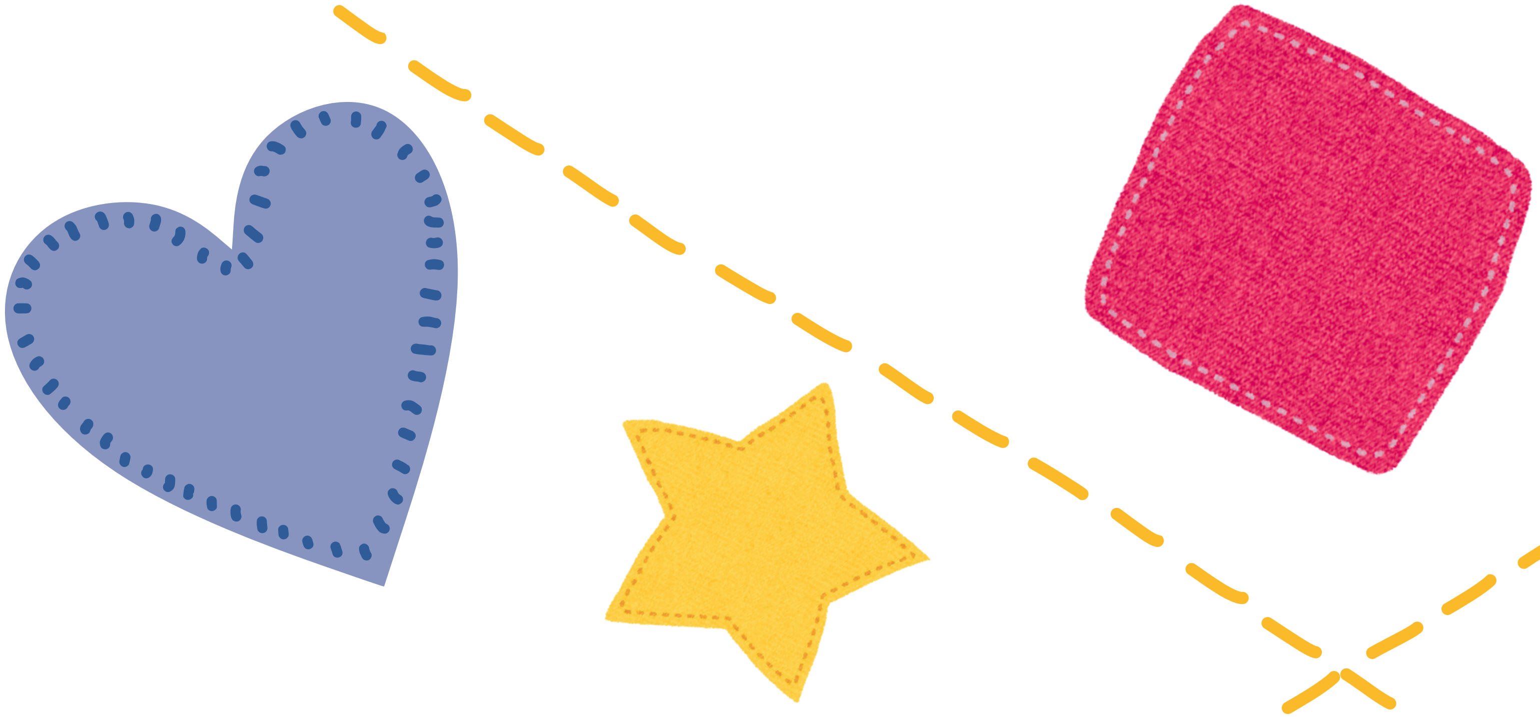

Self-Directed Support: Implementation in Children and Families' Services

Rhiann McLean and
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In Control Scotland
Choice. Control. **Community.** Change.

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Introduction

For over a decade, Scotland has made a clear and deliberate commitment to changing the relationship between people and the social care system. Through the introduction of Self-Directed Support (SDS), the focus has shifted away from standardised responses and towards choice, control and outcomes that matter in the context of people's own lives. This journey has not been linear or uniform. Progress has been shaped by local context, professional cultures, resources and wider system pressures. Yet it has been underpinned by a shared ambition: that social care should work with people as individuals, not as service categories or problems to be managed.

SDS was never intended to be a specialist or marginal policy. From its inception, it was designed as a universal approach: one that applies wherever people draw on social care support. National policy has consistently reinforced this, most recently through the SDS Improvement Plan, which explicitly positions SDS as relevant across almost all groups of people who use social care, including children and families, older people, disabled people, people experiencing addiction, homelessness or mental ill health, and those at key points of transition. In this sense, SDS is less about a set of funding options and more about a way of thinking: how power is shared, how decisions are made, and how support is shaped around people's strengths, relationships and aspirations.

Within children and families' services, this ambition sits alongside - and should complement - Scotland's wider policy landscape. GIRFEC has long provided a national framework for understanding children's wellbeing in the round, emphasising early intervention, proportionate support and the importance of working with families rather than doing things to them.

The Promise has further strengthened this direction of travel, calling for relationships to be at the centre of practice, for systems to be flexible and responsive, and for children, young people and families to experience support that feels human, joined-up and grounded in trust. Many of the principles that underpin SDS - personalised support, flexibility, partnership and a relentless focus on outcomes - align closely with these agendas.

Despite this alignment, SDS is still often perceived within children and families social work as something separate, specialist or primarily linked to disability services. Across Scotland, the reality is *a patchwork of practice*: some teams have woven SDS into everyday decision-making, others apply its principles without naming them, and some areas struggle to see SDS as relevant to their role at all. This patchiness does not signal failure, it reflects a system adapting to context, resources and professional cultures. By exploring these variations, we highlight both the unevenness and the richness of SDS implementation, offering insights into how promising approaches can be strengthened and shared.

This report moves beyond a simple exploration of what is not yet working. While it acknowledges the structural, cultural and practical barriers that continue to limit SDS implementation, it also highlights areas where practitioners and services are already finding ways to apply SDS principles with confidence and creativity. These pockets of practice demonstrate how SDS can sit comfortably alongside GIRFEC and The Promise, and how the ambitions of the SDS Improvement Plan can be realised in real-world children and families contexts.

By capturing and sharing this learning, the report aims to contribute to a growing collective understanding of SDS as a universal, adaptable and relational approach, that can continue to evolve in response to the lives of children, young people and families.

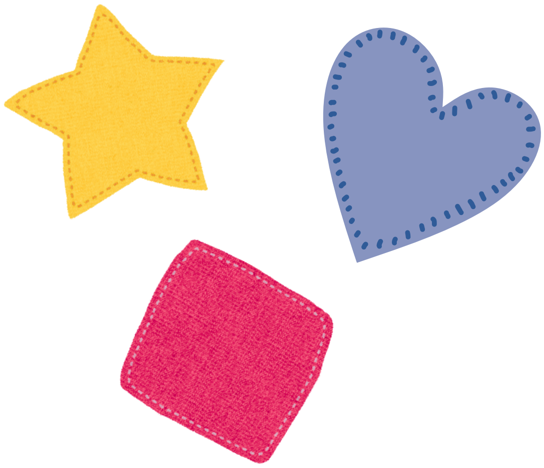
Pauline Lunn
Director

Background & Rationale

Self-directed Support (SDS) is the primary mechanism through which people in Scotland access social care support. While SDS is well-established within adult services and specialist children with disabilities teams, far less is understood about how SDS is interpreted and put into practice across the wider landscape of children and families social work.

This seeks to understand how children and families social work teams implement Self-Directed Support (SDS) across different local authorities. We are curious not just about the scale of SDS delivery or individual stories of how outcomes have been met, but about the operationalisation of SDS in children and families' contexts.

This report summarises different approaches to SDS implementation in children and families' teams across Scotland, with illustrative case studies and practice examples. As well as generating useful learning from practice, this work aims to spark more energised conversations with practitioners who wish to make change in this area, and to develop opportunities for future projects.



Methods

Professionals were invited to contribute to the research through a one-hour interview on Teams. Interviews were semi-structured and flexible to account for the different backgrounds and perspectives of each participant. There was scope for variation, with one participant returning for a follow-up discussion and one interview conducted with a team rather than an individual. Transcripts were generated using Copilot, then checked for accuracy before analysis. Initial themes and trends were identified, and illustrative case studies were selected and agreed with participants.

We disseminated information about the research across In Control Scotland's networks, Social Work Scotland's networks, and national and local SDS development spaces. Participants received an information sheet outlining the nature of the research, how data would be used, their rights, and how to raise concerns before consenting to take part. Participants were also given the choice of whether they and their local authorities would be named in the final report.

Twelve people were interviewed to inform this research. We had representation from nine local authorities across Scotland, with urban, rural, remote and island communities represented.

We were open to speaking to anyone with an active role in SDS implementation, including practitioners from children with disabilities teams, children and families' teams, young people's teams, community justice teams that work with children, drug and alcohol use and mental health partnerships, services supporting care-experienced young people, and child protection teams. The majority of respondents were social workers or social work leaders, and most worked primarily with disabled children.

We know that there are significant variations in how SDS is delivered across Scotland, including within children and families. The research identified extensive differences in SDS delivery across the nine local authorities engaged. Therefore, this research cannot comment on a national 'Scottish picture' but instead offers a snapshot of the current delivery landscape across these nine authorities.

Known Challenges to Implementation

The evaluation of SDS pilots noted that parents of disabled children were less likely to be involved in pilot activity, with only 14% of participants in pilots under the age of 18 [1]. Early statutory guidance [2] outlined how the act impacted on the duties of children and families services, including what pre-existing duties remained in place, and what new duties were in place. This guidance recognised the tension between the statutory duty to offer choice and control, and wider legal duties to safeguard children from harm. However, further evidence from children and families published by the ALLIANCE in 2018 [3] demonstrated ongoing challenges in delivering SDS to children and families, with two thirds of children and young people saying that their SDS provision did not meet their needs, and lower overall rates of satisfaction with social care. Other challenges noted in this report are communication with families, and support to choose the SDS option that worked best for them.

The wider implementation of SDS has been challenging, as documented in the Independent Review of Adult Social Care (2021), the Care Inspectorate thematic report (2019) on SDS delivery across six partnerships, and Audit Scotland's (2017) report on SDS progress. Identified barriers include: appropriate resourcing, meaningful involvement of people with lived experience, differing applications of flexibility in spend, challenging processes where finance and legal teams are not fully involved, inconsistent availability of options, and differing approaches to assessing and allocating resources.

In 2016, a paper by Mark White [4] identified ongoing "professional hesitancy" in applying SDS in practice across children and families' services. This paper also identified key differences between the approach taken with adults and the approach taken with children (Figure 1 below). Many of these same tensions are reflected 12 years on in this research.

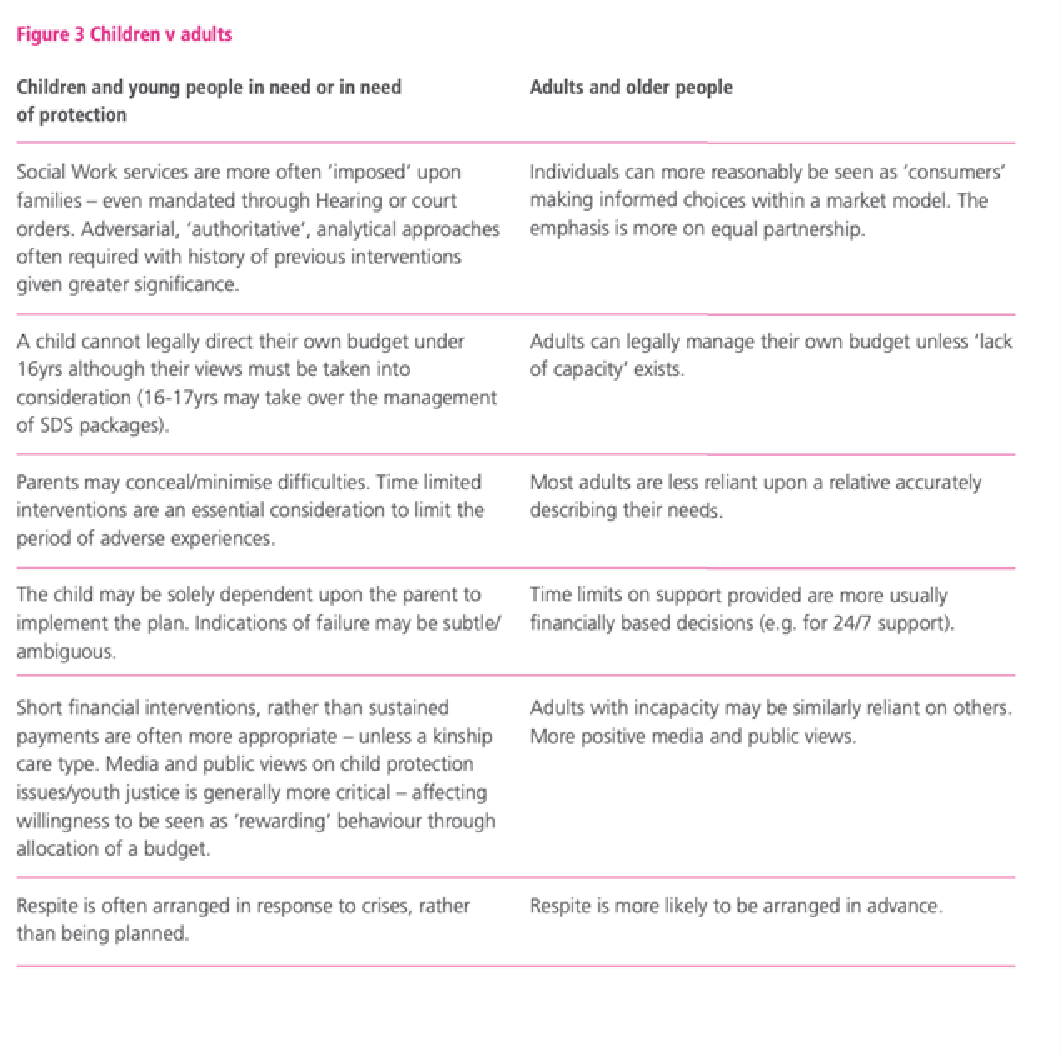


Figure 3 Children v adults

Children and young people in need or in need of protection	Adults and older people
Social Work services are more often 'imposed' upon families – even mandated through Hearing or court orders. Adversarial, 'authoritative', analytical approaches often required with history of previous interventions given greater significance.	Individuals can more reasonably be seen as 'consumers' making informed choices within a market model. The emphasis is more on equal partnership.
A child cannot legally direct their own budget under 16yrs although their views must be taken into consideration (16-17yrs may take over the management of SDS packages).	Adults can legally manage their own budget unless 'lack of capacity' exists.
Parents may conceal/minimise difficulties. Time limited interventions are an essential consideration to limit the period of adverse experiences.	Most adults are less reliant upon a relative accurately describing their needs.
The child may be solely dependent upon the parent to implement the plan. Indications of failure may be subtle/ ambiguous.	Time limits on support provided are more usually financially based decisions (e.g. for 24/7 support).
Short financial interventions, rather than sustained payments are often more appropriate – unless a kinship care type. Media and public views on child protection issues/youth justice is generally more critical – affecting willingness to be seen as 'rewarding' behaviour through allocation of a budget.	Adults with incapacity may be similarly reliant on others. More positive media and public views.
Respite is often arranged in response to crises, rather than being planned.	Respite is more likely to be arranged in advance.

Children and families' teams also work within additional policy and practice frameworks, including Sections 22 and 23 of the Children (Scotland) Act 1995, the Children and Young People (Scotland) Act 2014, and the Carers (Scotland) Act 2016. Additional frameworks include GIRFEC (Getting it Right for Every Child) and The Promise. It is not always clear how SDS aligns with these agendas, although attempts have been made to do this, e.g. In Control Scotland's Model Resource Allocation System for Children, Young People and Families [5].

The 2023–27 SDS Improvement Plan [6] emphasises the universality of SDS, including its use with children and families, homeless people, older adults, and people experiencing addiction. It commits to ensuring "SDS is embedded into key national priorities including NCS, The Promise, Dementia Strategy, Ethical Commissioning and GIRFE themes as they develop, drawing on stakeholder evidence and expertise."

A changing profile of needs

Across interviews, practitioners described increasing levels of need, compounded by the COVID-19 pandemic, rising living costs, and sustained financial pressure on health and social care partnerships. Families were struggling financially and less able to contribute "out of pocket" for support.

> *"Yeah. And my biggest concern... there's the Council budget, I get that. But for the parent on the ground with the child, effectively what's happened is that there's no longer the option within the house finances."*
> *(Practitioner describing a playgroup cost increase from £25 to £80 per week)*

Universal services were also under strain- reducing availability or increasing costs. Some participants managed this proactively, working with welfare rights officers and carers centres. One local authority discussed how the Whole Family Wellbeing Fund [7] had been invested in expanding the local community provision for disabled children and young people and their families.

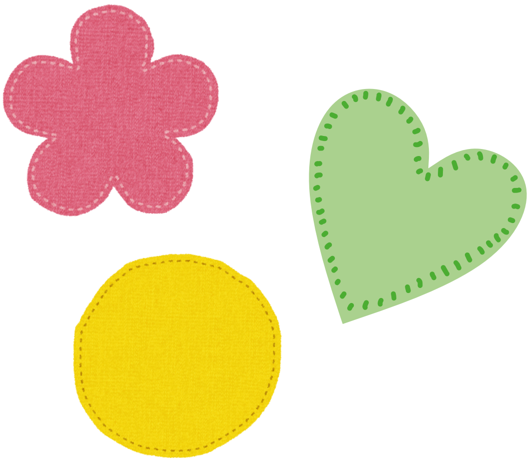
Practitioners also spoke about a growing number of children and young people with health and social care needs. Suggested contributing factors included:

- greater awareness of additional support needs
- the longer-term impact of COVID-19 on health and wellbeing
- young people with complex needs living longer lives in the community

Who funds what?

A key barrier identified across children and families was the complexity of wraparound funding already accessible to families. Examples included:

- joint health/social care budgets for children with complex needs, which were described as rare but possible, with challenges operationalising these shared budgets
- funded childcare hours where providers may lack the skills to support children with additional needs
- separate education funding, including questions about who bears the responsibility for funding support when school cannot accommodate a children's support needs
- carers' assessments and carer's budgets, with difficult boundaries and uncertainty about how funding should be allocated in situations where the whole family needs support to meet their outcomes



The size and scope of SDS implementation in Children and Families

Participants were asked to share, if possible, the number of children or families in receipt of SDS in their area, and the split across Options 1, 2, 3 and 4. Not all practitioners had access to these figures, mirroring similar findings from In Control Scotland's research on Option 2 and Option 3 [8]. However, approximate data shared provides insight into variation in uptake, likely reflecting choices available locally.

LA1	Not able to share figures
LA2	No access to figures
LA3	No access to figures
LA4	No access to figures
LA5	Approximately 500 - 256 Option 1, 23 Option 2, 91 Option 3 and the remaining unmet need/inactive packages
LA6	No access to figures but estimated "hundreds"
LA7	482 SDS support packages, mainly Option 1 with an increase in Option 2. 40% Option 1, 60% option 2 split, with no provision for Option 3 currently available
LA8	Approximately 263 cases. Not all 263 will receive SDS budget but will have support in relation to disabled children. 83 families receiving a Direct Payment, one family using option 2 and the majority using Option 3
LA9	320 young people in transition, a few years ago this figure would have been 80

Team structures differed significantly. In some areas, a geographical or locality approach meant that social workers engaged with all children from a geographical area, regardless of presenting needs. Some of the practitioners interviewed were members of specialist children with disabilities teams. Some teams had a multi-disciplinary structure and teams had different relationships with adult social work teams (some working closely and co-locating, others with less connection).

Practitioners in specialist children with disabilities team reflected on how helpful it was to have dedicated teams working with children with disabilities as it allowed them to develop their skillset working with one group, and focus their attention beyond urgent child-protection cases:

> *“Rather than a generic social worker that doesn't really have an awful lot of understanding about various disabilities and conditions... you know what's available out there because actually their priorities are child protection, care-experienced young people and all that.”*

Frequent application of SDS was associated with increased practitioner confidence:

> *“They hold the disability cases... they’re really familiar with SDS. They know how to explain it to families and reassure people.”*

Decisions between options reflected available support, family capacity, or individual circumstances. Some teams allowed families to use providers in neighbouring local authorities to increase access to choice.

One local authority reflected on changing trends in choice of SDS Options, with an increase in Option 2 choices. The practitioner reflected that this is likely due to PAs setting up as micro providers as a response to capped rates of pay and drives to build on offers of support locally. The financial impact of this shift was significant due to the differences in hourly rates charged against budgets.

Examples of SDS-funded support included respite (building-based or short breaks), after-school and summer clubs, community groups, Personal Assistant support, and one-off purchases such as trampolines or sensory spaces. One participant noted that the split of Options represents the final choice, not always the preferred choice.

One practitioner reflected on shifting practice:

> *“They’ll talk through the different options… historically people focused on Option 3, but it’s inflexible… with a PA or off-framework provider under Option 1 or 2, you can have flexibility.”*

Two local authorities discussed support for young carers, one saying that the young carer would be included in assessment and may themselves have support needs. Another local authority noted that support for young carers was typically accessed in the community or at school, without an allocated 'fund' to support this group through Self-directed Support.

Allocating budgets

Assessment and resources different across local authorities, with a mix of Resource Allocation Systems, Resource Allocation Panels, Equivalency models and needs-based models. Some participants noted that these processes were under review.

The challenge of equivalence and RAS models is to what extent they account for changing costs of care. One practitioner added that equivalency models were sometimes more challenging to navigate for Newly Qualified Social Workers, who would struggle to benchmark costs in other forms of support. Some local authorities used Resource Allocation Panels to discuss individual cases. In one local authority, a needs-based model was introduced to provide more flexible support.

Some local authorities required a diagnosis in order to access SDS, whilst others were able to work with children without a formal diagnosis based on need. Eligibility criteria were described in some local authorities. In some areas, children needed to meet thresholds of consistent needs, in others there needed to be evidence that needs could not be met within universal support pathways. In one local authority, a practitioner described how a clear eligibility criteria shared with families was important for equity of resource distribution:

> *"Eligibility criteria for a service is all sort of out on our public website, so people can see that... it's looking at what universal services are in place, what other people can use, and then we're the top level where there's nothing else... it helps us to focus our resource at the highest need, as opposed to maybe the loudest voice."*

The language of self-directed support

Across this research an early finding was that the language used across children and families teams did not always reflect the language that may typically used in adult services. For example, practitioners were more likely to speak about the needs of children and young people than their outcomes, likely to reflect the established language of The Children (Scotland) Act 1995. They were also more likely to use terminology such as 'universal pathway' or 'universal services' to describe community-based supports. Interviews surfaced that while some of the principles of SDS are evident in the practice described across children and families teams, the language of SDS was not always used. In fact, some practitioners felt it was more helpful to say what SDS is not (e.g. a crisis fund), because of the confusion in a complex delivery landscape.

SDS (and personalisation more broadly) emerged from the independent living movement and so often use the language of associated with this movement. However, the circumstances that bring children, young people and families into contact with social work and social care practitioners may have nothing to do with disability and may reflect needs relating to housing, safety, parenting, poverty, abuse, exploitation.

Barrier: The perception that SDS is not for everyone

The SDS Improvement Plan identifies a series of 'golden threads' that should be considered in all implementation of SDS. One of these golden threads is *"the universality of SDS, including its availability to children and families and other groups including homeless people, older adults and those living with addiction."* Across interviews, almost all SDS activity to support children and families was focused on children with disabilities.

Some practitioners described SDS as something only certain teams "do," while others emphasised integrated assessment rather than separate SDS processes:

> *"We don't have an SDS assessment. We all do integrated assessments."*

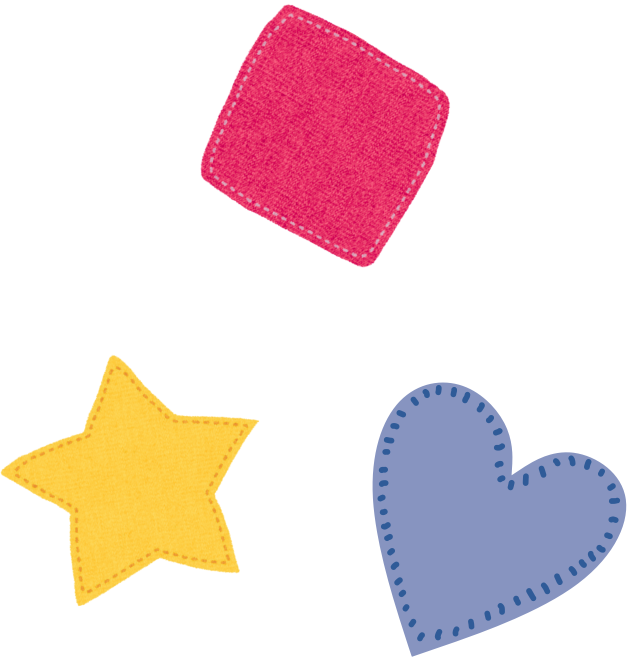
Workload pressures were also raised:

> *"90% of my time doing SDS is in my own time or it just will not get done."*

Some areas, however, noted a shift towards broader more universality:

> *"You can actually do it within your own service. And managers are also beginning to realise that it's possible for them to agree out of their own budgets what can be providing what can't. So there has been a lot of shifts."*

One practitioner reflected that SDS information and resources made available through their local Independent Support Organisation used the imagery and language of the disabled people's movement.



Case Study 1: SDS Implementation beyond children with disabilities

Introduction

In East Lothian work is underway to scale the delivery of Self-directed Support (SDS) beyond the children with disabilities team. Building on successes in the children with disabilities team, this project describes a pilot to introduce the principles of SDS using a proportionate and flexible approach.

Issue to be resolved

There is a perception across children and families team that the implementation of Self-directed Support has been focused historically on adult services. With the exception of the specialist children with disabilities team, which has an established process for delivering on the four SDS options. However, despite not using the language of SDS, small budgets are currently allocated to meet children's outcomes across different teams. The processes in place to support the allocation of resources to meet families needs flexibly is not recognized as SDS in practice and there are limited systems in place to review arrangements.

However, there is now recognition that the context, scope and delivery of the four options is likely to be different across different areas of practice (for example, fostering or youth justice) A project lead was appointed to design and pilot the embedding of SDS principles and practice beyond children with disabilities. SDS presents the opportunity to support families more creatively and be more outcomes focused. With local authorities facing stretched budgets, smaller and preventative spends can benefit families and make best use of local authority resources.

Action taken – and key learning points from across the pilot

Reflecting on what works – In the early days of this work, the project lead communicated with the children with disabilities team leader and business support lead to explore how SDS is currently implemented, what works and why.

Starting small – Following these initial conversations, the pilot decided to take a deliberately small and iterative approach, learning along the way. This allows for regular evaluation, and provides additional reassurances that budgets are manageable and well-allocated. In times of increasing financial pressures, fear of 'spiralling' budgets was noted as a barrier to implementation, so this scale of pilot reduced these anxieties.

Proportionate assessment, sign off and monitoring – The process for assessing, monitoring and reviewing a small SDS budget is proportionate to the level of spend. It was important that the paperwork for assessment was open, facilitated a good quality discussion and takes account of family strengths. Based on the GIRFEC framework, the paperwork is designed to facilitate conversation rather than add administrative burden and draw out strengths and assets as well as support needs:

> *"The paperwork facilitates that open conversation for the assessment and is about needs and outcomes and existing family strengths."*

Resource allocation – The children with disabilities team and adults' teams use a Resource Allocation Panel for the allocation of SDS budgets. However, a reflection early on in the process was that using a panel may create a bottleneck for assessments, and would not be proportionate for the smaller, preventative budgets used across other teams. The decision was made to work on a solutions-led model, where professionals and families are supported to think about what solutions would best support the young person to meet their outcomes. Plans and budgets are then signed off by service managers and put in place for up to 52 weeks. As soon as the budget is signed off at service manager level, business support can begin to put the budget in place, reducing waiting times to put support in place.

Review – A consideration of this pilot was how to best manage ongoing SDS packages, which currently remain unallocated to a social worker. It was identified as a priority to develop a way to monitor and review budgets to make sure support worked for families, increasing the accountability and opportunity for good conversations with families. A senior practitioner within the social work team will take on the responsibility of reviewing budget for unallocated families and reassessing at the end of the 52 week period.

Staffing resource – A senior business support officer was involved in the design of the pilot and systems, and two allocated business support officers will be named contacts for setting up budgets, but also a go-to for social workers with questions about the process. It should be noted there is no additional resource, so this is added work, and will be continually evaluated.

Supporting resources – A brief practice guide was developed for staff teams that outlines the process of accessing SDS, with visuals and flowcharts hosted on Mosaic. This was eight pages long, and streamlined to ensure it is accessible and inviting. The team has also created a short presentation about SDS that talks about what SDS is about, the value, the principles, the standards and includes early test cases to demonstrate how SDS can support different teams.

Informing families – The project lead noted that resources from the local independent support organisation was very focused on adults with disabilities, and don't represent the range of families and support needs who would benefit from SDS across children and families teams.This is a consideration for wider implementation following on from the pilot.

The four options - The pilot will continue to evaluate which SDS options are the best fit for families across different teams. Often, the choice between options reflected what was most convenient for families. Option 1 can allow for one-off purchases, and options 2 or 3 may be more suitable if a young person is attending an afterschool club or council-run resources. Choice is at the centre of this pilot, and will be continually reflected on

Bringing people along on the journey - as this is a small pilot, leadership buy-in at service manager level was enough to begin the work. However, as the pilot continues to develop, the lead has identified the importance of bringing in wider strategic leadership and partners from across the system (including education, health).

What's next?

The work to embed SDS beyond children with disabilities is ongoing and will be evaluated over the course of the next 6 months. It is important for the team to understand the opportunities, challenges and enablers that broader SDS implementation offers.

Barrier: The responsibilities associated with Option 1 (Direct Payments)

Direct Payments were sometimes complex to administer, with questions raised about whether young people could hold their own funds, and concerns about families' abilities to appropriately manage budgets.

Only one local authority described a child under the age of 18 holding their own budget. While this was not a specific area of inquiry for this work, there may be value in exploring the practice of supporting young people to maximise their control through Direct Payments.

One participant reflected on the challenges in awarding a direct payment to foster parents who do not have parental responsibilities. In this case, arrangements were made to award the direct payment through an increase of foster carer payments. Intended to be an 'under the radar' arrangement, this example demonstrates the additional complexities in Self-directed Support across children and families.

Some families felt that using a Direct Payment to hire a PA was not a good option for them, citing:

- The administrative burden of managing a Direct Payment
- The discomfort of having a Personal Assistant entering home
- The fear of depending on just one person, rather than a provider who could provide cover if needed

Participants described some very positive outcomes for young people through Direct Payments, indicating that they are a positive fit for some families. However, some families had no other choices available to them at the point of assessment.

Barrier: Effective commissioning and procurement

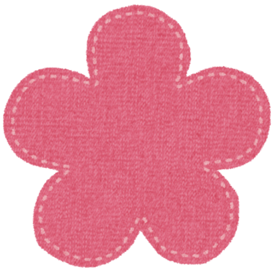
Across these interviews, practitioners agreed that availability of suitable support was a key concern for families. In some areas, particularly rural areas (See: Case Study 2), there was very limited choice of providers.

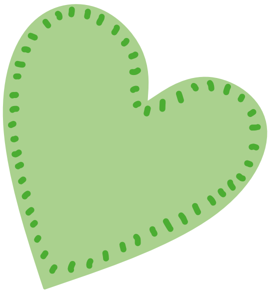
In other areas, providers of care and support were not able to do things that young people wanted to do. For example, one local provider was unable to spend longer periods of time with young people or go to events. Some local authorities were constrained by formal provider frameworks which limited who families could pay for support, whilst others were more flexible. This was not without challenge, with one incident reported where the care provided by an off-framework provider did not meet standards and put the young person at risk of harm. An example of the tension between enabling choice and quality-assuring provision.

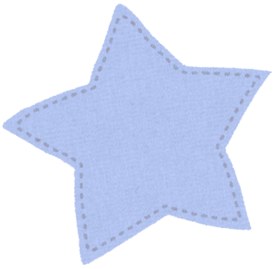
Other local authorities allowed families to access providers in neighbouring local authorities, or allowed young people to seek support from adult organisations where this was appropriate. In other areas where there was more choice, getting the right support was harder when children had more complex needs. One participant described how COVID had impacted on the local market for children's social care, and cited barriers to registering as a provider, regulatory requirements and low levels of pay as key reasons why there were commissioning gaps:

> *“I would use the word, even desperation, that there's not an agency in place…our children's agencies stopped providing services, so there's all the issues that come with that. So we've just done quite a big consultation and we're looking at finding an option 2 provider.”*

Some local authorities described a concerted effort to build stronger local market of available support, including playschemes and afterschool clubs, community and council-run supports to enhance choice. Additionally, one local authority described particularly strong relationships with a local independent support organisation who were working hard to expand the pool of available Personal Assistants to families locally.







Case Study 2: Rural Considerations

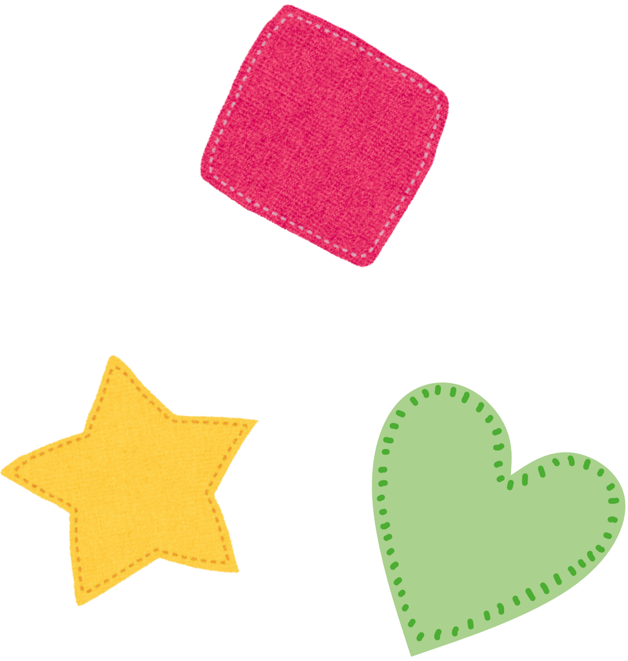
Additional barriers in rural and remote areas of Scotland were noted across interviews. In this section, shared challenges are summarised to bring attention to ways in which context influences the implementation of SDS across Children and Families. Practitioners working in remote and rural local authorities noted:

- Commissioning and procurement challenges that resulted in very limited, and sometimes no availability of local support providers. This impacted on the availability of Option 2 support.
- Accompanying these challenges in Option 2 delivery, Option 1 can be challenging for families due to pressures on Personal Assistant recruitment and retention. Some areas are very under-populated with a very small working population. In very remote areas, access to a car is essential, and travel is costly.
- Equity of access to universal services (supports available to all families regardless of disability or support need) with more populated towns often having much more formal provision for families than more remote areas.
- A disconnect between assessed outcomes and budget and actual implementation of support. One local authority responded to this by only signing off budgets once support had been arranged and named support was identified

> (whether PAs or Option 2 provider) to ensure that where possible, time spent on assessment led to real change for families rather than an extended waiting period.

However, there are pockets of innovation to broaden the choices available to parents. Including a pilot where a third sector organisation was partially funded to deliver drop-in summer groups for parents and children with disabilities. Contribution from the local authority meant the drop in was only £5, and families could opt-in if they felt it met their families outcomes. Any family can access this resource, and do not need to be assessed by social work teams or access a budget in order to use the provision.

Parents and carers have been positive about this new service, which has led to stronger peer connections between parent carers. Innovations like these depend on strong relationships with communities and families, in order to really understand what options families feel would benefit them, and strategically commission local supports.



Barrier: Resource Constraints

All of the participants in this project noted significant, rising concerns about the budget constraints facing their teams, particularly when coupled with rising needs in the population. Children and families teams were often able to support families to broaden their worlds, but worried that this could 'unrealistic' expectations of adult social care. For example, children and families teams may fund social activities to build connections, but in adult social care, demands on resources may mean that only personal care needs are supported. Participants grappled with how to best support families to navigate a challenging funding landscape:

> *"I think most families understand the difference when they get there, but it's still a painful time for for a lot of families, especially if their transition hasn't gone as smoothly as they would have hoped."*

Some participants reported that parents in the same area may talk and 'compare' budgets, not taking into account that each individual child has their own strengths and support needs, and that each family may be managing in different circumstances.

While Self-directed Support is a statutory function, some participants noted that they did not 'advertise' SDS, to manage demand amongst families. Many of the interviews touched on anxieties that demand from families could significantly outstrip the resources currently available, sharing similar sentiments that they are wary that too many people may feel entitled to support.

Enabler: Flexibility to meet outcomes

There were varying levels of flexibility in how SDS budgets could be spent across children and families.

For example, allowing families to increase the rate of pay to recruit a PA, staying within their indicative budget:

> *"But that's a real sticky point for some managers to say, oh, that's OK, because actually we're giving them more than the next person. But my argument is, well, no, we're not, because it's their indicative budget, as long as they stick within that and they're happy with slightly less [hours of support]"*

Practitioners also shared that Direct Payments could be used creatively to create space through sheds or garden rooms for young people at the cusp of transition to have their own independent space. In areas where practitioners described limited local provision for disabled young people, Direct Payments was an option that could allow families to be more creative at home to meet outcomes.

However, some participants were critical of flexibility that didn't focus on the support plan. One local authority described the practice of SDS assessment as becoming a 'wishlist' where parents named one-off purchases, rather than a more iterative process of assessment that took into account the young person's needs and outcomes. Another Local Authority described the challenges in trying to achieve outcomes when there are delays in PA recruitment:

> *“This person can find a PA, they've got £500. Can they use it to go on a holiday? And I'm like, well, that's not what the assessment was and that's not meeting that need.”*

One participant reflected on how circumstances were always changing, and said an open-ended approach to support planning enabled more flexibility:

> *“We've developed a system with parents. It's kind of informal that basically says right, this is what we're agreeing it for, and largely it's things that are in the best interests of your child…But see if you have an idea of something that you need that you think would be really good for your child. Come speak to us.”*

An independent support organisation involved in this work reflected that the practice between social workers was so varied that it was difficult to offer consistent information to families, as decisions appeared to be made on one-off basis based on individual professional judgement.

Enabler: Systems to effectively monitor Direct Payments

Children and families social care does not mirror adult social care. Often, interventions are short and intensive, intended to support families to become more resilient and manage without social work support. Having cases open, but unallocated, and in regular review was not always enabled through existing systems and processes.

However, one local authority noted that when teams were beginning to increase uptake of direct payments, they noticed it was challenging to monitor how funds were being spent to achieve outcomes within current processes. In this way, Self-directed support is not always congruent with reporting systems:

> *"[Staff] think of SDS as a budget to pay for things. And now I know it does pay for things, but it pays for it within a plan. It's not sort of like a crisis fund."*

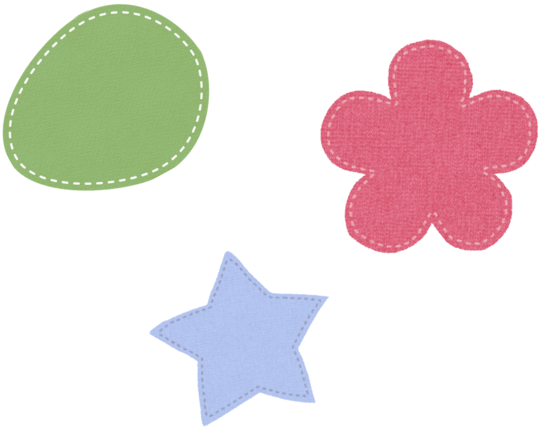
The management of the administration of SDS varied across local authorities. Some local authorities had dedicated teams to monitor direct payments, for others this was managed by individual workers. Two participants were concerned with the perception that Direct Payments were simply a way to purchase items, rather than a way to meet outcomes.

Enabler: Working with the whole family

Children and families teams are working with whole families rather than just children, considering the families strengths and risks alongside the needs of the child. In some local authorities, there was poor coordination with carers assessment and carer support packages (often processed through adult social care). Respite or short breaks were a common way that parents asked for support, but it was also important to consider not just carers' needs, but how children could use respite as an opportunity to meet outcomes:

> *"But actually, what is the gain for the child? What's the opportunity that comes with that for the child and to have their developmental, you know, opportunities or peer connection...?"*

Some practitioners mentioned that they may work with young sibling carers, but that this provision was often available through carers centres or education and would not require a full assessment to access.



Enabler: Good quality conversations

The development and implementation of SDS has been criticised for a lack of meaningful and effective involvement of people drawing on care and support and their families (Pearson et al, 2014). Across this research, practitioners described a range of engagement and consultation methods including consultations, surveys, planning groups and routine parents and carer forums.

One participant shared feedback from parents that they felt over-consulted, indicating the difficult balance between including families and recognising pressures on their time and energy. Practitioners also spent time with young people at school, home and in the community to draw in their views as part of assessment, where possible.

- Communication apps
- Visual tools
- Conversation prompts around ‘describing a good day and a bad day’
- Strengths-based approaches
- Shadowing young people at work or in school to better understand how they used the support around them

It was important for conversations to do more than explore or quantify support needs, but to understand the strengths of the child and family, as well as natural supports they could draw on.

Enabler: Multi-disciplinary working

A strength identified across this work was multi-disciplinary working. Children and families social workers had a range of supports available within teams to support families and did not require a SDS budget to access these.

For example, in one team when parents were struggling with sleep and in the process of seeking a short break, they could also work with a specialist learning disability nurse who could offer practical sleep support. Another local authority noted their strong relationships with schools and local carers centres.

Some participants noted strong relationships with independent support organisations, who were able to offer families information and support to navigate SDS and make choices about options for support. These independent organisations were described as more connected with communities, with more awareness of available resources. One participant noted how vital it was to have independent support and advice around Direct Payments and PA employment, which could be complex. Other participants were connected to national Self-directed Support organisations and networks.

Barrier (or enabler...?): Transitions

Transitions were identified as a particularly challenging time across the literature. Participants in this research had different arrangements in place to support transitions, and some worked closer with colleagues in adult social work.

However, practitioners were still concerned that some children were still ‘falling off the cliff edge’ without appropriate planning:

> *“It could be like, literally at the last minute when kind of they're reaching 18 where children where I've said children, families like our support will be stopping new services have to take over. That's nothing's been put in place”*

Case Study 3: SDS through transitions

The transition between children and adults social care is a known challenge amongst children with disabilities, care experienced young people and young people in the criminal justice system. Across this research, transitions were identified as a challenge in SDS implementation. This case study focuses on how a dedicated transitions team in North Lanarkshire applies the principles of SDS in practice.

The transitions team, recently expanded to be 1 Senior Social Worker and 3 Social Workers and has responsibility for transition planning and support across North Lanarkshire, for young people moving on from Education. Historically, when the team was first established, they worked solely with pupils attending Additional support needs schools, and numbers were around 80-90 young people per academic year group. However, numbers are now closer to 300 per year group and these numbers are continuing to increase.

The team has strong partnerships with schools, in a recent development, the team now engages with all secondary provision in NLC, as young people with additional support needs are increasingly attending mainstream schools. The team was also involved in supporting Education colleagues to develop their transitions policy. This partnership was viewed as an enabler to positive relationships with parents:

> *“We have good partnership working with our schools and are very much viewed as colleagues, the staff have confidence in us to work alongside them when planning for young people…This in turn helps us develop relationships with not only the young people we are working with but also the parent/carers, who can be hesitant to engage with social work services”*

The transitions process starts early, from age 15 and meetings start to take place when the young person moves into fourth year. There are six planned transition meetings over a 3-year period, and this is adapted depending on individual need, as some young people need more and some less. The function of these meetings is to bring together the young person, parents/carers and all relevant professionals to work on a post school plan.They allow the team to identify the young persons, goals, aspirations, and to review support arrangements.

The team spoke about having dedicated support for transitions had a wider benefit for locality teams and families, by reducing lengthy waiting lists, engaging with families before they reach a crisis point and adding dedicated expertise.

The team aim to enable young people to become as independent as possible, while still balancing their individual needs. The transition process offers a natural opportunity to review supports in place. The team highlighted that when supports have been introduced historically, it can become the norm.

It's therefore important to review arrangements to ensure supports in place remain appropriate, and is aligned to the young person's move into adulthood. The transitions team work to raise the profile of their work, and SDS more generally through events, roadshows, aiming to reach a broad audience, not just people with an interest in Self-directed Support. This engagement has been useful in myth-busting around SDS, for example:

1. **The myth that SDS always means 'a budget'**, and that there are no other ways to meet outcomes. For example, the local authority has many resources that can be accessed to meet needs, one of these is a service called Locality Support Services, which is delivered directly by the Local Authority (Option 3), This service provides personalised support which is community based, helping individuals link to their community. Young people accessing this can choosing what outcomes they want to work on and achieve (for example, independent travel).

2. **The myth that SDS budgets can pay for everyday costs**. While the team is flexible about how to meet outcomes, it was important for there to be a clear rationale for how support meets outcomes.

3. **The myth that you need a diagnosis to access the transitions team**. The team does not require a diagnosis to begin the transitions process, as they recognise the complexity of pathways to diagnosis, but there must be a social work assessed need and young person is in the process of obtaining a diagnosis. The team understood that the context and family life was important, seeing young people as more than a diagnosis or condition and considering their wider family background and strengths. However, they have recently

strengthened links with colleagues in health which have been helpful to access necessary assessments, and link into the supports available through health.

4. **The myth that you must already have SDS in place before transitioning to adult services** or else you won't be eligible for adult support is not true. It is common for families to have had little or no input historically, but that does not prevent access to support at the point of transition. Needs often change when circumstances change.

Multi-disciplinary support was seen as important in understanding young people's needs and streamlining transitions planning. The transitions team could also link in with locality hubs for access to technology team, district nurses, occupational Therapy etc The team also has links to the local disability forum, who are well placed to signpost to universal and specialist supports locally.

The team reflected that choices between Options 1, 2, 3 and 4 change depending on point in transition, for example a family may be happy with an Option 1 (Direct Payment) to hire a Personal Assistant (PA) for their child, but as needs increase or if the budget was to increase, they may choose to move to a support provider to meet the outcomes of the young person and a discussion can take place about how the family wants to manage an increasingly complex support.

> *"We are focused on building strong relationships with young people and their families, taking time to embed full person-centred planning process"*

Future Directions

This learning report reinforces what national reviews of Self-directed Support have consistently found: the core challenge is not a lack of policy intent, but how SDS is understood, enabled and enacted in day-to-day practice. The following future actions focus on strengthening implementation in ways that are practical, relational and grounded in the realities of children and families' services.

1: Position SDS as core children and families' practice, not a specialist add-on

National policy is clear that SDS is a universal approach. Future work should focus on supporting local authorities to embed SDS principles into mainstream children and families practice, rather than confining SDS to specialist children with disabilities teams.

This includes:

- Making explicit how SDS aligns with GIRFEC and The Promise in everyday assessment, planning and review
- Supporting teams to recognise when they are already working in SDS-aligned ways, even if they are not naming it as such
- Developing proportionate approaches to SDS that reflect the different contexts of child protection, youth justice, family support and early intervention

The aim is not uniformity, but clarity: SDS should feel relevant and usable across the full breadth of children and families work.

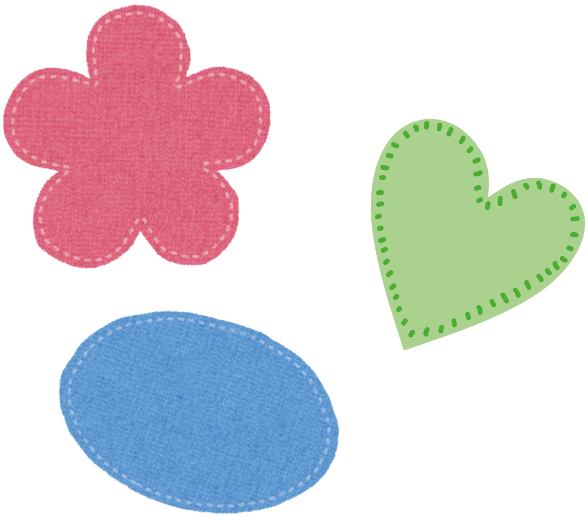
2: Shift from compliance-led processes to learning-led implementation

Both the post-legislative scrutiny inquiry and the National SDS Improvement Plan highlight the need to move away from overly bureaucratic approaches that undermine practitioner confidence and delay support for families.

Future action should focus on:

- Supporting local authorities to design proportionate decision-making and sign-off processes, particularly for small, preventative SDS budgets
- Reducing unnecessary panels and paperwork where they create bottlenecks without adding value
- Creating safe spaces for practitioners and managers to reflect on practice, share learning and adapt approaches over time

This aligns with a learning-oriented approach to improvement, where SDS is strengthened through iteration rather than tightened through additional control.



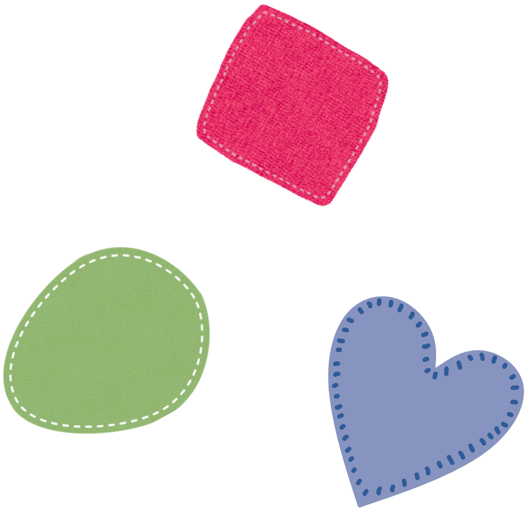
3: Invest in practitioner confidence, not just guidance

The learning echoes long-standing findings about “professional hesitancy” in children and families SDS practice. Addressing this requires more than refreshed guidance.

Future work should prioritise:

- Practice-based learning opportunities that bring together social workers, managers, finance and business support staff
- Support for supervisors and service managers to feel confident in authorising flexible, outcomes-focused use of resources
- Practical tools and examples that help staff navigate the tensions between safeguarding, accountability and choice

Building confidence at all levels of the system is essential if SDS is to be used creatively and consistently.



4: Strengthen the voice of children, young people and families in shaping SDS

While this research centres practitioner perspectives, future activity should deepen understanding of SDS through the lived and loved experiences of children, young people and families.

This should go beyond consultation to explore:

- How families experience assessment, decision-making and review processes
- What helps or hinders meaningful choice and control at different points in a child’s life
- How SDS is experienced during key transitions, particularly into adulthood

This learning should be fed directly back into local and national improvement activity, ensuring experience informs action.

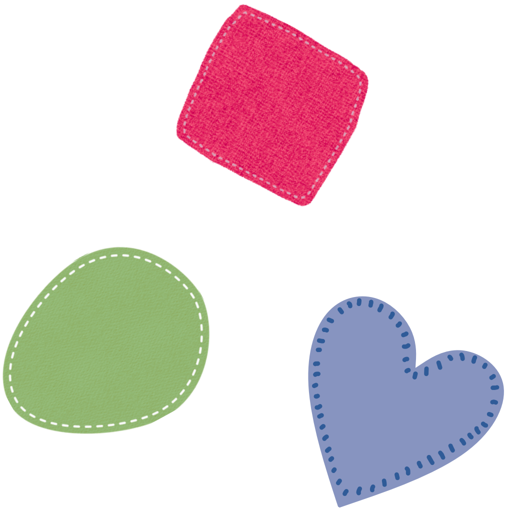
5: Address commissioning and market challenges as part of SDS implementation

Choice and control are only meaningful when there is something to choose from. Future action should recognise commissioning and market development as integral to SDS delivery in children and families.

This includes:

- Supporting local authorities to work with communities, third sector partners and independent support organisations to build local, flexible forms of support
- Exploring creative and preventative uses of funding that reduce reliance on formal packages
- Ensuring commissioning approaches are responsive to rural and remote contexts, where standard models may not work

National leadership has a role in enabling this, but solutions will need to be locally shaped and relationally led.



6: Use data to support learning, not just assurance

There is a clear need for better information about SDS implementation in children and families. However, future work should focus on data that supports learning and improvement, rather than data collected solely for performance reporting.

This could include:
- Developing shared questions that local areas can use to reflect on practice (e.g. who SDS is reaching, where it is being used, and where it is not)
- Using qualitative insight alongside quantitative data to understand variation
- Supporting national and local conversations that focus on what the data is telling us, and what to try next

7: Focus sustained attention on transitions

Transitions remain a point of heightened risk and complexity. Future action should prioritise:

- Earlier, relational transition planning that reflects SDS principles
- Stronger alignment between children's and adult services in how choice, control and outcomes are understood
- Learning from areas with dedicated transitions approaches and sharing this more widely

Final reflections

This learning reinforces a familiar but important insight: the challenge facing Self-directed Support in children and families is not a lack of policy ambition, but the difficulty of translating that ambition into everyday practice. SDS sits comfortably alongside GIRFEC, The Promise and the SDS Improvement Plan, yet it is still too often experienced as separate, specialist or hard to apply within the realities of children and families' work.

Across the findings, SDS appears most effective when it is understood not as a process or funding mechanism, but as a way of working that shapes conversations, relationships and decisions. Where practitioners are supported to exercise judgement, where decision-making is proportionate, and where learning is valued, SDS principles are more likely to be realised in meaningful ways for children, young people and families.

This points to the importance of focusing future effort on the conditions that surround practice. Confidence, clarity and trust matter as much as guidance or tools. So too does creating space to reflect on what is working, where SDS is not yet reaching families, and how practice can adapt in response.

Ultimately, the future of SDS in children and families lies in deepening approaches that already align with good social work practice. Treated as a relational, flexible and learning-led approach, SDS has the potential to support systems to respond more humanely and effectively to the complexity of children's and families' lives.

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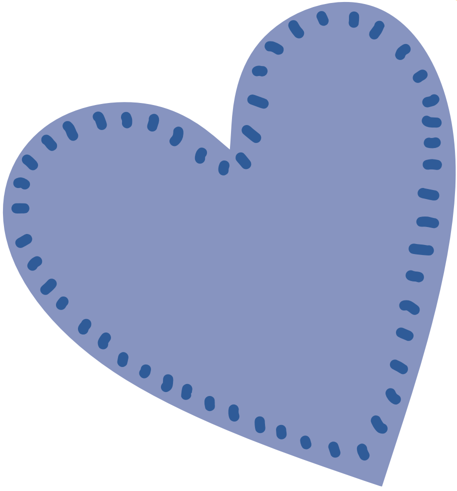

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