

**ORIGINAL ARTICLE**

# Changing the culture of social care in Scotland: Has a shift to personalization brought about transformative change?

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**Abstract**

In April 2014, the Social Care (Self-directed Support) (Scotland) Act 2013 (SDS Act) was implemented in Scotland. This marked a major shift in how social care is delivered and organized for both users and professionals across the country. Whilst it emerged through the personalization agenda—which has dominated international social care systems over recent years—self-directed support (SDS) represented a significant shift in thinking for service provision in Scotland. In this article, we review the initial stages of policy implementation. Drawing on two Freedom of Information requests from 2015 and 2016 and a series of interviews with local authority practitioners, we argue that, to date, SDS has yet to produce radical transformative change. We explore the reasons behind this through four key themes. First, we highlight the challenges of promoting the principles of co-production in policy and suggest that, in reality, this has been compromised through SDS implementation. Second, we suggest that SDS has been caught up in a policy overload and ultimately overshadowed by new legislation for health and social care integration. In looking at the impact of this relationship, our third theme questions the role of new partnership working. Lastly, we argue that the timing of SDS in a period of acute austerity in social care has resulted in disabled people being offered limited choice rather than increased opportunities for independent living.

**KEYWORDS**

independent living, personalization, Scotland, self-directed support, social care

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## 1 | INTRODUCTION

In April 2014, the Social Care (Self-directed Support) (Scotland) Act 2013 (SDS Act) was implemented in Scotland. This marked a major shift in how social care is delivered and organized for both users and professionals across the country. Whilst it emerged through the personalization agenda—which has dominated many social care systems over recent years—self-directed support (SDS) represented a significant shift in thinking for service provision in Scotland. It also marked a scale of change that was unprecedented elsewhere in the world. The roll-out of the personalization of social care in England has been subjected to an emerging critique (see e.g., Slasberg, Beresford, & Schofield, 2012, 2014) and elsewhere (see Christensen & Pilling, 2014). However, to date, there has been limited commentary on policy change in Scotland.

As we set out in this article, SDS legislation was strongly influenced by concepts of partnership, personalization, and co-production. Impetus for change also drew on a number of parallel policy drivers. These included discourses of cost-efficiency and effectiveness underpinning wider motivations for welfare reform both in Scotland, across the United Kingdom, and globally, alongside a push from disabled people and their organizations to facilitate independent living (Pearson & Ridley, 2016).

SDS has also emerged as part of a drive by the Scottish Government towards policy-making and public service reform informed by deliberative public policy analysis (Dryzek, 2000; Hajer & Wagenaar, 2003). This deliberative turn in policy seeks to create “new spaces for participatory decision-making and accompanying modes of citizen problem-solving that fill gaps created by the failure of traditional approaches” (Fischer, 2009, p. 68). SDS forms part of a group of policies that seek to tackle disengagement by encouraging partnerships between individuals, communities, and institutions (Jenkins, Kirk, & Smith, 2002). Other policies under this guise include the Public Bodies (Joint Working) (Scotland) Act 2014, and the Community Empowerment (Scotland) Act 2015. Central to this ideology is a belief that for all those who use services, participatory democracy and social solidarity go hand in hand. Under the SDS Act (Scottish Government, 2014), the general principles state that care users must have as much involvement as they wish in relation to both the assessment of their needs and the way that support is provided. Ensuring the ability for individuals to participate in the life of the community is also a central principle of the Act.

SDS then has seen the emergence of a shift towards greater emphasis on what Le Grand (2007) terms “voice” in contrast to earlier delivery models of care based on “trust”, where professionals, managers, and others deliver high-quality services to service users. Conversely, SDS is also built around a new form of liberalism, through which disabled people are granted equal access to goods and services through a program of individual autonomy and increased choice. It is also true that this shift to voice has also operated alongside the third of Le Grand's (2007) delivery types: targets and performance management with cost-effectiveness and efficacy also prevalent. The overt use of legislation and regulation in the reform of public service is, perhaps, unique to Scotland.

In this article, drawing on data from a series of telephone interviews with practitioners from local authority, health, and third sector organizations and two Freedom of Information (FOI) requests detailing policy uptake in 2015 and 2016, we review the initial stages of policy implementation and argue that—to date—SDS is failing to produce the radical transformative change. Findings from the FOI data shows that little has changed in the type of services people are receiving, and that option 3—services organized and provided through the local authority—remains, by far, the dominant SDS mode. This suggests SDS is being distanced from its policy origins, moving it a long way from the original intentions of direct payments (DPs) and the Independent Living Movement (Campbell & Oliver, 1996). This contention is then explored in more detail through four main themes. First we argue that the rolling out of SDS has been compromised by a failure to fully engage in meaningful co-production. We highlight how the principles of co-production, where the design and delivery of services are shared between the service user and provider (Barker, 2010), have so far struggled to form a part of mainstream practice in social care. In exploring the reasons behind this failure to embrace the values of SDS, we examine a second theme, policy overload. Whilst local authorities were attempting to embed SDS and adapt to new structures and working cultures in social care, the changes have been swiftly followed by further major legislation. This has seen the implementation of the Public Bodies (Joint Working)

(Scotland) Act 2014—the blueprint for health and social care integration (HASCI) in Scotland—put in place just two years on from the SDS Act, in April 2016. Third, we look at the role of health as a partner in the SDS process. As SDS moves into a wider policy environment co-opted by HASCI, discussion asks whether there is adequate understanding of the SDS model in the health domain to promote this new approach to partnership working. Lastly, we examine the impact of austerity on SDS, and argue that its potential to deliver more flexible and user-led services and promote independent living for disabled people has been greatly eroded by its timing (Pearson & Ridley, 2016). Before looking at these themes in more detail, we set out a brief overview of how SDS emerged on the statute.

## 2 | SELF-DIRECTED SUPPORT AND THE PATHWAY TO POLICY CHANGE

The emergence of legislation for SDS in Scotland reflected a push by the Scottish Government to reconfigure social care services and instill concepts of personalization, partnership and co-production at the heart of service provision (Pearson & Ridley, 2016). Global recognition of the changing policy sphere for disability also played a part in the emergence of SDS. Notably, the adoption of the Convention on the Rights of Persons with Disabilities (CRPD) by the UN Assembly in 2006 marked the culmination of many years of work to place disability rights on the international agenda and to integrate disability issues fully into the broader human rights and international development framework (Power, Lord, & de Franco, 2013). The CRPD therefore served as an impetus for disability law and policy reform at both domestic and regional levels, and defined a framework from which to understand the concept of personalization and its operationalization in both law and policy.

It is clear from its application across different systems of social care that personalization can be seen as an umbrella term, encapsulating a range of approaches and including DPs, individual budgets (Glendinning et al., 2008), and SDS (Leadbeater, 2004, 2008). All emphasize choice, control, and flexibility in social care support, but there undoubtedly remains a confusion over the terms, whereby DPs, personal budgets and SDS can be seen as the same thing (Manthorpe et al., 2014). However, as Beresford (2009) notes, there are important differences in their underpinning ideologies. As discussed elsewhere (see Pearson & Ridley, 2016), DPs were a grassroots development emerging from the disabled people's movement and a desire to equalize opportunities and increase independent living, whilst personal budgets and SDS evolved from developments largely driven by professionals critical of the welfare state and its ability to promote independent living. In particular, the work of the *In Control* project (see Poll, Duffy, Hatton, Sanderson, & Routledge, 2006) in England informed a pilot project in the Scottish authority of North Lanarkshire (Etherington, Hatton, & Waters, 2009), which set in place an appetite for the delivery of personalization north of the border. Yet throughout the evolution of the personalization agenda in social care, allegiances and partnerships between often opposing groups have been critical to securing policy change. As detailed shortly, a link between proponents of the market and disability activism was key to moving forward with DPs in parts of England, whereas resistance led to a lower take-up in Scotland (Riddell et al., 2005).

Throughout its inception, SDS has been described as an “evolving concept”, poorly understood by many practitioners and often confused with DPs (Ridley et al., 2011). However in a clear departure from earlier DPs legislation (Pearson, 2004), the SDS Act requires local authorities in Scotland to offer *all* assessed care support in the form of SDS in the first instance. Furthermore, DPs form only one option (option 1) of the framework on offer. Users may also use option 2, a selection of support by the user, but arranged through the local authority or other agency on their behalf; option 3, support organized and provided by the local authority; or option 4, a mixture of these options (Scottish Government, 2014). Critically, support for SDS brought policy into the mainstream of social care provision and thereby increased the numbers of people directing their own support from the time of the SDS Act's implementation in April 2014.

Looking at the policy development of SDS, it is clear that a central focus required for the structural and cultural transition hinges on the key role given to partnership working and co-production. As set out earlier, this represents a growing trend in Scottish social policy, where over the past 20 years, the partnership agenda has become much more

prominent and has incorporated a clear shift from voluntary to mandatory arrangements (Cook, Mulherin, & Seditas, 2015). This was underlined in the recommendations of the Christie Commission on Public Service Reform (Scottish Government, 2011). In his report, Christie set out plans for “radical change in the design and delivery of public services” (Scottish Government, 2011, p. viii), with a specific call for services to “empower individuals and communities...by involving them in the design and delivery of the services they use” (Scottish Government, 2011, p. 26). Policy rhetoric has therefore been increasingly focused on reducing negative outcomes and adopting preventative measures, with an emphasis on building services around individuals and communities (Garven, McLean, & Pattoni, 2016). Partnership has been conceptualized as a means to address a wide range of complex issues, including health inequality (see Perkins, Smith, Hunter, Bambra, & Joyce, 2010) local regeneration (see e.g., Diamond, 2004), community empowerment (see Garven et al., 2016), and increasing employability (see Lindsay, McQuaid, & Dutton, 2007). Co-production describes a particular approach to partnership between people who rely on services and the people and agencies providing these services (Hunter & Ritchie, 2007). Policy discussion of SDS has been mainly located in the direct delivery of services to individuals in a manner that increases user satisfaction and improves efficiency by making better use of the resources that both providers and users bring to the table (Pearson, Ridley, & Hunter, 2014). Before examining the four themes set out above, we review how policy has been addressed in other welfare regimes.

### 3 | THE GLOBAL GROWTH OF PERSONALIZED SOCIAL CARE AND CHALLENGES FOR AN AGENDA FOR INDEPENDENT LIVING

The role of international disability activism in facilitating a bottom-up drive towards cash-based models of support has undoubtedly been a pivotal moment in policy change. As detailed extensively elsewhere (see e.g., Campbell & Oliver, 1996; Morris, 1993) the idea of cash-for-care as an alternative to directly provided services originated in the 1970s in the United States and gradually gained global interest over the next 40 years. From the late 1990s, many European countries—including all devolved administrations in the United Kingdom—began to adopt legislation. Support for change has been underpinned by grassroots disability activism and pan-European disability strategies such as the European Union's Disability Strategy 2010–20, which has promoted specific actions to improve health, accessibility, social protection and the employment of disabled people. However, as well as integrating a history of support from disabled people, cash-for-care and subsequent personalization schemes have also developed with a discourse of cost-efficiency (Pearson & Ridley, 2016). This was in place from the outset of DPs policy development, whereby using cash alternatives for care was evidenced as a main driver for change for the then outgoing Major Government (Zarb & Nadash, 1994). Whilst very attractive for many Conservative local councils in the south of England, which formed partnerships with local disability organizations to implement DPs (Pearson, 2000), until relatively recently Scottish local authorities have been more suspicious and tended to view the policy as “backdoor privatisation” (Pearson, 2004).

More recently, Australia has moved from small, local cash payment schemes (Laragy & Ottmann, 2011) to a centralized funded scheme of individual budgets—the National Disability Insurance Scheme (NDIS). The adoption of legislation in 2013 also reflected an alliance between the then Labor Government and disability groups, with its impact likened to the introduction of universal health care in Australia (Steketee, 2013). However, like the experience of personalization across the United Kingdom, the role of neoliberalism in reshaping disability support services has been criticized. As Thill (2015) observes, concerns have been raised that disabled people are more likely to be offered limited opportunities for consumer choice, rather than rights to participation and voice through the NDIS. In addition, the scheme is seen by some as a means to privatize services, by undercutting public and not-for-profit sectors, and threaten the quality of services (Kirkwood, 2015).

Scotland's legislation for SDS draws in part on the legacy of DPs, whereby the role of cash-for-care remains at least a partial focus of provision. However, as personalization in social care has secured a more influential role in policy change since the early 2000s (see Leadbeater, 2004, 2008), we have seen a shift from bottom-up cash-for-care schemes inspired by local disability activism to a more top-down agenda pursued enthusiastically by UK governments. As set out above, as well as the broader shift towards partnership working and co-production across public services,

the adoption of the personalization of social care in Scotland grew out of work with people with learning disabilities and the philosophy of “normalization”. Consequently, its inception has focused more on the integration of individuals, rather than challenging barriers and discrimination. In Scotland, this was linked with ideas set out in *Changing Lives: Report of the 21st Century Social Work Review in Scotland* (Scottish Executive, 2006). The Review placed personalization at the heart of its strategy, and, like HASCI, drew strongly on themes around prevention, encouraging individual capacity to manage their own lives, participation in shaping and delivering service solutions, and promoting consumer choice. In contrast with the slower development of DPs, personalization was adopted across UK governments much more rapidly—a shift without global precedent (Boxall, Dowson, & Beresford, 2009), yet one which has been carried out with a very limited evidence base of its impact on individual users.

Indeed, as welfare states have faced increasing pressures on existing resources and anticipated growth in future demand (Newman, Glendinning, & Hughes, 2008), personalization models of social care have formed an integral part of welfare reform programs. For commentators such as Ferguson (2012) this has been a divisive issue, and one that has effectively eroded the values of independent living instilled by disability activism, replacing them with a neoliberal social and economic agenda. More recently, this view has been compounded as the implementation of the SDS Act in April 2014 coincided with a massive reduction in social care spending. Scotland's budget has continued to fall, and by 2020 it will be 12.5 per cent lower in real terms than it was in 2010 (Scottish Government, 2015). This has had a major impact on the planning and delivery of services (Main, 2013), with significant reductions taking effect from 2016 (Scottish Government, 2014).

In the next section, we move the discussion to outline the details of the study, which we set up to examine the issues relating to the initial implementation of SDS. As advocates of personalization and with a long history of research into personalization in Scotland, we wanted to explore how the possibilities afforded by SDS were being realized at an early stage of its implementation.

## 4 | METHODS AND BACKGROUND TO THE STUDY

We sent out two FOI requests to all 32 Scottish local authorities. The first was sent in March 2015 and the second, a year later. We took the decision that an FOI request would also ensure a better response rate than a survey. Each local authority was asked: What are the total numbers of users currently receiving SDS for each of the four options? In 2015, 26 local authorities replied. Twenty-two of these offered full information on the questions asked, three included only partial data, and two local authorities declined the request on grounds of cost. In 2016, 23 local authorities replied, with 22 willing to provide the full information on the questions asked.

From May 2015 to September 2015, a series of semi-structured telephone interviews were conducted with local authority and health staff working in SDS. The telephone interviews were carried out with 11 personnel located in local authorities, three in health, alongside representatives from six third sector organizations. These included groups for, and of, disabled people, including those representing different impairment groups, alongside provider and support organizations.

We selected our sample to ensure representation from the range of authorities including those covering rural, remote rural, and urban areas, and to take account of the diversity of the returns from our initial FOI. Overall, we recruited respondents from 11 out of the 32 Scottish local authorities. This represented the diversity of local authority circumstances across the country. We wanted to speak to lead officers for SDS. In recruitment from the health boards we selected those who were most closely involved with social care in the newly emerging integrated joint boards (IJB), formed as part of the ongoing implementation of health and social care in Scotland.

The interviews ranged between 20 and 60 minutes, with the majority taking about 40 minutes. Telephone interviews have been shown to be a useful and user-friendly tool for qualitative data collection (Ward, Gott, & Hoare, 2015), and participants in this study welcomed the opportunity and the flexibility of our approach. Some respondents, for example, were initially reluctant to commit to be part of the study until they learnt that data collection was to be via a telephone interview. This was viewed as less demanding in terms of their time commitment, and allowed them to take

charge of the time and set the parameters of the interview. We aimed to keep the interviews focused on SDS and its implementation, and participants were invited to comment on a range of topics linked to this. This included their involvement in policy implementation, the impact of changes on existing arrangements, the role of consultation, and engagement in the local area. Interviewees were also asked to comment on the relationship between needs and resources in their line of work.

Invitations to participate in the interviews were emailed out to named personnel working in SDS and/or IJBs across the 32 Scottish local authorities, and interviews were carried out with all those who agreed to take part. In addition, staff identified in health boards with a specific interest in SDS in a health setting were also contacted and invited to take part in the study. On completion of 20 interviews, the project team reflected on the key findings and it was felt that “thematic data saturation” (O’Reilly & Parker, 2013)—the collection of data until no more new patterns or themes were emerging from the data—had been reached.

Ethical approval for the interviews was received from the College of Social Sciences Ethics Committee, University of Glasgow. As SDS was implemented in April 2014, staff had been working in new systems of social care for just over a year at the outset of the telephone interviews. This had therefore clearly represented a period of major transition across social care. As we set out in the following sections, this rapid period of change instigated a fundamental shift in existing cultures of care.

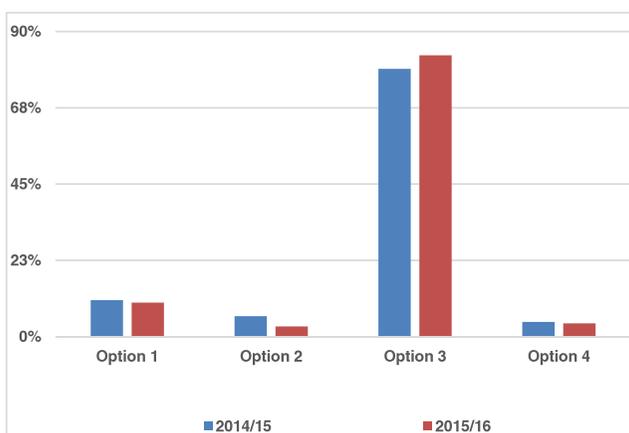
All interviews were transcribed for subsequent analysis. The data were read by all members of the research team and independently coded according to standard qualitative research methods (Bryman, 2015). We met as a research team to discuss our findings and to draw out the key themes.

## 5 | FINDINGS

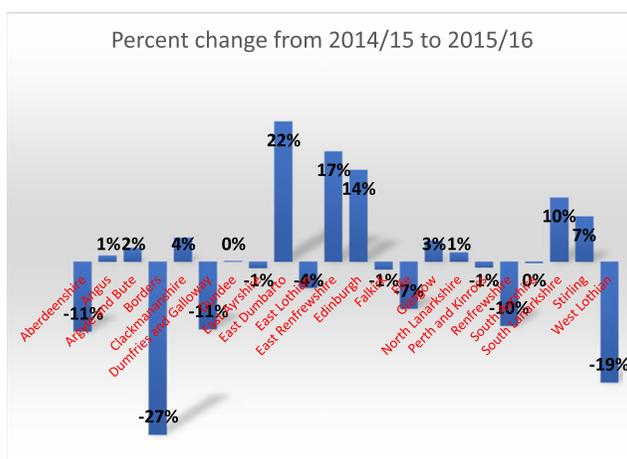
### 5.1 | Mapping the uptake of self-directed support: Findings from the freedom of information returns and the implications for independent living

Twenty-two local authorities out of a total of 32 replied fully to the FOI request across both years. These are aggregated in Figure 1, which gives the percentage of users by year and SDS. The returns from the FOI request suggest that in terms of raw numbers, SDS has not to date achieved the transformative change it was hoping to implement.

Overall, the introduction of SDS has resulted in little change in the way that social care is delivered. These aggregated data may hide the fact that there may well be changes across the two periods within local authorities and these are presented in Figure 2. Three local authorities have shown relatively large increases in uptake of option 1, but across most of the country uptake remained either static or had fallen.



**FIGURE 1** Uptake of self-directed support across the four options from 2014–15 and 2015–16 [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]



**FIGURE 2** Changes in uptake of option 1 by local authority [Colour figure can be viewed at [wileyonlinelibrary.com](http://wileyonlinelibrary.com)]

It is true that these data are not able to determine if the actual way social care is being implemented has changed, or if choice was offered allowing people to make informed decisions about which SDS option to choose. SDS is of course about more than just DPs (option 1) and the policy intention was to extend the choice and control of a DP to those who did not want to assume the responsibilities they demand. From these data, we do not know if users felt that they are in greater control of the way their care is delivered and their lives. However, the fact that option 3—service as was—remains dominant, suggests that this was not the case and that policy is not promoting transformative change. In the next section, we examine this contention in more detail through our qualitative data and the four themes set out earlier.

## 5.2 | In search of an agenda for transformative change: Self-directed support and the problems of co-production

The focus on partnership and co-production, whereby users and practitioners work together at all stages of the design and delivery of support, formed a key part of the SDS legislation. However, our findings show that this focus appears to be a major challenge for policy implementation. From the interview data, there seemed to be a number of explanations for the imbalance in uptake of the different options. Local authority workers and organizations of, and for, disabled people cited the failure of staff to offer choice to care users. We were told that it was unlikely that all users had been reassessed through the new SDS system and therefore remained on option 3:

“The majority of people we support would be option 3. But...that’s not necessarily because they’ve chosen option 3, it’s probably because we’ve not got round to asking them what they want.”  
(Interview with SDS lead officer, North Scotland)

Others conceded that there was still a need to secure an understanding of SDS amongst frontline staff:

“I don’t think we invested sufficiently in winning the hearts and minds of our frontline teams and installing the virtues of policy that we’re trying to adopt...I think there’s been a disconnect in that previous senior teams who were overseeing this have now actually left...So there’s a lack of continuity and consistency.” (Interview with SDS lead officer, West Scotland)

We were also told that staff and service users had not been brought together by the changes. The reluctance of frontline staff to routinely offer the full range of SDS options and engage with co-production was reiterated by the representatives from the disabled peoples’ organizations we spoke to:

“The increase in option 3 typifies the approach of social work...They have the duty to do the assessment but that doesn’t mean that they have to comply with the spirit of the Act.” (Interview with disability organization)

One of the organizations of disabled people remarked on the speed that people were being put through the system, stating that this did not allow them to take account of their specific needs in planning services. It was therefore apparent from our interviews that whilst there had been some change in discourse and language surrounding SDS, practice had not been transformed in accordance with the values of the legislation. The next section examines this further by looking at the broader picture of legislative change.

### 5.3 | Policy overload and changing cultures of care

The Scottish Government's strategy for SDS published in 2010 (Scottish Government, 2010) noted that policy implementation was a ten-year plan, and therefore full enactment of changes would take time. Two years after the introduction of SDS, the Public Bodies (Joint Working) (Scotland) Act 2014—legislation to develop new structures for HASCI—was due to come into place from April 2016. The overshadowing of SDS by the demands of new changes in the administration of health and social care was a common theme in the interviews across all sectors. As one disability led organization observed:

“We’ve had this big push on SDS. That’s kind of been and gone and now authorities are really interested in health and social care. And certainly the fear from a lot of our members is...are people going to stop caring about SDS?” (Interview with disability-led organization, Central Scotland)

This was reiterated across the third sector organization interviews, one of which suggested that the requirements for integration have “pretty much bulldozed SDS right out of the way of anybody’s thinking”.

Likewise, senior staff across both health and social care also acknowledged that the timing of HASCI so soon after SDS implementation was challenging. The following quote typified many of the responses from local authority lead officers for SDS:

“I mean we’re in the early days of [HASCI] partnership and yet it seems a bit of a shame that we didn’t get SDS fully embedded before we embarked on another huge change.” (Lead SDS officer, Central Scotland)

For some staff, particularly those from health, the dominance of HASCI was viewed as an inevitable part of policy change:

“I think for all the right reasons the focus in [the local authority] and probably [neighboring authorities] as well, has been on integration to the detriment of SDS. And it’s just that massive structural, cultural and managerial change that we’ve all just lived through [that] has...got in the way of focusing on the other major piece of policy around personalization [SDS].” (HASCI officer, West of Scotland)

These data make it clear that SDS had fallen down the agenda and that it was now secondary to other policy reforms. The discussion in the following section explores this in more detail as we examine the role of health in the SDS framework.

### 5.4 | Self-directed support and the role of new partnership working: Where does health fit in?

Although the interviews took place in the year prior to HASCI, all health boards and local authorities had already put systems in place to roll out integration which was formally due to start in April 2016. As discussed above, the notion of partnership working and co-production has been set out as a dominant theme in SDS legislation, reflecting a broader trend across Scottish social policy over the last decade (Scottish Government, 2011).

Partnership working across and between different sectors was also integral to the development of HASCI. In practice, we found there was considerable variation within our sample as to how this concept was being rolled out and delivered in local areas. In some areas, staff in both sectors spoke positively about the new relationships and the potential they afforded:

"We've got three directors who work incredibly well together, they meet on a weekly basis along with our director of acute services, so we have the infrastructure in place to actually knit the whole thing together really nicely." (HASCI officer, West of Scotland)

Others acknowledged that the change in values would require a longer-term cultural shift in working practices:

"Health is basically at the very early stages of co-production...and has less of a relationship with third sector and commissioning...it's a bit like a marriage...it's a good thing but it doesn't work for everyone because there needs to be certain pre-conditions in place. I think many of those pre-conditions are simply not in place and therefore some marriages will work really well and others will be disastrous." (HASCI lead officer, Central Scotland)

"[The] Scottish Government haven't necessarily joined up integration and SDS and they've kind of been dealt with by two different sets of people and not necessarily joined up." (SDS officer, local authority, Central Scotland)

However, even in the areas where partnership was seen as productive, it is clear that "partnership working" referred to partnerships across largely professional organizations. There was little evidence of user involvement, despite this being a key element of the legislation both for SDS and HASCI.

Different approaches to partnership working and the delivery and commissioning of services was also affecting the implementation of SDS, with many in health having little or no experience of working in this way:

"I'm not saying there's no understanding of it [consultation] or there is no value in it...But I think for a lot of straightforward, mainstream health interventions, it'll be new to them. They won't have felt the need to engage with it." (HASCI officer, West of Scotland)

Unlike in England, where Personal Health Budgets were introduced in 2014 (Forder, 2014), Scotland does not have this provision in place, and has been openly resistant to such developments, with health having only limited experience of commissioning services. Therefore, whilst the option of drawing on alternative providers for health services is not normal practice, within the health sector through SDS, option 1 allows a DP to be made as an alternative to directly provided services (see Pearson & Ridley, 2016). Clearly, this represents an important division between health and social care services, and one which was understandably causing some confusion:

"I've always had this feeling talking to [health] people, it was like 'This [SDS] is social work's responsibility...it's really nothing to do with us'. So we've been revisiting that with the health teams." (SDS officer, local authority, West of Scotland)

In other sectors, staff based in health conceded that although they had worked closely with the SDS policy team in the Scottish Government and funded key roles to promote policy in the context of HASCI, there was "still a lot of work to be done with frontline staff around changing the mind-set and moving away from...a service-led model of delivery" (interview with HASCI lead officer, North Scotland). Others commented about "lost opportunities" in failing to get health colleagues on board with SDS earlier (interview with SDS lead, South Scotland) and another lead officer called for joint health and social care assessments on SDS.

One HASCI lead officer was very negative about the relationship and the possibility for partnership working:

"I think the health people would say they've found it very hard to meaningfully engage with that [SDS] process. There have been overtures for engagement and participation but they've found it hard to be

partners and collaborators in that process...So I don't think you would find very much of harnessing of joint values around outcomes for service users." (Interview with HASCI lead officer, Central Scotland)

Despite the strong rhetoric of partnership working and focus on promoting independent living as a policy outcome (Scottish Government, 2014), concerns were expressed throughout the interviews over a potential power imbalance between health and social care. This was most pronounced for organizations of, and for, disabled people, many of whom expressed concerns that progress made towards promoting a social model of disability (Oliver, 1990) and independent living principles in policy over the past decade would be undermined by HASCI. This was underlined by one of the disability organizations:

"With the health service I just don't think they understand the issues, so I think there's a massive issue about culture that...has implications for training and clearly also about co-production and involvement. They're not used to listening to people, they're not used to giving people money, they're not used to giving away power. All of these things are essential if we're going to make this work properly." (Interview with disability-led organization, Central Scotland)

Others spoke openly about their concerns that involvement of health in support packages would mean a return to a more medical model of support.

## 5.5 | The impact of austerity on self-directed support implementation

The timing of SDS implementation in a period of acute austerity and prolonged cuts in social care has been set out in a previous article in this journal (Pearson & Ridley, 2016). As the discussion highlighted, the agenda to transform the framework for social care in Scotland through SDS has been severely challenged by the unfavorable economic climate in which it emerged. This had seen a long-term reduction in social care budgets exacerbated by austerity cuts, and a dramatic reduction in community services and infrastructure such as libraries, leisure centers, and further education programs. Our interviews showed that this remained a major problem in most areas, and was emphasized strongly particularly by those working in third sector organizations:

"I think you have to acknowledge that the way [local authority] have gone about the promotions of this has been to hide a budget cut...So people are very cynical about SDS as merely being a tool to get rid of services." (Interview with third sector organization)

Concerns over the type of support on offer through SDS were particularly acute for some user groups. This was illustrated in an interview with an organization working on behalf of persons with learning difficulties:

"People were looking for options that would allow their sons or daughters to get the same level of support as they got in the past. And a lot of members are now in day centres or day support that basically is still segregated. It's not allowing people to develop all the promises that SDS could bring." (Interview with organization of disabled people)

Commentators such as Hall (2011) have focused specifically on the impact of personalization for those with a learning disability. In doing this, he and others (see Needham, 2014) express concern over the loss of collective provision in local areas, which many users associate with a sense of belonging, safety, and support.

Likewise for people with mental health problems, the reduction in community resources resulting from SDS and the management of these changes was a major concern. This was explained by one of the support organizations:

"I think that in [local authority] it was rolled out pretty quickly and a lot of our members that we were supporting were in day centres at that time. Alongside the roll-out of SDS, there was a closure of the Adult Training Centre. It was a big panic for our members...because they'd been in day centres all their

lives. And...there wasn't a lot of time to actually sit down with people and their families and really look at other viable options." (Interview with organization representing people with mental health problems)

Others were sympathetic to the financial constraints, but were uncomfortable with the service outcomes for users:

"Although I can be very critical of social work...they've got a very difficult job to do with completely inadequate resources...They [social workers] make no bones about the fact that they cannot be the answer to people's demands for independent living...they have to work on increasingly restrictive guidelines which are more and more simply about the kind of bed and breakfast support rather than a meaningful life." (Interview with organization of disabled people)

In local authorities, most lead officers for SDS also acknowledged the impact of reduced budgets on their work:

"We have found [the financial climate] particularly challenging in terms of implementing this. And that has led to less people being less willing to be more flexible about how we might meet people's needs." (Interview with SDS lead officer, East Scotland)

However, in a very small number of interviews, the link with austerity was refuted:

"I would like to think that the drive for SDS is not about making savings. And I really think that's the message we've got across in [local authority]...Obviously we need to be clear to people that we have limited resources...and we didn't get any new money for SDS...We know people don't like that...but it's one way of managing our resources." (Interview with SDS lead officer, West Scotland)

## 6 | DISCUSSION AND CONCLUDING COMMENTS

There is, to date, little evidence to suggest that in its first two years, the SDS Act has delivered transformative change to Scotland's social care system. The low uptake of option 1 and the lack of any change over the way social care is delivered—with almost identical rates in options 2, 3, and 4 over the two-year period—coupled with the many issues raised by those working with SDS highlighted above, suggest that there are significant issues in both implementation and design. Therefore, the key question that has to be answered is: Is this a problem with the policy and the philosophy of personalization or is it simply a problem with implementation? Whilst acknowledging that the study is focused on the early stages of SDS implementation, our data would suggest it is a mixture of both. The use of telephone interviews in this research proved to be a very effective tool for data collection, enabling us to capture data from across Scotland. As SDS rolls out, a larger scale and more in-depth study exploring these themes in greater detail with more focus on the views and experiences of users is needed, if this question is to be answered fully.

Scotland's problems with personalization are by no means unique. As well as being replicated in England (Slasberg et al., 2012, 2014), personalized social care across Europe (Hauben, Coucheir, Spooen, McAnaney, & Delfosse, 2012) and North America (Power, 2014) has been beset with similar concerns. Austerity, reduced funding, and cutbacks in service provision have limited the impact of personalization (Pearson & Ridley, 2016). There has been a cut in the support offered to disabled people coupled with a worsening in the working conditions of care workers, including a growth in zero-hours contracts, loss of holiday and sick pay and pension entitlement (Pearson et al., 2014). This is the case even in countries with well-established personal budget schemes, such as the Netherlands, Sweden, and Belgium, where access to support has been greatly restricted (Hauben et al., 2012). In others, such as Greece and Portugal, policies to support independent living more widely have been shelved (Pearson & Ridley, 2016). It is also clear that some of the issues with implementation are not to do with austerity. Slasberg et al. (2012; 2014), for example, point to the paucity of evidence linking personalization with transformational change in England. This was underlined by the National Audit Office (2016) in its review of personal budgets in England. It found that the Department of Health's

monitoring of the impact of personal budgets in social care was so poor that no firm conclusions could be made as to the success of policy (Brindle, 2016).

Some of the problems Scotland is facing in implementing SDS may be due to the actual legislation, as opposed to broader structural factors or the way it is being implemented. Option 1 is, in essence, a DP; yet, despite their capacity to radically change lives, DPs were never universally popular with service practitioners in Scotland and uptake has always been relatively low (Pearson, 2004). Its new incarnation as part of SDS has not changed this. Even in England, where in general personalization has been more embedded within social care, uptake of DPs remains low, at about 20% (National Audit Office, 2016). However DPs can be life-changing, and it is right that their advantages and their inherent flexibilities are offered to all, including those who are unable to take on the responsibility they demand. This is one of the main aims behind SDS, and the fact that this is not yet being realized is problematic. Whereas DPs were developed through global grassroots disability activism, SDS draws more strongly on the top-down focus of the personalization agenda (Leadbeater, 2004). The way the SDS Act has been implemented has moved the values away from the goals of independent living promoted by the disability movement and towards a more consumerist model of individualized care planning. Despite the focus on co-production as a core value in the legislation, our research shows that its impact so far has, in fact, been limited. For many users, this has seen the radical edge of DPs, and the autonomy they afforded, diluted by support options that enable little positive change to their day-to-day lives.

The original ideas of the Independent Living Movement and DPs sought to transform disabled people from passive recipients of welfare to active subjects, empowered to participate in the democratic process and in the assessment and interpretation of their own need (Morris, 2003). The aim of the movement, in the United Kingdom at least, was not to dismantle all of the state institutions that provided care and support, but to transform them into agencies that would promote and express justice for disabled people (Barnes & Mercer, 2006). In the guidance published to support the SDS Act (Scottish Government, 2014), the language of empowerment, inclusion, and participation are to the fore. However, it appears that in practice this is not being enacted, and the hoped-for partnerships between those who use the services and those who fund, design, and deliver them is not being achieved.

In the same way that SDS has yet to connect to the majority of those who use the service, neither has it connected to those who design and deliver the service at the local level. The policy has been implemented without bringing social workers and other key professionals fully on board (Ridley, Spandler, Rosengard, & Menhennet, 2012). It may well be that the constant demands for change and the implementation of new systems has meant that workers have not been able to fully engage with SDS. This will become increasingly important in a new era of integrated health and social care services. For co-production to work it has to involve not just those who receive the service, but also those who deliver it; it cannot be a top-down dictate imposed on the system without buy-in from all levels.

Achieving meaningful user engagement still remains a problem in SDS; a trait that is found in other personalized care systems internationally (Slasberg et al., 2012; Thill, 2015). In Australia, for example, Thill has argued that under the recently implemented NDIS, "disabled people may be end up being marginalized within a new system that simply offers 'more of the same' rather than being genuinely included in a transformed approach to the provision of disability supports where voice is valued." (Thill, 2015, p. 25). In contrast to Scotland and other European countries (Pearson & Ridley, 2016), the NDIS is a generous scheme with a long-term commitment to significantly increased government expenditure (Miller & Haywood, 2016). Whilst policy has appropriated the language of the disabled peoples' movement, the needs of disabled people are still not being met on an individual basis.

Needham and Glasby (2015) have recently argued that SDS has the potential to provide support that is both less individualized with more focus on community than the equivalent English policy. Whilst the discourse that surrounds this policy is undoubtedly progressive, it does appear that the practice is not radically different from that found in England. If the real benefits of SDS are to be realized, local authorities, care providers, and the Scottish Government need to act to both bring social care providers more in line with the policy. They need to ensure that the necessary structures are in place for engagement with disabled people, and it is only then that they will be able to take advantage of the SDS Act. Without such changes, it is unlikely that SDS will provide the quality of support disabled people need.

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## CONFLICT OF INTEREST

None declared.

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