

Stroke, Advocacy and Self-directed Support

A guide for health and social care professionals



Contents

Introduction	4
Key messages	5
What is a stroke?	6
Ischaemic stroke	6
Haemorrhagic stroke	6
Transient Ischaemic Attack (TIA)	6
The impact of stroke	7
Rehabilitation	8
Common effects of stroke	9
Physical impairment	9
Visual impairment	11
Communication impairment	13
Cognitive impairment	15
Bladder and bowel control	16
Swallowing	18
Loss of sensation	20
Psychological changes	21
Inattention/Neglect	22
Support for daily living	24
Assessment of needs	24
What is Self-directed Support?	27
Legal background	27
SDS options	28
Assistance	30
Information	30
Carers	31
Older people and SDS	31
The role of the NHS	32
Health and social care integration	33
Further information about SDS	33
The role of independent advocacy	34
Instructed and non-instructed advocacy	35
Who can access advocacy?	35
How can advocacy help with SDS?	36
Useful Contacts	38

Introduction

This publication is the first of its kind to bring together the topics of stroke, Self-directed Support (SDS) and advocacy. It has been produced as a result of Scottish Government funding awarded to the Stroke Association to further awareness, understanding and uptake of SDS by people who have had a stroke.

Advocacy and SDS both have individual choice at their core and this guide aims to ensure that people who have had a stroke are supported to exercise informed choice by the health and social care professionals who work with them. Advocacy aims to help people have control and be as fully involved as possible in the decision making process by supporting them to gather relevant information, consider options and potential outcomes, make informed choices and ensure that those views are listened to and fully considered. The process of SDS ensures that people who access social care services are given choice in the way that they receive support.

We are not expecting people to necessarily read this guide from cover to cover. It is designed to be used as a reference tool to support professionals who work with people who have had strokes and their families to make sure that the person is appropriately supported to access SDS. Your role may simply be to highlight to a stroke survivor or family member that they have a right to a community care assessment and that SDS can be used to address their eligible needs. Or you might be involved in supporting a person to prepare for the assessment or involved in carrying out the assessment itself. Either way, this guide aims to provide you with the information you need to understand the issues and help ensure the person you are working with gets the support they need.

We would like to thank the Scottish Government SDS team, Self Directed Support Scotland and our colleagues in the health, social care and advocacy organisations who supported to the development of this guide.



Key messages

- One in six of us will have a stroke in our lifetime.
- Around 13,000 people have a stroke each year in Scotland. Over 3,000 of them are of working age or younger.
- There are over 120,000 stroke survivors in Scotland.
- Stroke is the largest cause of complex disability in Scotland - half of stroke survivors have a sensory, physical and/or cognitive impairment after their stroke and a third require support to live independently.
- Local authorities have a duty under the Social Work (Scotland) Act 1968 to assess a person's community care needs.
- The Social Care (Self-directed Support) (Scotland) Act 2013 requires local authorities to offer people who have been assessed as having community care needs four options for how their assessed needs will be met.
- Independent advocacy can help people find out about SDS, prepare for assessments, explore the four SDS options and weigh up the pros and cons of the different options.

What is a stroke?

Every year around **13,000** people have a stroke in Scotland. That's around one every **40 minutes** or **35 strokes** per day. Most people affected are over 65, but anyone can have a stroke, including children and babies.

A stroke is a brain attack; it happens when the blood supply to part of the brain is cut off. Stroke should be treated as a serious medical emergency, just like a heart attack, especially as early treatment of stroke can greatly increase a person's chances of recovery.

For many people stroke happens suddenly and without warning, and often there is little time to prepare for one. Every stroke is different and the impact on the person can vary from minimal to substantial. In some cases a stroke may leave little or no lasting effects. In other cases a stroke can drastically change a person's life, affecting how the person moves, feels and thinks.

There are three categories of stroke: ischaemic stroke, haemorrhagic stroke and Transient Ischaemic Attack (TIA).

Ischaemic stroke

Ischaemic stroke is the most common type of stroke, accounting for about 85% of cases. It happens when the blood supply to part of the brain is cut off by a blockage. This may be caused when:

- a blood clot forms in a main artery to the brain (sometimes called a cerebral thrombosis)
- a blockage, usually a blood clot from the heart, is carried in the bloodstream to one of the arteries supplying the brain (called a cerebral embolism)
- a blockage forms in the tiny blood vessels deep within the brain (called a lacunar stroke)
- blood vessels become narrow or weakened (called a small-vessel occlusion).

Haemorrhagic stroke

Haemorrhagic stroke accounts for about 15% of cases. It happens when the blood supply to part of the brain is cut off by bleeding in or around the brain. This may be caused when:

- a blood vessel bursts within the brain (an intracerebral haemorrhage)
- a blood vessel on the surface of the brain bursts, causing bleeding into the area between the brain and the skull (called a subarachnoid haemorrhage).

Transient Ischaemic Attack (TIA)

A TIA or transient ischaemic attack (also known as a mini-stroke) is the same as a stroke, except that the symptoms last for a short amount of time and no longer than 24 hours. Every year 46,000 people in the UK have a TIA for the first time.

Although the symptoms may not last long, a TIA is still very serious. It is a sign that there is a problem and that the person is at risk of going on to have a stroke that could cause considerable harm. Because of this it is often called a warning stroke. The greatest risk of having a stroke is within the first few days after a TIA. More than 1 in 12 people will have a stroke within a week of having a TIA. Just like a stroke, a TIA is a medical emergency.

For more information please refer to our *What is a stroke?*, *Ischaemic stroke*, *Haemorrhagic stroke* and *Transient Ischaemic Attack* factsheets at www.stroke.org.uk/about-stroke

The impact of stroke

Every stroke is different and people who have had a stroke are affected in different ways. For some people, the symptoms are quite mild and last a short time. Other strokes may cause more severe and lasting damage.

When a stroke happens, some brain cells are damaged and others die. Dead brain cells cannot start working again, but some damaged cells may recover as the swelling caused by the stroke goes down. It is also possible for some parts of the brain to learn to take over from the damaged areas. This is known as 'neuroplasticity'.

The greatest phase of recovery is within the first days and weeks post-stroke. It is currently not certain whether this is due to therapy input or spontaneous recovery. It is likely to be a combination of the two. Some people can continue to recover for several years.

The effects of a stroke depend on the following issues.

- Which part of the brain has been injured – in general, the right half of the brain controls the left side of the body and vice versa. Specific areas of the brain control a person's ability to move, speak and write. Other areas control memory, emotions and vision.
- How bad the injury is – in general, the greater the area of brain affected, the more severe the impact will be.
- The person's general health when the stroke happened – in general, people in good health prior to their stroke are likely to have a better recovery.

The following section concentrates on the impact of stroke on the individual. However, it is important to recognise that stroke also impacts on the stroke survivor's family. They may feel a deep sense of loss as the person they know and love may not be the same. These changes may affect their feelings towards the person and they may have to keep reminding themselves that any changes in the person are the result of the stroke and that they have no control over them.

In some cases family members may take on the role of carer for the stroke survivor. A carer is someone who provides unpaid support to family or friends who could not manage without this support. Carers can also access SDS (see 'Carers').



Rehabilitation

Rehabilitation helps people who have had a stroke relearn skills that are lost as a result of their stroke or learn new ways of doing things. This can include coordinating leg movements in order to walk, relearning how to speak, and learning alternative ways of carrying out tasks of daily living like washing and cooking perhaps with the use of just one hand.

Rehabilitation should begin in the acute care setting within 24 to 48 hours after the stroke. This is important because the earlier rehabilitation begins the more likely the person is to regain lost abilities and skills.

Rehabilitation is often an ongoing process and could involve the person working with specialists or practising the exercises they have learnt on their own for months or years after the stroke.

Some stroke survivors may wish to continue with professional therapy input after NHS rehabilitation is no longer available to them. Independent advocacy organisations may be able to support people in this situation to access information about the options for private rehabilitation and work with them to establish whether SDS could be used to access the service.



Common effects of stroke

Stroke affects people in different ways. The impact can be physical, sensory, psychological and/or cognitive and people may experience these effects in different combinations and to varying extent.

Physical impairment

Weakness of an arm, leg or both is probably the most common and widely recognised effect of a stroke. Weakness can vary in its severity. People may lose power in one limb, or have weakness of both arm and leg on one side ('hemiparesis'); or have paralysis of the arm and leg on one side ('hemiplegia').

Limb weakness can be a result of the nerve cells in the brain that send electrical messages to the muscles being damaged by the stroke or as a result of loss of muscle tone post-stroke.

In the case of nerve cell damage, if the messages can't be sent from the brain to the muscles then the muscles can't move.

In the case of loss of muscle tone post-stroke, without tone muscles become floppy and unable to work. This may result in the person not being able to hold their arm up without support or not being able to move their leg independently. If muscles recover, it is expected that the tone will return to normal. However, some weak and damaged muscles may develop high tone. The muscle feels stiff and tight, and can become painful (called 'spasticity').

Stroke often causes some degree of facial weakness, and damage can include everything from mild weakness to paralysis. Facial weakness in stroke is a result of damage to nerves that control the muscles that make the face move symmetrically. Stroke-related facial paralysis usually affects only one side of the face and most commonly it is the lower part of the face that is affected.

If a person has facial weakness it is likely that their face will droop on one side which may result in the person finding it difficult to smile voluntarily. If the person's mouth is weak this may result in drooling. These effects can be distressing for the person and may lead to feelings of depression.

For more information please refer to our *Physical effects of stroke*, *Communication problems after stroke*, *Visual problems after stroke* and *Swallowing problems after stroke* factsheets at www.stroke.org.uk/about-stroke.



Impact on daily living

Upper limb weakness can affect a person's ability to undertake a wide variety of daily living tasks such as cooking, cleaning, washing, getting dressed and eating. It can impact on writing, enjoying hobbies such as gardening and sewing, and also driving and caring for others. The impact is potentially significant. Some stroke survivors are able to adapt well and put in place coping mechanisms for these challenges and will not require support. Others may find they need support or aids and adaptations in order to manage.

Lower limb weakness can affect a person's ability to walk, to dress, to go shopping, to drive, to cook and to undertake housekeeping tasks. As with upper arm weakness, the impact is potentially significant and some stroke survivors may find that they need support in order to manage these tasks or that they need to use a mobility aid such as a walking frame, a walking stick or a wheelchair.

Facial weakness can impact on a person's ability to eat and drink and can have a detrimental effect on confidence and the person's willingness to socialise. This can lead to isolation and depression.

Having any form of physical impairment also means that energy is being used in different ways. For example, walking and completing other daily activities may well take up much more energy than they did before the stroke, making the person more likely to feel tired.

Physiotherapy and occupational therapy can help people with a physical impairment post-stroke regain movement or learn new ways of using and moving their weak limbs.

Occupational therapy involves relearning everyday activities to enable the person to lead a full and independent life. It helps people to regain the skills they need to do what they want. It may be that the person needs to regain the ability to do day-to-day tasks such as getting out of bed, washing or making a hot drink. Perhaps they would like to continue with a hobby that they had before their stroke such as painting or playing a musical instrument. If the person worked before their stroke, occupational therapy can help them return to employment.

Physiotherapy uses techniques such as exercise, manipulation, massage, skills training and electrical treatment to help the stroke survivor heal and recover their movement. The main focus of physiotherapy after stroke is to help the person learn to use both sides of their body again and regain as much strength and movement as possible.

In the early stages, and for people with relatively mild problems, physiotherapy will focus on preventing complications and restoring the person's ability to move and be active again. As time goes on, and for people with more complex impairments, a full recovery is less likely and so physiotherapy focuses on helping the person to become more independent and to do what is important to them, for example using equipment or doing things a different way.

For more information please refer to our *Physical effects of stroke*, *Physiotherapy after stroke* and *Occupational therapy after stroke* factsheets at www.stroke.org.uk/about-stroke.

Visual impairment

A stroke can cause many different types of visual problems. In the case of retinal strokes, visual problems are due to a stroke affecting the eye only. However, visual problems post-stroke usually happen because of damage to the brain and not the eye. How the person is affected depends on exactly where the stroke occurred in their brain.

There are four main types of visual problem and the person may experience one or more.

1. Visual processing problems

When we look at something, our eyes receive visual information which must then be processed by our brain to find out what it means. This enables us to recognise colours, someone we know, or familiar objects. Visual processing can be affected by stroke.

Stroke survivors may also experience a change in their awareness and perception of the world around them. This is called 'visual neglect' and is the most common visual- processing problem. It is more common in people who have had a stroke which affects the left side of the body. Visual neglect is a disorder which can reduce the person's ability to look, listen or make movements towards one half of their environment. They may be unaware of objects and people on their affected side and may ignore people or bump into things without realising they are there.

2. Central vision loss

Central vision loss is the partial or complete loss of vision in the area a person is directly looking at.

3. Visual field loss

The visual field is everything a person can see - from straight ahead to outwards to the side (periphery). Visual field loss after a stroke usually affects both eyes. It means that the person is

unable to see properly either to the left or to the right of the centre of their field of vision. The area of visual field affected is directly related to where the stroke occurred in the person's brain.

There are many types of visual field loss, but the most common is homonymous hemianopia. This is a condition where the person can see only the right half or the left half of the world out of each eye. It affects two thirds of people with visual field loss following stroke. This happens when a stroke occurs towards the back of the brain.

Other types of visual field loss include loss of a quarter of the visual field, loss of the entire upper or lower field of vision, and patches (scotomas) missing in the person's field of vision.

4. Eye movement problems

A stroke can lead to a variety of problems with the fine nerve control that is needed to move the eyes. People who have had a stroke may have impaired eye movements, affecting their ability to move from looking at one object to another or to follow a moving object, like someone walking past.

Stroke survivors may also experience an inability to move both eyes up, down, sideways or inwards. This may result in blurred vision or double vision (diplopia). Or the person's eyes may move constantly, resulting in the person seeing objects constantly wobbling. This is called nystagmus and can be very distressing and disorientating.

Lastly, the person may experience impaired depth perception and difficulty locating objects. This can affect activities of daily living such as making a cup of tea, as the person may misjudge the position of the cup and pour water over its edge rather than into it.

Impact on daily living

Visual problems post-stroke can affect a person's ability to read, cook and undertake personal grooming, to handle money, to move about safely, to interact with others and to write. It can also affect a person's ability to drive and to use public transport independently.

Professionals within the eye care team can help people with visual problems post-stroke manage the impairment and lessen its impact.

- An orthoptist: an eye care specialist who can assess and manage a range of eye problems particularly problems with eye movements and visual field loss.

- An ophthalmologist: a medical doctor who specialises in diagnosing and treating diseases of the eye.
- An optometrist (optician): an eye care specialist who tests sight, prescribes and dispenses glasses or contact lenses and can screen the person for eye disease.

These specialists assess stroke survivors and arrange for the treatment and management of conditions such as poor vision, double vision or visual field loss. The person may also be given an assessment and advice on using magnifiers or other visual aids.

For more information please refer to our *Visual problems after stroke* factsheet at www.stroke.org.uk/about-stroke.



Communication impairment

It is common for people to experience communication problems after a stroke. The most common problems are aphasia, dysarthria and dyspraxia.

Aphasia

Aphasia (sometimes called 'dysphasia') is the most common language problem caused by stroke. Aphasia can affect how a person speaks, their ability to understand what is being said, and their reading or writing skills. The two broad forms of aphasia are 'receptive aphasia' and 'expressive aphasia'.

1. Receptive aphasia: If a person's problems are mainly with understanding what is being said, this is called receptive aphasia. A person with receptive aphasia may experience some or all of the following issues.

- Not understanding much of what other people say and feeling as though others are talking in an unknown foreign language.
- Not understanding when people speak in long, complex sentences and forgetting the start of what was said.
- Not understanding others if there is background noise or if different people are talking in a group.
- Being able to read newspaper headlines, but not understanding the rest of the text.
- Being able to write but unable to read back what they have written.

2. Expressive aphasia: If a person mostly understands others, but has difficulty expressing what they want to say, this is called expressive aphasia. A person with expressive aphasia may experience some or all of the following issues.

- Not being able to speak at all. They may communicate by making sounds but not be able to form words.
- Having difficulty speaking in normal sentences. They may say only single words or very short sentences, missing out crucial words. They may write in a similar way.
- Speaking with frequent pauses and being unable to find the word they want to say despite it being 'on the tip of their tongue'.
- Answering 'yes' or 'no' but meaning the opposite.
- Thinking of the word they want to say, but saying another – for example, 'milk' instead of 'water'.
- Describing or referring to objects and places, but being unable to name them. They miss out the words they can't think of.
- Saying only a few set words in answer to any question. They may be emotional words, such as swear words.
- Getting stuck on a single word or sound and repeating it.

Dysarthria

Dysarthria happens when a stroke causes weakness of the muscles used to move the tongue, lips or mouth, and to control breathing when you speak or produce a voice. People who have dysarthria may have difficulty speaking clearly and some people find their voice sounds slurred, strained, quiet or slow. If their breath control is affected, they may need to speak in short bursts rather than in complete sentences.

Dyspraxia

Dyspraxia is a condition that affects movement and co-ordination. Dyspraxia of speech happens when the person cannot move muscles in the correct order and sequence to make the sounds needed for clear speech. The individual muscles used to produce clear speech may be working well and the person may have no weakness or paralysis, but if they cannot move them as and when they want to in the right order and in a consistent way, this may lead to slurred or unclear speech.

Impact on daily living

Communication is vital to so many areas of our lives that experiencing barriers to communication, whether through receptive or expressive aphasia, can be hugely frustrating. It can impact on everything from ordering a pizza, reading a newspaper and listening to the radio, to discussing health concerns with a doctor, taking part in support groups and being involved in family decisions. This can lead to the person restricting the activities they take part in that require communication and other people leaving them out of communication-based activities, both of which can lead to social isolation.

Speech and language therapy can help people with communication impairments and they may be able to improve their speech and ability to understand over time. Anyone who has communication difficulties after their stroke should receive a full assessment of their difficulties from a speech and language therapist (SLT) with specialist knowledge in stroke and rehabilitation.

The therapist will assess the person's strengths in language and communication skills and use a variety of tests to establish the nature of their problems. The SLT will establish the stroke survivor's personal needs and priorities for communication and their goals for therapy.

The therapy someone has will depend on the nature of their communication difficulties and their general health following the stroke. It is likely to involve a variety of practical exercises to help rebuild their communication skills. If they have dysarthria, it is likely to involve physical exercises to help strengthen their muscles.

The SLT may introduce communication aids such as simple charts to point at or more specialised equipment, including electronic aids and software programmes. The therapist can also assess whether home-based computer-supported therapy would help recovery.

For more information please refer to our *Communication problems after stroke* factsheet at www.stroke.org.uk/about-stroke.

Cognitive impairment

Many people experience cognitive problems after their stroke. These problems can affect memory, attention, perception, planning, decision making and social cognition. Some cognitive problems will improve over time but not everyone will return to the same level of function they had prior to the stroke. Some stroke survivors are able to develop coping mechanisms which help to overcome their cognitive impairment.

Stroke can cause vascular dementia. As dementia develops, a person's condition will deteriorate and worsen. Vascular dementia tends to worsen in stages, with changes in a person's condition being 'stepped' rather than gradual. This means that often people with vascular dementia deteriorate suddenly with each new stroke and then make some improvement in between.

Impact on daily living

Cognitive impairment can have a substantial impact on a person's life as it may affect their ability to return to work, make important decisions, drive, socialise with family and friends, and plan activities. They may be frustrated that they are no longer able to perform cognitively in the way they could before their stroke and their family and friends may be frustrated by the cognitive change.

If a stroke survivor develops vascular dementia the person might experience memory problems, weakness or paralysis on one side of the body, incontinence, balance problems and unsteadiness, communication problems and difficulty following conversation, and mood changes such as depression. Therefore the impact on daily living can be wide ranging and varied.

For more information please refer to our *Dementia after stroke* factsheet at www.stroke.org.uk/about-stroke.



Bladder and bowel control

It is common for people to have problems controlling their bladder and/or bowels after a stroke. Though initially very distressing, these problems are often resolved with time.

About half of people admitted to hospital with a stroke will have lost control of their bladder, and a third will experience loss of bowel control. This is called incontinence. It is quite normal for incontinence to be a source of concern after a stroke. For many people loss of toilet control is a very sensitive and personal issue and some people may feel that they have lost their dignity.

There are different reasons why a person might develop continence problems after a stroke. For example, as with any serious illness or accident, if the person is not fully conscious or aware of their surroundings, they may wet or soil themselves without realising it. Or the stroke may have damaged the part of the brain that controls the bladder and/or the bowel. As with other after-effects, it may take time to recover. Also, if the stroke survivors have difficulty walking or moving around or need help getting to the toilet, they may not always be able to get there in time. The same may be true if they have communication difficulties and their need to go to the toilet is not understood in time.

Being less mobile than usual can also make a person more prone to constipation (difficulty emptying your bowels), which in turn may cause continence problems. The person may not be able to eat or drink as much as usual because of the stroke and may be undernourished or dehydrated. This may also lead to constipation.

Some medicines, including ones commonly prescribed after a stroke, may affect bladder or bowel control. However, there is a lot that can be done to help, and just 15% of stroke survivors will continue to have continence problems a year after their stroke. It is generally easier to regain bowel control than bladder control. Regaining control can improve both a person's morale and overall recovery.



Impact on daily living

Continence issues can impact on a person's willingness to leave the safety of their own home and can lead to complications with outings as the person may need to include access to toilets in all plans, even if they just want to go to their local shops. The person may be able to manage the challenges of incontinence themselves or may require support from a carer or personal assistant for toileting. Adjusting to the latter can be difficult for people who have not required personal care in the past.

Dietitians and physiotherapists can help people with bladder problems post-stroke. A dietitian assesses dietary requirements and can help people who have difficulties with their dietary needs or who have any problems with eating and drinking. A dietitian helps people who have problems eating enough food because of swallowing difficulties or poor appetite. They check a person's nutritional needs and order special fluids and/ or meals if required.

Dieticians can also provide advice on eating a healthy diet, especially when people have weight problems or have diabetes. A healthy diet is important for reducing the risk of strokes in the future.

A dietitian may also be able to advise alternative feeding methods such as by a naso-gastric tube (NG) or gastrostomy tube (PEG).

For more information please refer to our *Continence problems after stroke* factsheet at www.stroke.org.uk/about-stroke.

Swallowing

About 45% of people have difficulty with swallowing after a stroke, though many people recover quickly. Swallowing is a complex activity that involves the co-ordination of many nerves and muscles. Swallowing problems, sometimes called 'dysphagia', occur after stroke when the parts of the brain that control swallowing are affected. Muscle weakness, problems with attention and concentration, balance difficulties and poor co-ordination can also affect a person's ability to swallow food and drink safely.

Most people regain the ability to swallow safely within several weeks. How long it takes depends on the severity of the stroke and the parts of the brain which have been affected. Recovery is different for everyone.

There are several reasons why swallowing problems need to be managed properly, including the following.

- **Aspiration:** this is the medical term used to describe something 'going down the wrong way'. The entrances to the airway and the oesophagus (the tube to the stomach) are very close together. Aspiration occurs when food, fluid and/or saliva enters the airway and lungs. Usually if this happens the person will cough. However, the effects of the stroke may mean the person is not aware something has gone down the 'wrong-way' and the coughing reflex may not happen.
- **Aspiration pneumonia:** this is a chest infection that occurs when food or fluid gets into the lungs causing irritation and inflammation. Symptoms of aspiration pneumonia include a cough, high temperature, chest pain and difficulty breathing. The condition will usually be treated with antibiotics.
- **Malnutrition:** if a stroke survivor is not able to swallow properly they may not be able to eat a balanced diet, which could lead to malnutrition.
- **Dehydration:** people who have difficulty swallowing may not drink enough fluids, which can lead to dehydration.



Impact on daily living

Eating and drinking are a large part of daily life. As well as ensuring the body gets the necessary fluids and nutrients to maintain good health, they are also pleasurable and social activities. However, swallowing problems can lead to:

- coughing or choking before, during or after swallowing
- difficulty controlling food or fluid in the mouth when swallowing which can result in food being pushed up the back of the throat into the nose
- bringing food back up, sometimes through the nose
- drooling.

This can impact upon a person's enjoyment of food and drink and their willingness to share mealtimes with others.

If the swallowing issues are likely to be longer term, the person may be fitted with a percutaneous endoscopic gastrostomy (PEG) tube. This is a tube that is inserted directly through the wall of the abdomen into the stomach. People who have a PEG tube fitted no longer eat through their mouth and this can have a real impact on the person psychologically. People with long-term swallowing difficulties therefore may feel they have lost the enjoyable experience of eating, both alone and in company. This can also have an impact on the person's family.

Physiotherapists and speech and language therapists can help people with swallowing issues post-stroke.

For more information please refer to our *Swallowing problems after stroke* factsheet at www.stroke.org.uk/about-stroke.



Loss of sensation

There are various ways that stroke can affect a person's senses. The person may be less sensitive, for example to touch, so may not feel something they bump into or may experience feelings of numbness. This is called hypoesthesia.

Loss of sensation in one side can also affect balance. If the person cannot feel where their leg and foot are, especially when their foot is safely on the ground, it is very difficult to know how to move.

People automatically use their vision to compensate for the lack of feeling, which takes a lot of concentration and is tiring. It also means that they may be less aware of their surroundings. All of this increases the risk of slips, trips and falls.

In contrast, people may experience increased sensitivity post-stroke. This can affect a range of senses such as taste, hearing, touch and muscular sensitivity to pain. This is called hyperesthesia.

Some stroke survivors may also experience abnormal and unpleasant sensations such as the feeling of burning, cutting, tingling, stinging or numbness. This is called dysesthesia or paresthesia.

Stroke survivors may also experience pain after stroke, such as muscle tightness (spasticity) or shoulder pain. They might also feel pain and changes in sensation if the 'pain centre' in their brain has been damaged.

Some people also experience central post-stroke pain. People who have central post-stroke pain report different types of pain. Many people describe it as an icy burning sensation, or a throbbing or shooting pain. Some people also experience pins and needles or numbness in the areas affected by the pain.

For most stroke survivors with central post-stroke pain, the pain occurs in the side of their body that has been affected by the stroke. The pain may begin immediately after the stroke but more often it begins several months later. Some people find this pain becomes worse because of other factors such as movement or a change in temperature.

Impact on daily living

Sensory loss can affect a person's confidence in moving around, especially when out and about. The risk of slips, trips and falls may be such that the person is not confident in being out and about on their own, or such that the concentration involved in moving about safely fatigues the person to the extent that they have to limit their activities.

Physiotherapists and occupational therapists can help people with sensory loss post-stroke.

For more information please refer to our *Balance problems after stroke* and *Pain after stroke* factsheets at www.stroke.org.uk/about-stroke.

Psychological changes

If the part of the brain that normally controls emotions is damaged by a stroke, the result can be a change in how the person thinks, feels or behaves.

Depression is the most common psychological change that people experience after stroke. It is an illness characterised by intense feelings of persistent sadness, helplessness and hopelessness. It is often accompanied by physical effects such as a loss of energy or physical aches and pains.

Stroke can cause depression in a number of ways. A stroke causes physical damage to the brain. When brain cells are damaged, the parts of the body and mental functions controlled by these cells may not work properly. This physical damage can cause a number of psychological effects, including depression.

Depression can happen at any time following a stroke. It can develop soon afterwards or sometimes it can happen several months later. It can range from mild to severe and can last from a few weeks to over a year.

People who have had a stroke may also experience emotionalism. This describes being more emotional than usual and and/or having difficulty controlling one's emotions. Emotionalism is usually worse soon after the stroke happens, and often lessens or goes away as the person recovers.

People with emotionalism may experience very intense emotional reactions when talking to people, watching television, carrying out tasks, or even thinking. Although these emotions may reflect how the person is feeling, they may be expressed in a particularly strong way. It might be that the person's emotions are very close to the surface, with the smallest thing upsetting them. For example, they might get upset more easily, or cry at things they would never have cried at before.

Similarly, they may laugh at inappropriate times (although this is less common). They may even swing from crying to laughing quite suddenly. These reactions usually do not mirror the person's actual emotions. They often seem out of place and can come and go very quickly, unlike when the person feels genuinely upset or happy.



Impact on daily living

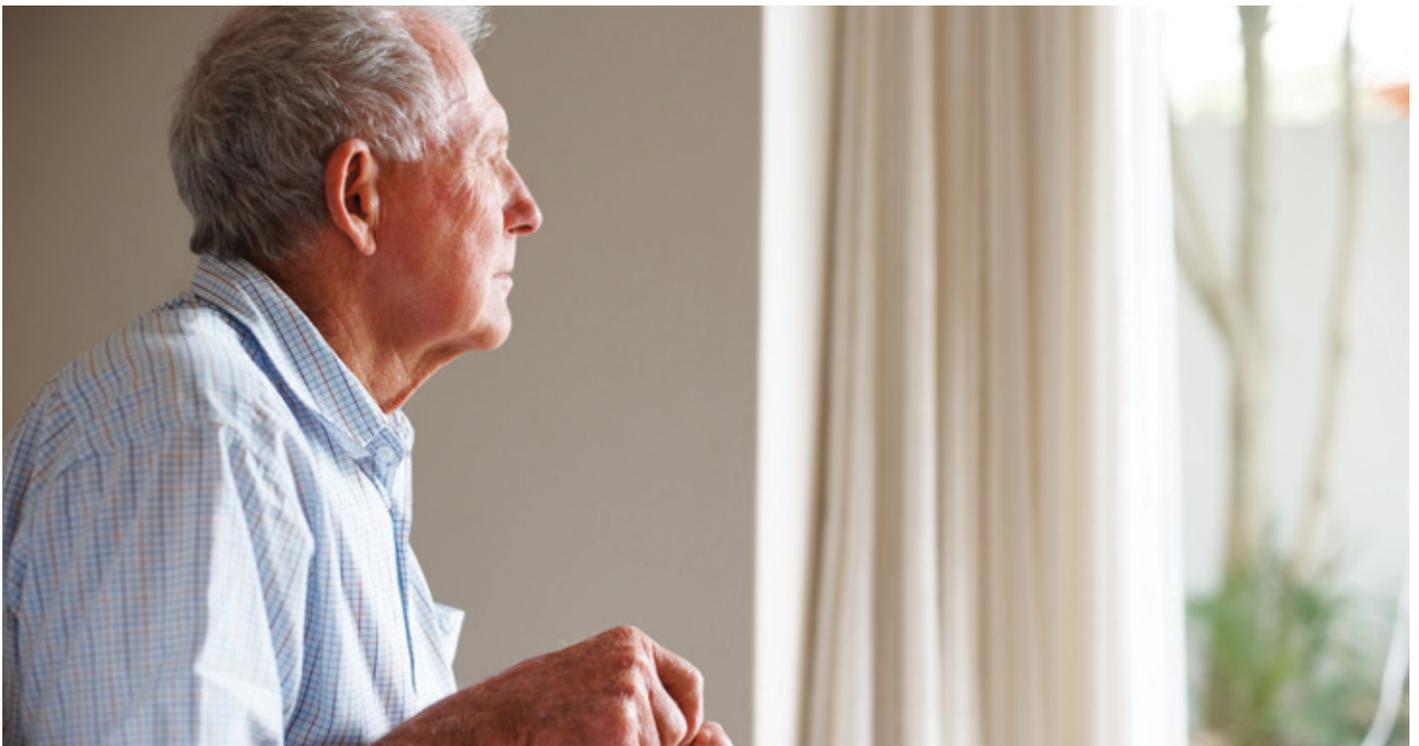
Depression is characterised by intense feelings of persistent sadness, helplessness and hopelessness. It is often accompanied by physical effects such as a loss of energy or physical aches and pains. Depression can affect the person's ability to take part in any and all activities of daily living as well as socialising, working and being proactive in their rehabilitation. Depression may be accompanied by anxiety which can also lead to social isolation.

Emotionalism can be very distressing for the person who has had a stroke, especially if they were not an emotional person before their stroke. Crying, swearing or laughing at inappropriate times can be embarrassing and frustrating for the stroke survivor and difficult for their family and friends to understand.

The person may seem very different to those around them if their inhibitions have lifted and behaviour is out of character. This can impact on all interactions and can result in the stroke survivor withdrawing from social events and potentially becoming isolated and depressed.

Clinical psychologists can help people who experience depression and/or emotionalism post-stroke. Clinical psychologists are specially trained in assessment, formulation and treatment of psychological difficulties, including specialist neuropsychological assessment and management of cognitive impairment.

For more information please refer to our *Depression after stroke* and *Emotional changes after stroke* factsheets at www.stroke.org.uk/about-stroke.



Inattention/Neglect

Following a stroke a person may be unaware of the side of the body affected by the stroke and the space around them on the affected side. They may not notice things on their affected side. This is different from visual field loss – the person's visual fields may be unaffected by the stroke but the way information is processed by the brain is affected.

If the person's brain has difficulty processing information from their body then it might feel as if the affected side is not part of their body. Some people dislike their affected side, think that it belongs to someone else or give it a nickname.

As well as awareness of the body, neglect can affect how the person responds to the world around them. They might not notice things on one side, usually the left side. For example, if you approach the person on their affected side they might not realise you are there.

Inattention or neglect is difficult to compensate for or adapt to as the person who has had a stroke may be totally unaware of the problem. They do not recognise that they have to compensate for it as they are unaware that they are failing to attend to this half of their world.

The stroke information in this publication is based on the Stroke Association's factsheets and was correct at the time of publication. Our stroke factsheets are regularly reviewed and the most up to date versions can be found on our website at www.stroke.org.uk/about-stroke.

Impact on daily living

People who experience neglect may find that they bump into objects more than before because they are not aware of things on one side. This can put them at risk of accidents. They might also encounter problems with personal care and eating - the person might put makeup on only one half of their face, wash only one side of their body and eat meals from only one half of the plate.

Physiotherapists, occupational therapists and members of the eye care team can help people with inattention/neglect post-stroke.

For more information please refer to our *Visual problems after stroke* factsheet at www.stroke.org.uk/about-stroke.



Support for daily living

People who have had a stroke may find that they can no longer manage activities of daily living the way they used to.

Local authorities have a duty under the Social Work (Scotland) Act 1968 to assess a person's community care needs and decide in light of that assessment what sort of support a person needs.

The support might be support at home to help a stroke survivor with daily tasks such as:

- washing
- eating
- housework.

Or it might be support to help the person do things outside the house such as:

- shopping
- going to college
- visiting friends and family.

Assessment of needs

A community care assessment is a review of the individual's personal circumstances, needs and ability to manage day-to-day living. The individual can request this assessment, as can other people (as long as the stroke survivor agrees to it) such as friends and family members or professionals who are working with the person who has had a stroke.

The person who has had a stroke may be able to access independent advocacy support to help them through the process (see 'The role of independent advocacy').



Professionals working with stroke survivors should encourage the person to consider the following.

At home

- What can they do themselves?
- What would they like some support with?
- What do they think would help?

Their aims

- What would they like to do?
- What are their goals?
- What would they like to do in the future?

Managing their money

- Do they need support with budgeting and banking?
- Do they need a benefits check?
- Do they have financial worries?

Help from friends and family

- Has the person received offers of help from friends and family?
- Do they want this?
- Are there things they would prefer a paid carer to do?

Relationships

- Would they benefit from support with existing relationships?
- Do they have the opportunity to make new connections?
- Are they keeping in touch with people?

Being active

- Are they getting out and about?
- Can they move around ok outside?
- Would support help?

Emotional life

- How are they feeling?
- Are they depressed or sad?
- Are they laughing or crying a lot?

Thinking and concentrating

- Are they remembering things ok?
- What are their coping strategies?
- What support might help?

Communication

- What are the effects on their life?
- What might help?
- Do the people around them need support?

Work

- Would they like to return to work?
- Would they like a new job?
- Are they interested in volunteering?

In most circumstances this assessment will be a single shared assessment. This is a process that allows one health or social care professional to co-ordinate an assessment of a stroke survivor's needs and to produce a care plan. The single shared assessment can be carried out by a range of different professionals working in the local authority or the NHS, such as a social worker, district nurse or occupational therapist. Whoever is undertaking the assessment will consult with other health and social care professionals to gather information and, as long as the individual agrees, will share the outcome of the assessment with the other professionals. It may be that a joint approach is then taken between the local authority and health board to meet the person's assessed needs (see 'The role of the NHS').

The assessment involves the individual and the professional discussing the person's circumstances, needs and ability to manage day-to-day living. The individual and the professional should work together and think creatively about ways in which the person's desired outcomes can be met. The person who has had a stroke should be at the centre of the process and involved in all decisions. The general principles of assessment are collaboration, involvement and informed choice.

Throughout this process the professional should bear in mind how the stroke survivor's needs might change over time. They should be aware of potential hidden needs that the person might have. The list of considerations above will be helpful in this regard.

The person should be given a copy of the assessment once it has been completed.

The next stage is the development of a support plan which sets out the specific goals or outcomes the person wants to achieve, how the local authority (potentially in conjunction with the health board) could meet the person's needs and how much it would cost. If this plan is accepted by all parties then this calculation becomes the person's individual budget.

This process, introduced by the Social Work (Scotland) Act 1968 is unaffected by the Social Care (Self-directed Support) (Scotland) Act 2013. The new Act affects the mechanism through which the support is received, but does not affect the process of assessment of needs.



What is Self-directed Support?

Self-directed Support (SDS) is an approach to social care that offers people more control and choice over the support they receive. SDS describes the ways in which individuals and families can have informed choice about how their assessed health and social care needs are met. It does not affect the process of assessment of community care needs (see 'Support for daily living').

SDS is there to help the person maintain their independence by putting them at the centre of decisions about what they do and how they do it. It is about supporting the person and their hopes for the future.

Legal background

The Social Care (Self-directed Support) (Scotland) Act 2013 came into force in April 2014. It puts people with community care needs in charge of how these needs are met.

It builds on the Community Care (Direct Payments) Act 1996 which placed a duty on local authorities to make direct payments available to people assessed as having community care needs.

The new Act goes beyond this by requiring local authorities to offer four options to individuals assessed as requiring care and support. It also requires authorities to provide information and assistance to individuals so they can make an informed choice about the options available.



SDS options

The Act gives people a range of options for how their social care is delivered, thereby empowering people to decide how much ongoing control and responsibility they want over their own support arrangements.

The Act requires local authorities to offer people the following four choices for how they can receive their assessed care and support.

1. Direct payment

The local authority makes a cash payment to the person instead of arranging the services it has assessed the person as needing. The payment is then used to secure the relevant services. As long as the local authority is satisfied that the person's assessed needs will be met through the arrangements made using the direct payments, then the local authority is relieved of its responsibility to arrange the services for that person.

Case Study

Philip is 22 years old and had a stroke during his gap year when he was travelling abroad. He's moving out of his parents' home and into his own flat. He wants to be as independent as he can be, go to college and go out with his friends. Philip decides that employing his own personal assistant is the best option for him as it would give him the greatest level of control and enable him to best maintain his independence.

2. Individual service fund

The person asks the local authority or an organisation of their choice (such as a centre for independent living) to manage their support arrangements. The individual budget is held by the council or paid to the organisation the person chooses, who then arranges the support that the person selects. This means the disabled person is in charge of how the budget is spent but they do not have to handle the money. For example, they could have their budget allocated to a local voluntary organisation so that they can provide support that is more appropriate to the person's needs than what the local authority would normally provide.

Case Study

Mizbah had her stroke ten years ago and has been living at home since, with support at home provided by her local authority. Mizbah felt she needed more support and asked her local advocacy organisation what she should do. Together they requested a review of her community care needs.

The social worker who reassessed her agreed that Mizbah now needs more support. Following discussions with the local authority and the advocacy organisation about her options, Mizbah decided to ask her local centre for independent living to arrange the support she needs because she felt they understood her cultural and religious requirements.

3. The local authority arranges the support

The person's budget is managed by the council and it selects and arranges a service for the person. The council should have talked to the person about their wishes and preferences. This is the traditional way community care services have been delivered and may still be preferable for some people.

Case Study

Mary is 45 years old and has just left hospital following a stroke. She lives on her own and is assessed as needing two hours of support per day for personal care and meal time assistance. Mary decides to let the council arrange this for her because she is coming to terms with the way her life has changed following her stroke and doesn't want the added complication of employing a personal assistant. Mary is assured by her social worker that she can always change her mind in the future.

4. A mix of the options above

Alternatively the person can choose a mix of all these options for different types of support.

Case Study

Nigel has type two diabetes, is chronically obese and uses a wheelchair as a result of a stroke three years ago. Nigel is assessed as requiring support in preparing meals and ten hours per week of personal care. Nigel decides to purchase a meals on wheels service from a local charity with a specialism in meals for people with diabetes and asks his local authority to arrange personal care to meet his assessed needs.

Whichever option is chosen the person must make sure that the support they want to buy meets their assessed needs. Needs may be met in creative ways as well as more traditional ways. For example, SDS funding can be used to arrange respite and this could involve purchasing a caravan for short breaks, booking time in a residential home or hiring a personal assistant for a short period to allow a carer to go on holiday.



Assistance

Section 6 of the Act sets out the provision that must be made for people who require support in either making or communicating their decision about SDS. The two groups eligible for assistance are as follows.

1. People who have a right to advocacy under the Mental Health (Care and Treatment) (Scotland) Act 2003, ie people with:
 - mental ill-health (for which a diagnosis is not required)
 - dementia
 - a personality disorder
 - an acquired brain injury.
2. People who have 'difficulties in communicating due to physical disability' who would benefit from receiving assistance from another person in relation to communicating decisions.

In these cases the local authority must identify someone who is able to assist the disabled person, and (as long as the disabled person agrees) involve this person in assisting the disabled person in making or communicating their decision about SDS.

Independent advocacy organisations are well placed to provide this support (see 'The role of independent advocacy').

Information

Section 9 of the Act sets out the provision of information for people who are going through the process of making decisions about SDS. It states that local authorities must give the person:

- an explanation of the nature and effect of each of the options for SDS
- information about how to manage support
- information about potential providers of:
 - assistance or information to the person to assist the person in making decisions about the options
 - information about how to manage support.

Also, if the local authority considers it appropriate to do so, they must provide information about providers of independent advocacy services (see 'The role of independent advocacy').

It is really important that people are given appropriate, accessible information about SDS so that they can be armed with all the relevant information about the implications of the different options before they make their decision. Independent advocacy organisations are well placed to provide this information (see 'The role of independent advocacy').

Independent support organisations can also provide information and ongoing, practical support around SDS. Contact details for local organisations providing this information can be found at www.sdsinfo.org.uk.

Carers

There are estimated to be over 650,000 unpaid carers in Scotland. This is one in eight of the Scottish population who are involved in providing care and support to a family member, friend or neighbour to enable that person to continue to live in their own community.

The Act gives carers who provide a substantial amount of care on a regular basis the right to request an assessment of their needs as a carer. This is known as a carer's assessment. Professionals working with people who have had a stroke also have an obligation to inform any relevant carer of the right to request an assessment.

As with the individual's assessment, a good quality carer's assessment begins with a problem-solving conversation between the professional and the carer with a strong focus on personal outcomes.

Carer support might be the provision of information, signposting to a voluntary organisation that can provide specific support or to a universal service available in the community. It could also be the provision of a funded service or support such as a peer support group, training or a short break. Carers also have the choice of the four options of SDS: direct payments; individual service funds; accepting arranged services; or a combination.

Older people and SDS

All older people aged 65 and over and living at home are eligible for SDS to meet their assessed personal care needs. This is their entitlement as part of the free personal and nursing care available to people aged over 65 years in Scotland.

Free Personal Care is a legal entitlement for people aged 65 or over who have been assessed as having personal care needs that require services to be put in place. Free Nursing Care is similar but is available to people of all ages who are assessed as requiring nursing care services.

People who are aged 65 or over and wish to use SDS to buy personal care services at home will not be asked to contribute towards the cost of these services.



The role of the NHS

The Social Care (Self-directed Support) (Scotland) Act 2013 does not place a requirement on health boards to offer SDS. However, the Scottish Government's statutory guidance on SDS makes it clear that health professionals have a vital role to play and that a joint approach can be taken to meeting an individual's assessed health and social care needs.

'Health needs' in this context refers to community-based healthcare, not acute, hospital-based healthcare. This includes NHS-funded support provided by Allied Health Professionals, such as occupational therapists and physiotherapists, and district nurses.

The joint approach starts with the single shared assessment (see 'Assessment of needs') and continues through support planning and review. It is a person-centred, outcomes-focused and solution-driven approach which requires health and social care professionals to work together with the stroke survivor and think creatively about how best to meet their personal outcomes.

The ability for health and social care professionals to work jointly in this way is not new.

For a number of years health professionals and social care professionals have been able to work together on:

- single shared assessment and support planning
- jointly funded packages of health and social care where an individual has been assessed as requiring both health and social care services.

The difference made by the 2013 SDS Act is that individuals can now direct their own health and social care support through the four options of SDS. The only exception is that Direct Payments cannot be made directly from a health board to an individual. Therefore SDS option one can only be used where there a person has both health and social care needs or only social care needs.



Case Study

Veronica is 35 years old and has complex health and social care needs following a brain stem stroke in 2009. Veronica lived with her parents following discharge from hospital but was keen to regain her independence by living in her own home. She requested a community care assessment and this resulted in Veronica being found to need 35 hours per week of personal care and daily support from the District Nursing Service for certain aspects of her care including bowel management and administration of certain medications.

The NHS arranged to meet Veronica's healthcare needs and she asked her local centre for independent living to arrange her personal care through an individual service fund. She felt this would give her more choice and control in relation to her support team without having to employ her own PA.

The Scottish Government statutory guidance states:

"A supported person's needs and outcomes will not always respect traditional boundaries between healthcare services and social care services. The authority and the Health Board and the relevant health and social care professionals should consider their respective roles, contributions, expertise and resources, along with their combined role to support the individual to make informed choices regarding the care they receive."

Health and social care integration

The Public Bodies (Joint Working) (Scotland) Bill sets out the framework for the integration of health and social care in Scotland. It is driven by the need to make better use of scarce resources, shift care out of acute settings into the community and deliver better support for the growing number of frail older people and people with long-term conditions.

The Bill includes powers for local authorities and health boards to transfer funding to each other at both the high level of strategic budgets and funding at the micro level of individual. The Bill provides a real opportunity for health boards and local authorities to develop effective joint approaches towards SDS.

Further information about SDS

The Scottish Government's Self-directed Support portal provides information about Self-directed Support for people who use social care services and health and social care professionals.

www.selfdirectedsupportscotland.org.uk

Self Directed Support Scotland (SDSS) is a national membership organisation which actively promotes independent living by supporting, working with and championing the aims of SDS disabled people's organisations.

www.sdsscotland.org.uk

The role of independent advocacy

The Scottish Independent Advocacy Alliance describes independent advocacy as a way to help people have a stronger voice and to have as much control as possible over their own lives.

Independent advocacy is:

- about standing alongside people who are in danger of being pushed to the margins of society
- speaking on behalf of people who are unable to do so for themselves
- about standing up for and sticking with a person or group and taking their side
- a process of working towards natural justice
- listening to someone and trying to understand their point of view
- finding out what makes them feel good and valued
- understanding their situation and what may be stopping them from getting what they want
- offering the person support to tell other people what they want or introducing them to others who may be able to help
- helping someone to know what choices they have and what the consequences of these choices might be
- enabling a person to have control over their life but taking up issues on their behalf if they want you to.

People can access independent advocacy for help in a range of different situations, including support in meetings with health and social care professionals. Advocacy workers do not give advice on the best course of action to take but explore the implications of different options with people. Independent advocates are not impartial – they are on person's side.

Instructed and non-instructed advocacy

In instructed advocacy an advocate agrees an agenda with the individual and represents the individual's views and wishes or supports the individual to do so.

Non-instructed advocacy happens when a person who needs an independent advocate cannot tell the advocate what they want. This may be because the person has complex communication support needs or has a long-term illness that prevents them from forming or clearly stating their wishes and desires.

In non-instructed advocacy the advocate will observe the individual and their situation, look for alternative means of communicating with them, gather information from significant others in the person's life, if appropriate, and ensure the individual's rights are upheld.

Who can access advocacy?

In addition to the right to assistance for people who require support in making or communicating their decision included in the Social Care (Self-directed Support) (Scotland) Act 2013 (see 'Assistance'), a number of other pieces of legislation bestow the right to independent advocacy.

- The Mental Health (Care and Treatment) (Scotland) Act 2003 affords a legal right to advocacy to people with:
 - mental ill-health (for which a diagnosis is not required)
 - dementia
 - a personality disorder
 - an acquired brain injury.
- The Adults with Incapacity (Scotland) Act 2000 requires the wishes and feelings of an adult with incapacity to be taken into account when expressed by an independent advocate.
- The Adult Support and Protection (Scotland) Act 2007 places a duty on local authority staff to tell vulnerable adults about advocacy and how it might be able to help them, and how to contact their local advocacy organisation.
- The Education (Additional Support for Learning) (Scotland) Act 2009 places a duty on local authorities to tell parents about independent advocacy.
- The Patient Rights (Scotland) Act 2011 places a duty on health board staff to tell patients about advocacy and how to contact their local advocacy organisation.

For anyone else, access to independent advocacy will depend on what is available in their area. You can find out what advocacy is available in your area by checking the directory of advocacy organisations on the SIAA website or by contacting the SIAA (see 'Useful contacts').



How can advocacy help with SDS?

Advocacy support can help to ensure that the stroke survivor is in control and is the central focus of the SDS support arrangements.

This can include:

- the provision of information about SDS and how it can put the person in control of their care
- independent advocacy support to help the person understand their rights, entitlements and options for SDS
- support to enable the person to make well informed decisions in relation to SDS
- support to enable the person to communicate their preferences and decisions
- support at the assessment
- help in querying or challenging the outcome of the assessment.



Case Study

I am an advocacy worker and I am currently supporting a lady, 'Ms H', who has a learning disability and cannot read or write. She has had four strokes and has a number of other health issues.

Ms H currently lives with her brother and prior to the involvement of advocacy her brother provided her with support in accessing information and making decisions. However, with the support of advocacy Ms H has been able to state her desire to be independent and that she no longer wants to live with her brother. Ms H had lived on her own prior to her strokes but had moved in with her brother because her home was not suitable for her since her stroke.

Ms H and her brother did not know about SDS and did not know who to contact to find out about the options for Ms H. I have given Ms H information about SDS verbally and talked to her about the four different options.

I gave her time to understand what SDS is and the space to consider which option she wanted to choose. I referred Ms H to her local social work department for an assessment of her needs and I attended the assessment with her.

Ms H chose to receive a direct payment. Ms H's brother had in the past looked after all financial issues so I supported Ms H to set up a bank account and I made sure that she understood what is required of her in managing her account and using her bank card.

I am also helping Ms H source the relevant services she wishes to use and I am assisting her to find a new home that is suitable for her and meets her needs post-stroke. I am helping her to fill out application forms and I am in contact with people on her behalf regarding housing issues. I am also helping her to look for property and bid through the local authority process. Once a suitable property is found I will support and assist her in choosing the most appropriate care package for her with SDS.

I have found that the stroke survivors I am working with have vision problems due to their stroke and are unable to read the documents regarding SDS or they are unable to communicate verbally which makes it difficult for them to express their wishes/decisions.

Advocacy involvement is able to inform, explaining and reading out loud the SDS documentation. Advocacy will only take into account the stroke survivors wishes; this ensures that SDS requirements stated are what the person wants and not what family members or anyone else wants.

In my experience advocacy establishes a relationship with the person and over time the person trusts their advocacy worker as they know that the advocacy worker will listen to them and ensure their thoughts, views and decisions are taken into account. In regard to SDS it is particularly important that advocacy is involved to insure the person knows and understands SDS but also they have someone who will listen and aid in the implementation of SDS.

Useful contacts

Stroke Association in Scotland

Links House
15 Links Place
Edinburgh
EH6 7EZ

Telephone: 0303 3033 100

Email: Scotland@stroke.org.uk

Website: stroke.org.uk

Scottish Independent Advocacy Alliance

Melrose House
69A George Street
Edinburgh
EH2 2JG

Telephone: 0131 260 5380

Email: enquiry@siaa.org.uk

Website: www.siaa.org.uk

Self-directed Support Scotland

4 PURE Offices
Bonnington Bond
2 Anderson Place
Edinburgh
EH6 5NP

Telephone: 0131 516 4195

Email: info@sdsscotland.org.uk

Website: www.sdsscotland.org.uk

Scottish Personal Assistant Employers Network

Suite G4
Dalziel Building
7 Scott Street
Motherwell
ML1 1PN

Telephone: 01698 250280

Email: marionb@spaen.co.uk

Website: www.spaen.co.uk

This publication has been produced as part of the Stroke, Advocacy and Self-directed Support project funded by the Scottish Government in 2012 – 2015.

We are the Stroke Association

We believe in life after stroke. That's why we support stroke survivors to make the best recovery they can. It's why we campaign for better stroke care. And it's why we fund research into finding new treatments and ways of preventing stroke.

We're here for you. If you'd like to know more please get in touch.

Stroke Helpline: 0303 3033 100

Website: stroke.org.uk

Email: scotland@stroke.org.uk

From a textphone: 18001 0303 3033 100

Stroke Association in Scotland

Links House

15 Links Place

Edinburgh

EH6 7EZ

Telephone: 0131 555 7240