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Can Personalisation Work Within the Context of Mental Health?

An Examination of Risks and Barriers

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Acknowledgement

I tender my regards and blessings to everyone who supported me in any respect during the completion of this project.

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Abstract

The aim of personalisation is to ensure that universal access is provided to the public to ensure prevention, intervention and co-production of services. This policy measure contributes to the growth of available social capital in the social care sector and improves the availability of and accessibility to information. The personalisation of healthcare is thus established as one which is a panacea for catering to the needs of people with physical and mental disabilities. Given that this is a relatively new concept, it is important that it is examined with caution, with an emphasis on the degree of control and choice available for the services. A number of questions are raised with respect to the provision of mental health services and personalisation. This study has carried out a literature review and has thematically organised the risks and barriers associated with the implementation of personalisation in mental health initiatives from the perspective of different stakeholders. The role of a personalisation model in the context of social care and its relevance in modern day practice is also identified. It can be concluded that the challenges associated with the promotion of the "personalisation agenda" in the mental health framework should not be underestimated. The future of personalisation in this field requires a visionary approach, which promotes practical and energetic measures across different segments of the social and health care system, in order to ensure that beneficial outcomes are identified for service users afflicted with mental disorders.

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Chapter One: Introduction

1.1. Personalisation: An Overview

Enabling autonomy and consumer choice in the delivery of public sector services has resulted in the development of the umbrella term "personalisation of services", leading to a move from community or group based services to individually tailored services (Duffy, 2007). The introduction of direct payments as a policy objective was introduced in the mid 1990s and was categorised as personalisation. Personalisation involves the adoption of measures to meet the needs of individual service users in a manner that is most suitable for them (Carr, 2010). Personalisation is adopted at different stages including prevention, early intervention and self directed support when autonomy is given to the user to take decisions which will help their everyday living (Bartnick *et al*., 2007; Garrett and Garrett, 2012). The adoption of personalisation policies provided disabled people, people with learning disabilities, older adults, disabled children, users of mental health services and associated carers to obtain cash payments for their care directly from the government (Fisher *et al*., 2011). This measure avoided the provision of services through a mediating organisation like a local agency or an authority. The aim of adopting a personalisation approach is to promote self directed support and person centered planning wherein the choice and control is given directly to the individual. This measure not only provides more independence to its users but also provides them with control and dignity (Duffy, 2011).

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Social care policies and practices have become increasingly "personalised" over the last few years (Department of Health, 2005; Department of Health, 2006; Fulford, 2011), with the recent Health and Social Care Act 2012 supporting the need for personalisation. As a result of strong governmental support, the services are designed with the needs of individual users kept in mind, with limited focus on communities and groups (Holloway, 2012). Various systems have been developed which support the use of personalised support (Lymbery, 2012). These systems have been defined by the Social Care Institute for Excellence (SCIE) as follows:

Care Management: The individual care plans are developed and implemented with full participation from the user, in terms of understanding their wishes and needs. These plans are developed and assessed by budget holding care managers (SCIE, 2007).

Direct Payment: In direct payment method, service users are provided with money to pay for their social care directly after a detailed assessment. This assessment is carried out by their care managers, who take into account the needs of the users (SCIE, 2007).

Individual Budgets: An assessment of various funding streams is carried out in order to ensure that the allocation of resources to the individual results in transparency. This system provides resources in the form of cash or kind by making sure that the most suitable system is made available to them (SCIE, 2007).

When applied to the context of mental health services, the adoption of personalisation as a policy helps in the promotion and maintenance of the mental health of service users by providing them with the choice to control their life and

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wellbeing (Fulford, 2011). The aim of personalisation is to ensure that universal access is provided to the public to ensure prevention, intervention and co-production of services. This policy measure contributes to the growth of available social capital in the social care sector and improves the availability of and accessibility to information (Carr, 2010).

1.2. Purpose of the Study

The personalisation of healthcare is thus established as one which is a panacea for catering to the needs of people with physical and mental disabilities. Given that this is a relatively new concept, it is important that it is examined with caution, with an emphasis on the degree of control and choice available for the services. A number of questions are raised with respect to the provision of mental health services and personalisation. This dissertation aims at investigating the phenomenon of personalisation, examining its origin, development, challenges and benefits in the context of mental health provision. The dissertation also aims at investigating the mechanisms by which personalisation operates, such as professional partnerships, to determine whether there is sufficient correlation between theory and practice, thereby understanding the implications for individuals suffering from mental health issues.

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1.3. Research Questions

The following research questions are proposed in this study.

- What is the theory behind personalisation?
- Where is personalisation located in policy, and how is it located in practice?
- What are the major risks brought about by personalisation for those with mental health issues?
- What are the barriers to effective professional practice?
- What is the future for personalisation?

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Chapter Two: Review of Literature

2.1. Introduction

This chapter presents an overview of the current status of mental health care, mental health reforms, models of modern healthcare and the application of the personalisation model to mental health.

2.2. Current Status of Mental Health Care in the UK and Mental Health Reforms

Over the years, highlighted attention has been given globally with respect to the treatment of physical diseases (Institute of Medicine, 2010; WHO, 2011). This inevitably has resulted in gaps in the availability of models to promote utilisation of mental health services. The financial burden faced by individuals and families with respect to mental health has been examined in extant literature (WHO, 2010; Eaton *et al*., 2011). The need for further research on the financial burden has been examined due to the emergence of evidences relating to the prevalence of mental illness, disparities of care and the global attention on the impact of natural and human caused disasters on the mental health of humans (WHO, 2005). The consideration, development and utilisation of novel models of psychological treatments, directed towards the mentally ill, have been extensive, with increased recognition of individualised treatment plans (Reeves *et al*., 2011; WHO, 2010).

Significant mental health problems are found to occur among one in four people in their lifetime in the UK (Bhui *et al*., 2003; Collins *et al*., 2011). However, research indicates that despite the sympathetic attitude of the majority of the public towards mental afflictions, negative attitudes continue to persist and have grown across

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different demographics during the past ten to fifteen years (While *et al*., 2012; Chang *et al*., 2011). Despite the significant progress associated with the acknowledgment of mental health problems, lack of convincing evidence with respect to the associated stigma has resulted in renewed efforts in local and national policies (Skuse, 2010). There has been a great deal of negative perception related to mental health problems (Graham, 2010; Simmons *et al*., 2010), which, associated with the "Cinderella" treatment of the mental health services sectors, has led to inadequate progress in overall service quality of these services.

Recent efforts have been undertaken by the UK coalition government to promote the importance of mental healthcare with a focus on measures promoting personalised care (Holloway, 2012). However, there are criticisms associated with the type of professional expertise and related care management provided in term of access and allocation of funds. Some researchers indicate that the power to decide which treatment option is most suited for the service user is often directly linked to the service itself, leading to improper allocation of funding (Alakeson, 2008). Furthermore, the choice of utilisation of available funds may be different from the perspectives of the user and the care manager (Bird and Wooster, 2008). This leads to the need to examine the role of personalisation policies in the context of mental health support.

The creation of the National Institute of Mental Health in England (NIMHE) 2002 was a step towards the establishment of a new framework supporting policy innovation within the paradigm of mental health services. The organisation supported the promotion of mental health as a mainstream issue, challenged the associated stigma and inequalities, and provided the support which was necessary in order to carry forward policy innovations.

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The major mental health reform which was implemented over the last decade was the 2007 amendment of the 1983 Mental Health Act which revised stakeholder engagement and helped promote public safety and increase investment in mental healthcare (Holloway, 2012). However, the act was found to be a disappointment by the Mental Health Alliance as it did not enable a number of human rights based personalisation approaches (Carr, 2010). However, the positives associated with the Mental Health Act included the promotion of a new Code of Practice (Department of Health, 2008) which enabled value based influence on the interpretation of the act. Furthermore, Fulford and Woodbridge (2007) indicated that the importance of value based and evidence based practices has become central to personalised mental health approaches. They identified that the wishes, experience and beliefs of the service users are to become a vital component of personalised care.

2.3. Neoliberalism in Health Care: Evolution of Personalisation

The concept of neoliberalism emerged as a remedy to solve an economic crisis (Dahlgren, 2008). Neoliberalism involves the liberation of private enterprises, reduction of public expenditure for social services and lowering of trade barriers (Danis *et al*., 2008). The focus of neoliberalisation was deregulation, privatisation and decentralisation (Ezeonu, 2008). The neoliberal transformations of healthcare systems resulted in the promotion of cost effectiveness, the privatisation of healthcare, charging user fees and resource allocation based on health priorities. All of these resulted in decreased access to and equity of healthcare (Waitzkin *et al*., 2007), a decrease in efficiency and quality (Janes *et al*., 2006) and departure from values of social solidarity and public good (Martinez and Garcia, 2001).

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The earliest applications of self-directed support concepts date back to the 1996 Community Care Direct Payment Act which promoted the philosophy of "choices and rights" (Campbell and Oliver, 1996). Davey *et al*. (2007) reiterated that even ten years after the implementation of the Act fewer than 5% of payments were being made directly to the individual. This led to accusations of lack of focus by the Department of Health, which in turn led to the need for value based evidence promoting the personalisation approach. The importance of promoting independent living has been stressed in literature: *"there are likely to be dynamic, long-term benefits to the exchequer and society in the form of reduced reliance on health and social care services and a reduction in overall dependency on informal support."* (Hurstfield *et al*., 2007: 49)

Ferguson (2012) identifies that personalisation in the UK started as a neoliberal discourse which had its basis in austerity measures rather than a progressive agenda of the government. This view, though harsh, establishes the idea that the current personalisation policy is a hybrid of community welfare and individual support. In the white paper 'Putting People First', the Department of Health (2007) identified the need to transform social care in order to promote independent living for all adults. The adoption of personalisation presents implications of hybridisation between independent living models and neoliberal assumptions in terms of choice and control, enforced individualism and enforced collectivity.

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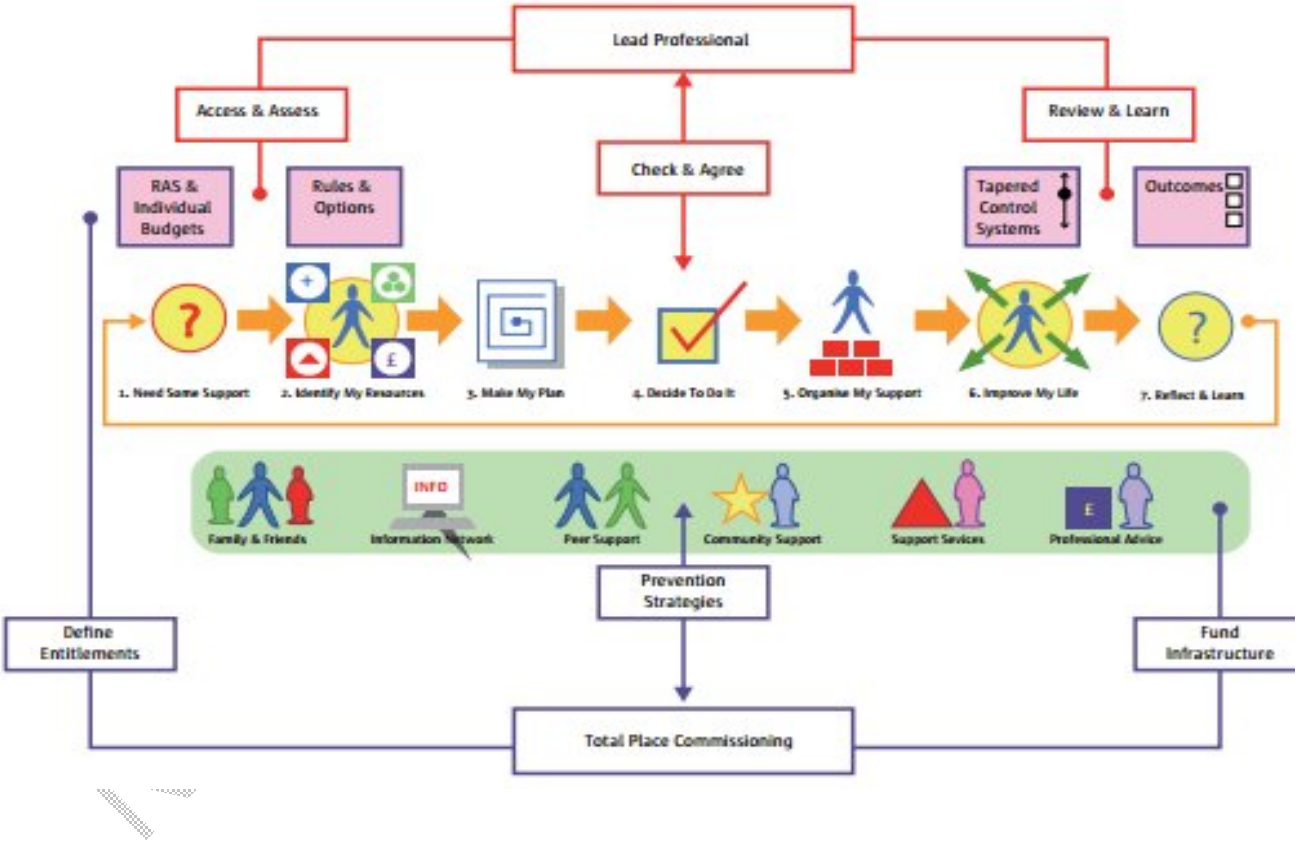
2.4. The Personalisation Model: Theory and Practice

The personalisation model proposed by Duffy (2010) is examined in this section. The effectiveness of the model components, its criticism and relevance to practice are

promoted in this section. This model is found to integrate concepts of health recovery, evidence based practice, total place and personalisation of health and social care. There are seven different elements which are proposed in the personalised model which are examined in detail in this section. The following Figure 1 presents an overview of the Duffy model of personalisation for mental health.

Figure 1: The Personalisation Model (Adopted from Duffy, 2010)



2.4.1. Total Place Commissioning

The purpose of total place commissioning is to ensure that shared accounts of outcomes are proposed. These outcomes are co-produced by locals, community

organisations and services in order to focus on infrastructure, prevention and entitlements (Duffy, 2010). The total place commissioning provides funding from the NHS and other sources to provide services for communities as a whole and for individual people (Needham and Tizard, 2010). This commissioning proposes holistic needs assessment, which is similar to the model assessed by Smith *et al*. (2009) in New Zealand.

Duffy (2010) acknowledges that total place commissioning implementation will be gradual as it should tackle complex systemic blocks. Furthermore, Willis and Bovaird (2012) remarked that the adoption of a common commissioning base is promoted by the adoption of the Social and Health Care Bill. Bovaird and Davies (2011) suggested that measures adopted to enable whole communities to address their own interlocking needs are often effective theoretically, but are difficult to implement in practice.

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2.4.2. Prevention

The second aspect of the personalisation model of Duffy (2010) is prevention. Prevention promotes measures to reduce the causes of mental ill health. This is carried out by tackling social injustice, promoting wellbeing, ensuring early intervention and seeking to avoid escalation. Kobau *et al*. (2011) remarked that mental health services should focus on promoting partnerships in order to analyse local needs and deal with social injustice. However, Manthorpe *et al*. (2012) remarked that, in practice, personalisation measures often do not reach certain ethnic communities like the black and minority ethnic communities. Fledderus *et al*. (2010) identified that personalisation will ensure the provision of responsibility to

service providers in order to allow individuals to take responsibility for their own health. However, Knapp *et al*. (2011) remarked that, in practice, it is difficult for individuals to identify signs of mental health deterioration or to identify the most effective personal strategies.

2.4.3. Individual Funding

In the Duffy (2010) model, individual funding is given a great deal of importance. The various facets promoted include individual budgets, grants, vouchers and individual services funds. Beresford (2008) and Henwood and Hudson (2008) identified that the NHS and local governments were aware of the need to promote resource targeting to individuals. This will ensure that flexibility and support is provided to the organisation. In mental health services, individual funding is promoted through Payment by Results (PBR) and the Resource Allocation System (RAS). These systems are found to function only partially and require further innovation to translate into reality (Duffy, 2010). Dixon (2004) promoted Payment By Results as the more effective measure, as it helps keep track of the progress of service users and promotes accountability when compared to the Resource Allocation System.

The personal budget which is allocated to an individual will enable planning of the spending, following which is assessed and monitored by professionals. The aim of individual budgets is the promotion of empowerment and co-production of support for service users (Manthorpe *et al*., 2010). However, Holloway (2012) identified that the degree of autonomy provided in allocating individual budgets is limited. According to Carr (2010), personalised support will be more effective for users with good mental health. It is observed in the Personalised Support Model (Figure 2) that the

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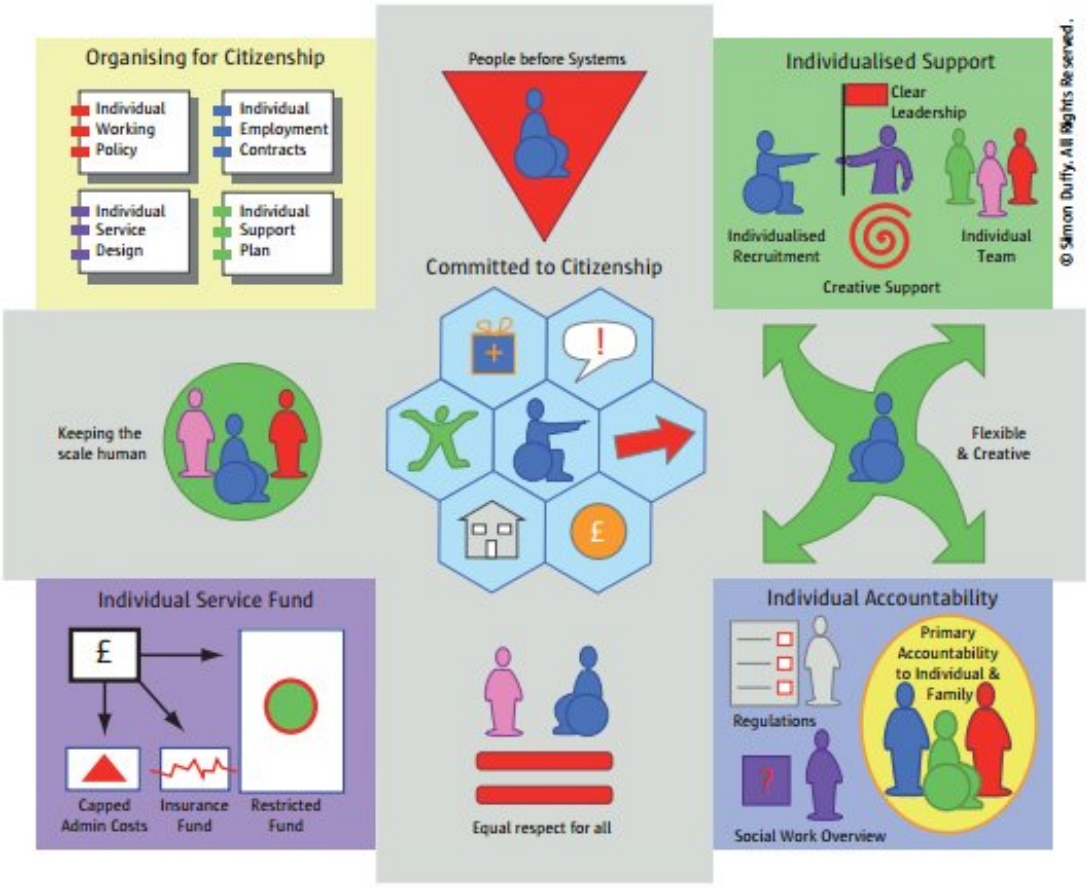
interaction of various elements will ensure accountability and creative provision of services to service users.

Figure 2: Personalised Support Model for Mental Health Service Users (Adopted From Duffy, 2010)



Furthermore, Manthorpe *et al*. (2009) remarked that this system is preferred by a number of mental health service users as it provides a number of choices while reducing the level of administrative responsibilities and associated risks.

2.4.4. Self Directed Support

The aim of self directed support is to set out clear rules to enable service users to plan for themselves, thereby ensuring that creative support solutions can be arrived at (Roulstone and Morgan, 2009). Duffy (2010) identified that in the context of mental health, new complexities may arise. Duffy's model promoted seven stages in self directed support, which involves identification of need, exploration of resources, designing of support plans, organisation of support and the use of available support. Duffy (2007) argued that, in mental health, self directed support in the form of co-designed solutions and controlled treatment are difficult to implement due to the nature of the disease, as well as the lack of flexibility in associated risk assessment.

The personal planning system has been promoted by the personalisation initiative. However, Renshaw (2008) notes that through other techniques like Essential Lifestyle Planning, measures of autonomy have been explored earlier and have resulted in limited success. It is therefore important to arrive at evidence based measures of personal planning and self directed support.

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2.4.5. Co-Production

Co-production aims at providing support to the service users in developing their personal plans (Tyson, 2008). The concept of co-production is most vital to mental health services as service users face complex needs including health, housing, employment, medication etc. An effective co-production programme which is promoted is the Care Programme (Bartnik *et al*., 2007).

However, Dunston *et al*. (2009) notes that co-production in practice may lead to a lack of effective control, with the power given back to the professional. It is important that personalisation promotes a tapered control, where the service user and the social care professional make combined efforts to ensure that there are no problems. Furthermore, the need for lead professionals who will integrate personalised services with overall organisational perspectives is stressed (Carr, 2010). Holloway (2012) remarked that the concept of co-production in theory is most effective; however, its implementation requires strong leadership and support.

2.4.6. Community Based Support

The need for community based support is strongly promoted in the personalisation model. In this model, community support, peer group influence and information resources are all important in providing control to service users in order to improve mental health (Boxall *et al*., 2009). According to Minkler and Wallerstein (2010), the promotion of community based support will be most effective in supporting measures of personalisation. It is to be acknowledged that the lack of clear guidelines for community networks has led to community and professional support being restricted to the service user, family and friends and the lead mental health professional in charge of the case (Wallerstein and Duran, 2010).

2.4.7. Outcomes Focus

The final attribute of the personalisation model is the need for evidence based focus at micro and macro levels. Duffy (2010) indicated that social outcomes are to be the

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focus of commissioners with emphasis on inputs, processes and outcomes. Social outcomes also deliver a wide range of aspects which need to be examined in order to arrive at a recovery framework for mental health service users. However, Holloway (2012) noted that personalisation plans in mental health are relatively new and require a great deal of empirical evidences before modifications can be made. He also remarked that the successful translation of theory into practice can be evaluated only after a few more years of effective implementation of policies.

2.5. Conclusion

The examination of this review indicates that the personalisation model makes efforts to move past the medical model and promote independent living. The personalisation model focuses on the social and emotional needs of the disabled people while the medical model focuses on the impairments faced by service users. There is a significant difference in the approach of these models and it is most important that the barriers and obstacles to implementation of personalisation be examined. The proposed agenda of the government to promote individual support is firmly placed within the realms of community support. However, the recent decision by the local authorities to present self-directed packages for a small sub-section of the population (CSCI, 2008) is in direct contrast with the modernisation of social welfare. Here the lack of organisational support can result in self direction taking on neoliberal characteristics.

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Chapter Three: Research Methodology

3.1. Introduction

This chapter provides information related to the research philosophy, associated research strategy and the research design adopted. This piece of research will take the form of a narrative literature review. The literature review will be critical, which means that the researcher will interpretively analyse the texts in order to form a deeper understanding of the phenomenon.

3.2. Research Philosophy

The study adopts an interpretivistic approach. According to Cooper *et al*. (2009), understanding of reality is relative and there is a presence of more than one reality. Furthermore, Denzin and Lincoln (2011) identified that the social world is inherently different from the natural world where construction and re-construction of worlds is dependent on interpretation of relationships, with limited focus on cause and effect. The interpretivistic research approach enables interpretation of events by the researcher wherein environmental factors impact the interpretation of collected data. In the current study, the researcher proposes to interpret the views expressed related to personalisation, in the context of mental health.

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3.3. Research Approach

There are two different types of research approach in a research methodology. These are inductive and deductive. According to Bryman (2012), the adoption of the

most effective research approach is dependent on the conceptual framework of the study. The current study adopts an inductive approach wherein specific observations are made, leading to generalisations. This approach involves personal observations of the researcher rather than the empirical application of theories. On the other hand, the adoption of a hypothetical deductive approach will help in knowledge building measures, arriving at identification of causes and effects. In this study, the researcher aims at identifying the various barriers and risks associated with the implementation of personalisation in mental health by identifying overlapping themes in literature. This study aims at synthesising available literature to arrive at a conclusion and therefore adopts an inductive approach.

3.4. Research Strategy

The collection of secondary data sources in order to analyse data contained in archival records is the purpose of an archival research strategy. In the current study, the adoption of an archival research strategy enables examination of trends in the development of personalisation over time. Marlow (2010) established the high external validity of archival strategy, as observer bias is limited. The adoption of an archival strategy also enables identification of various levels of evidence. For example, in the current study, the barriers and the risks associated with the personalisation process have been examined from the perspective of the system, the service user and the mental health professional.

However, it is to be acknowledged that there are some limitations associated with the archival strategy. These include filtering of information by the primary authors, as well as subjective bias during thematic analysis of data (Rubin and Babbie, 2012). In

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order to ensure that bias is excluded, it is observed that the current study will use data obtained from different governmental, non-governmental and academic reports by using standard key words.

3.5. Research Method

Any social research methodology will adopt one of three different research methods. These include quantitative, qualitative and mixed methods (Bryman and Bell, 2007). In a quantitative research method, it is seen that the numerical data are collected and computed to provide empirical resolution to a given problem. The adoption of a quantitative method is not justified in the current study as there are limited numerical data which are analysed.

In contrast, a qualitative research approach will ensure that words or themes are identified from the given data in order to identify common underlying patterns and thereby arrive at implications. Since this study adopts an interpretivistic inductive research approach, qualitative data collection is justified to be the chosen research method (Creswell, 2012). The adoption of a qualitative approach will help identify the perspective of an insider. Since this study aims at identifying the barriers and risks faced by different stakeholders of personalisation promotion, it will enable a deeper understanding of the study subject.

3.6. Data Collection Method

The study adopts a secondary data collection approach. The adoption of such an approach promotes re-examination of previously collected data in order to arrive at

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answers to the proposed questions. The adoption of a secondary data collection approach will enable analysis of large volumes of data within short periods of time (Bryman and Cramer, 2011).

The current study involves data collection from different sets of data related to the given research problem, following which data analysis is carried out. The adoption of such a data collection approach will enable reduction in time and costs, and ensures limited observer bias. The disadvantages associated with this data collection approach include the inability to check accuracy, sufficiency, the outdated nature of data and extensive volume of available data (Bryman, 2012).

3.7. Source of Data

In order to identify the most relevant published and unpublished data, the researcher reviewed literature from 2002 to 2012. A search on Google Scholar of '*personalisation* + *mental health'* has generated 22,400 results. In order to arrive at the most relevant studies, the researcher performed a database search on Google Scholar using the following categories of keywords:

1. Personalisation related key words: *personalisation, care programme, individual budget, personalised budget and direct payment.*
2. Stakeholder related key words: *mental health professional, national policy, and service users.*
3. Mental health related key words: *mental health, multi-agency, mental health social care and mental health social worker.*
4. Study related key words: *barrier, obstacle, dilemma, risk and safeguarding.*

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From these key words, different types of data were extracted, which were categorised under three main headings:

1. Academic articles - Peer reviewed articles published in reputable journals.
2. Government report - Reports published by the Department of Health in relation to personalisation and its role in mental health.
3. Non-governmental reports - Reports by different non-governmental organisations which support personalisation measures.

3.8. Conclusion

This study adopts an interpretivistic, inductive data collection approach. The following chapter discusses the study results.

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Chapter Four: Results and Discussion

4.1. Introduction

This chapter identifies the different barriers and risks faced during the process of personalisation by adopting the perspectives of the three main stakeholders in mental health promotion: the system, the user and the professional. The views expressed by authors and government reports are collected and categorised under the above themes.

4.2. Barriers to Personalisation: A Mental Health Perspective

Service users, who have mental health problems, have historically been the least well served with respect to national policies to improve choice and control, an example being direct payments (Spencer *et al*., 2012). The Social Exclusion Unit (2004) issued a report identifying that there was a very low up-take of direct payment by service users afflicted with mental health problems. In order to overcome this, the coalition government commissioned a report to identify the reasons for low up-take of services (NIMHE, 2006). This commission established that direct payments were not made to service users with mental health problems by one in four local authorities in England. The report indicated the need to look for measures to facilitate greater social participation among service users with mental health issues. The study by Glendinning *et al*. (2008) established that mental health service users indicated overall improvement in well being and quality of life after being provided with individual budgets. However, only 14% of the respondents in the above study were service users who had mental illness. Larsen *et al*. (2013) identified a number

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of barriers which restricted the up-take of personalised budget and care management by service users of this group. The need for a cultural shift in the professional mental health field has been stressed by Coppock and Dunn (2010), who characterised it to be authoritarian, risk averse and paternalistic. The role of social work has become marginalised in contemporary mental health law and policy. The replacement of the Approved Social Worker with Approved Mental Health Professionals has resulted in increased knowledge on the needs of service users with mental illness. However, there is a marked reduction in awareness of national policies and implications (Richardson and Cotton, 2011). This section examines the different barriers to personalisation of services for mental health service users from three different perspectives.

4.2.1. Barriers to Personalisation: Service User Perspective

Duffy (2010) identified that the number of service users adopting personalisation was very low, with a reduction in number in certain fields, including mental health. The occurrence of low take-up was attributed to lack of understanding, lack of access and lack of support (Simmons *et al*., 2010). A main barrier to increased implementation of personalisation and direct payment for mental health service users reported was the lack of awareness**.** Authors (Levin, 2004; Littlechild, 2009) report a lack of awareness and understanding about the different facets of personalisation including direct payments, care management, and care and control, as well as co-productive living. To overcome these obstacles, it is vital that the service users are given information on personalisation.

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Lyon (2005) and Spandler and Vick (2004) indicated that, in the move towards seeking individual solutions, the root cause of the mental illness is not addressed. A number of personalisation programmes do not provide a clear picture of the investments needed to improve the healthcare services provided in order to alleviate the mental distress of service users. Spandler (2007) identifies that mental health services are concerned with the management and control of "risk behaviour". This leads to the occurrence of obstacles related to risk management. Risk management requires insight in terms of designing and managing support.

Taylor (2008) reported that personalisation helps support service users to perform individual social and personal tasks, but prohibits pooling of resources with other service users. This results in fragmentation of users, and goes against the concept of co-production. To overcome this obstacle, care co-ordinators should be provided with the authority to oversee pooling of budgets to ensure that the health and wellbeing of the service users are promoted.

4.2.2. Barriers to Personalisation: Social Worker/Professional Perspective

This lack of awareness was also found to extend to mental health professionals. Ridley and Jones (2002) identified that a number of mental health professionals were unaware of the flexibility and forms of personalisation available for use, indicating the need for further training. Duffy (2010) remarked that most mental health professionals have a basic understanding of the personalisation process. This implies that progress has been made over the decade in terms of educating the mental health professionals on national policy measures.

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The implementation of personalised care is directly dependent on the assessment of an individual's need for care and his/her ability to obtain such an assessment. The organisation of mental health services in the UK is presented in a manner that governs the eligibility of the individual to access the service (Taylor, 2008). It is proposed that the assessment of social care needs should be promoted to reach different segments of the population to ensure that personalisation is a viable option to service users suffering from mental ailments. Cestari *et al*. (2006) remarked that a number of mental health professionals are not trained to assess and recognise the social care needs of service users. This forms a major obstacle in determining if personalisation and direct payments are to be implemented in the first place.

Spandler and Vick (2005) note that the main barrier to the promotion of personalisation in mental health is the concerns of mental health professionals and social workers with respect to the "willingness and ability" of the service user. This extends to consent and management of a personalised approach. Therefore, there is a need to look at the need for personalisation during recovery. Once the service user is recovering, a graduated autonomous control over their finances can be presented to them.

Another important barrier to the implementation of personalisation from a mental health perspective is the assumption of "incapacity" of the individual. The national policy clearly defined that, apart from a small proportion of people, the majority of service users should be exposed to personalisation (Fisher *et al*., 2011). However, Clark *et al*. (2012) and Larsen *et al*. (2013) identified that a number of mental health professionals were reluctant to promote personalisation due to assumptions of incapacity.

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4.2.3. Barriers to Personalisation: System Perspective

Researchers are concerned that understanding of personalisation and related awareness of the concepts of independent living, choice and control as well as co-production are relatively limited among local authorities and practitioners. This results in improper delivery of personalisation and choice and control. Therefore, the bureaucratic nature of the social and healthcare policy forms a barrier for promoting personalisation. Newbigging and Lowe (2005) identified that The Care Programme Approach is a well established framework for mental health policy in the UK, where practitioners often complain about excessive paperwork. The lack of a clear process is therefore a barrier to the promotion of personalisation of mental health. To overcome this obstacle, there is a need to ensure a single streamlined process towards personalisation.

Priebe and Slade (2012) remarked that the lack of appropriate support in the form of market for services needed is a reason why service users and carers put off applying for personalised support. Duffy (2011) supported this view by indicating that the availability of staff is a main barrier to establishing effective care. It is also presented that a high turnover of staff is a major barrier to this approach. Spandler and Vick (2006) indicated that personal assistants were often unavailable for service users with mental ailments. This was due to the specialised nature of their needs apart from transport, assistance with daily activities and education.

Thornicroft *et al*. (2009) identified that mental distress is considered to be biologically rooted, and so the emphasis is on treatment with limited support for independence and recovery. Furthermore Taylor (2008) identified that the organisational culture

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and practice associated with mental health services is often identified to be risk averse. This leads to the obstacle of limited support from mental health professionals and organisations who are reluctant to let go of their control and support the innovative concept of self directed support.

Personalisation is only understood by social care services (Cestari *et al*., 2006). This is an obstacle as mental health services integrate health and social care. The lack of role clarity with respect to funding as well as care co-coordination is an obstacle which can be overcome by promoting integration of health and social care. Mental healthcare is supported by health services rather than social services in the UK (Richardson and Cotton, 2011). The personalisation approach is to be used only for social and personal care. This is a great obstacle in the field of mental health services. It may result in providing long term solutions with limited focus on reducing the root cause of the problem.

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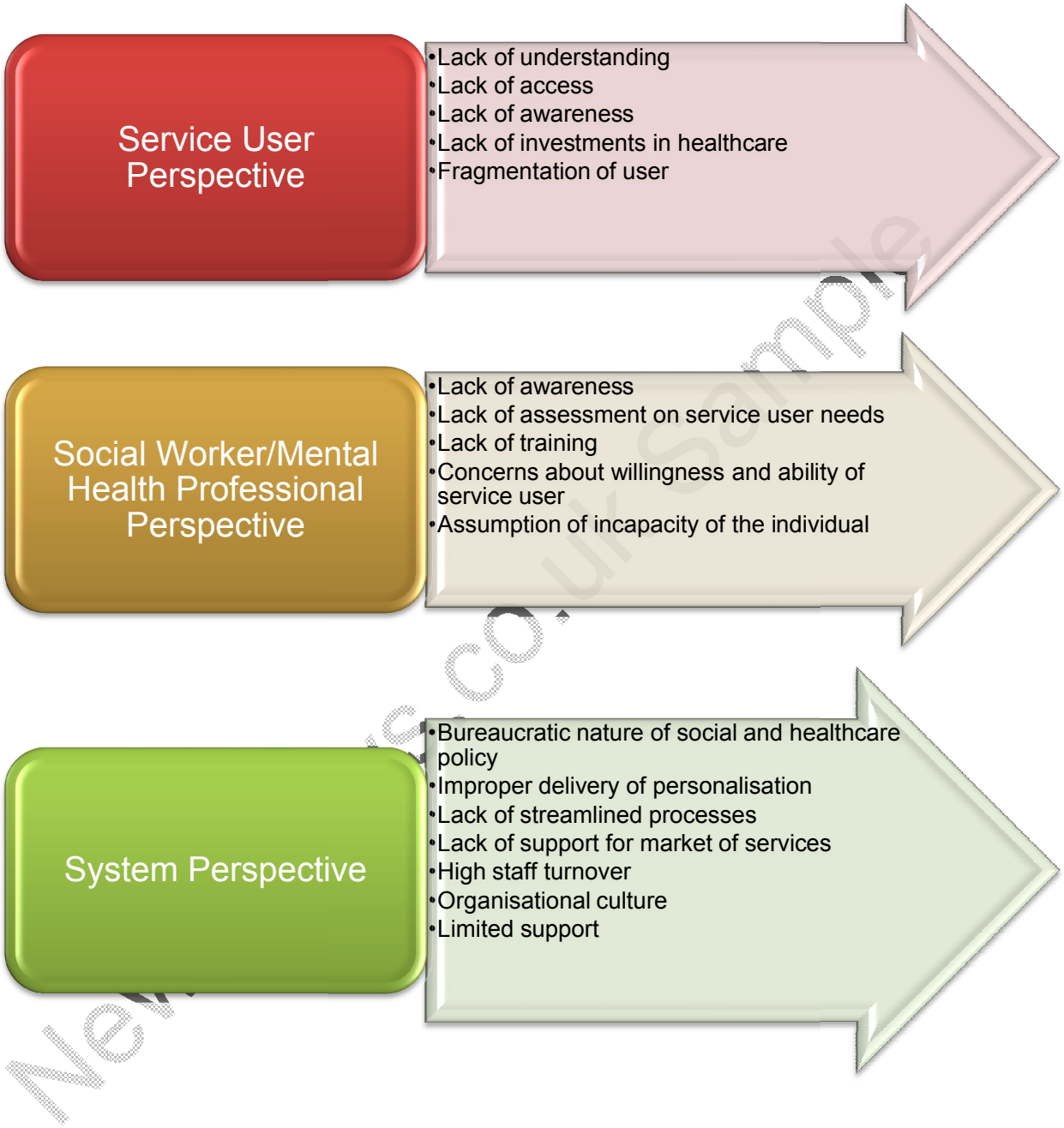
Figure 3: Barriers to Promotion of Personalisation in Mental Health (Source: Author, Current Study)



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4.3. Risks and Dilemmas Associated with Personalisation: A Mental Health Perspective

Any novel measure introduced in the context of social care should ensure that empowerment and protection are balanced. The services introduced should promote service user independent living as well as safeguarding. The recognition, negotiation and management of risks is important in the personal budgeting and self directed support process. Stalker (2003) and Mitchell and Glendinning (2007) identified that risk management dilemmas were inherent to the community social work process, even before the dawn of personalisation. Johnson *et al*. (2010) indicated that abuse and neglect in hospitals and institutional settings were the primary reasons for the promotion of independent living and personalisation. The risks associated with the implementation of personalisation are considered from the viewpoints of the individual service user, carers and social workers, and finally from the perspective of the social care system as a whole.

4.3.1. Risks: Service User Perspective

Glendinning *et al*. (2008) evaluated the need for individual budget pilot programmes and identified a number of risks which the service users may face by adoption of personalisation programmes, including vulnerability, technological complexity and asymmetric information availability.

Vulnerability is an important risk which needs to be examined from the context of mental health illness. Green *et al*. (2003) propagated that service users who suffer from mental health issues are often vulnerable and may be unable to take key

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decisions. Similarly, Gilburt *et al*. (2008) presented that a number of service users who suffer from mental health illness are unable to recognise and respond when their needs are found to change. Therefore it is to be examined if the adoption of personalisation will ensure effective articulation of the needs of these service users.

Another important risk to be examined is the level of technological complexity associated with the implementation of the process. The social care structure is a well thought of and established framework wherein the promoted services are often clear only to skilled professionals (Corrigan *et al*., 2004). Duffy (2010) proposed that service users with mental health issues may not be completely aware of the different measures by which their personalised budgets and direct payments can be used to improve their living conditions.

Asymmetric information is another risk which is to be confronted by service users who have mental health issues. Spandler and Vick (2006) propagated that unscrupulous providers who have better knowledge on the promotion of personalisation can take advantage of the individuals.

When examined from the context of service users with mental health issues, it becomes vital to identify if they are qualified to use their individual budgets in an appropriate manner. Duffy (2010) identified that inappropriate and unproductive use of individual budgets is a major concern among policy makers with respect to personalisation of mental healthcare. Furthermore, the ability of the service users to hire suitable workers to take care of their needs comes into question. This may stem from physical and financial abuse at the hands of unscrupulous family members or other service providers who pressurise the service user.

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According to Taylor (2008), policy reforms are associated with the identification of collective experiences. It is understood that the adoption of personalisation as a method of funding social care may lead to individual complaints. The lack of collective "voices" may delay any policy reforms which may be implemented.

4.3.2. Risks: System Perspective

Ferguson (2007), on examination of user choice and control, identified a number of risks associated with the process. These include the inability of personalisation to concretely address issues of poverty and inequality, de-professionalisation of the role of social work, and the associated stigmatic views of dependence on welfare. These views identify the risks of personalisation in general and a number of authors like Holloway (2012) and Fulford (2011) feel that the views of Ferguson are extreme and that effective risk management and safeguarding will help in the promotion of personalisation. When examined from the context of mental health, it is observed that these risks may be minimal. Duffy (2010) proposed that a number of service users with mental health issues look to their carers and social workers to participate in their decision making processes, thereby reducing the risk of de-professionalisation of social work or the associated stigma.

Newman *et al*. (2008) examined the transformation of social care and welfare governance and identified significant risks associated with personalisation. They felt that, despite the individual nature and focus of social spending, management of finite public resources and the related responsibility with respect to maximisation of efficiency lies with the care managers. Another risk identified by the authors is the competition among service users for limited resources. An example of this when

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applied in the context of service users with mental health issues includes limited availability of personal assistants (Duffy, 2010).

Another important risk faced by the system with respect to personalisation in the context of mental health is brokerage and monopoly of power. The personalisation process promotes independent choice by the service user. If the service users with mental health issues chose a particular system due to brokerage or monopolisation, then a few agencies would receive increased support with others suffering (Heslop, 2007).

Another dilemma which has been raised by a number of authors includes issues of accountability (Duffy, 2010; Needham, 2009). When the budgets are allocated on a "block" basis, justification of spending is easier. However, the ability to promote accountability by using personalisation is a major risk to be addressed.

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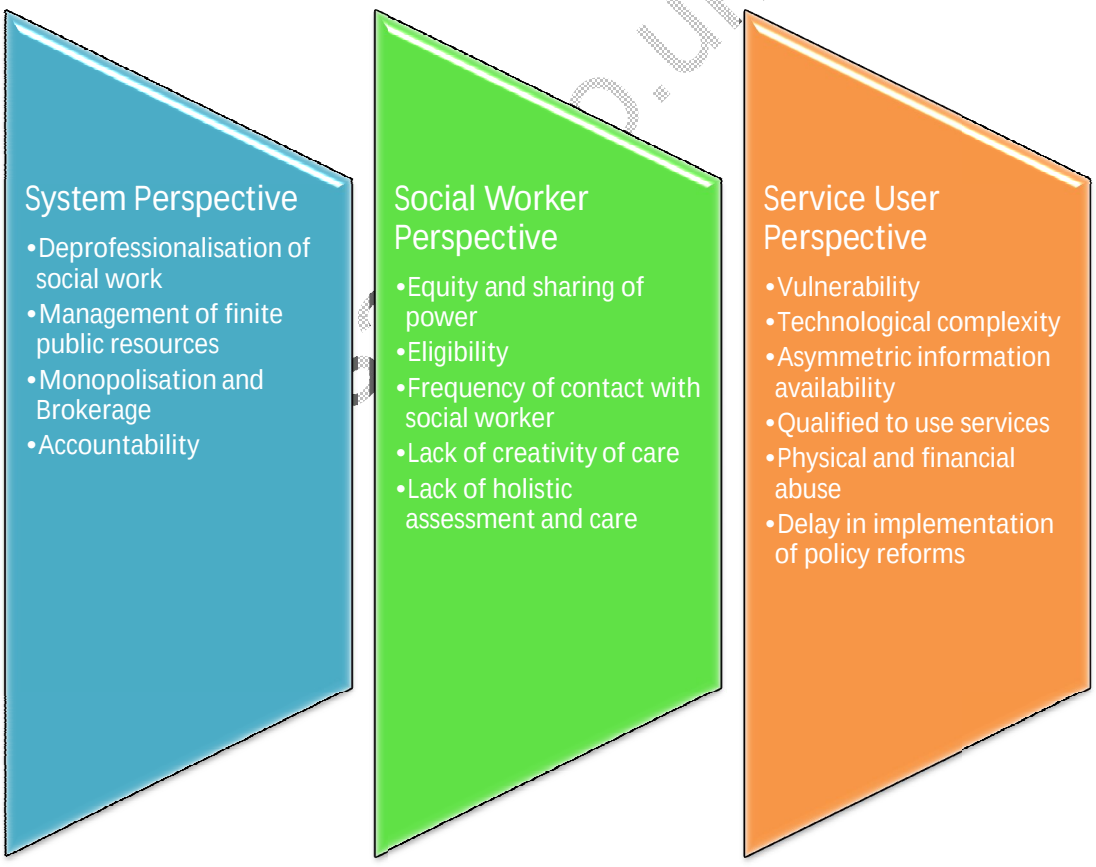
4.3.3. Risks: Social Worker/Professional Perspective

Glendinning *et al*. (2008) presented the implications for carers with respect to personalisation. Their study indicated that the Individual Budget (IB) projects did not take into account the potential risks faced by carers in the adoption of IBs for service users, as they have to ensure continuance of service provision to the service users.

Spandler (2007) identified that professionals raised concerns with respect to equity and sharing of power. Furthermore, issues with respect to eligibility and capability to manage direct payments are also identified. The report by Huslop (2007) identified that a number of social workers worry that the adoption of personalisation will reduce the frequency of contact that people with mental health issues have with

professionals. This is an important risk to be assessed as well as safeguarded. Furthermore, Taylor (2008) identified that the lack of direct involvement of a social worker in the process of recovery of service users with mental health issues leads to decreased support with respect to creativity and unfeasibility of holistic assessment and care. The following Figure 4 summarises the risks associated with personalisation of social care from the perspective of mental health.

Figure 4: Risks Associated with Personalisation of Mental Health (Source, Author, Current Study)



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4.4. Conclusion

This chapter has collected and thematically organised the risks and barriers associated with implementation of personalisation in mental health initiatives. The following chapter will present the implications of these findings and the associated recommendations.

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Chapter Five: Conclusion

5.1. Introduction

This chapter concludes the dissertation by providing implications, associated recommendations, limitations and the future outlook for personalisation.

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5.2. Implications and Associated Recommendations

The implications of the study are presented at three different levels.

5.2.1. System Level

The system level identifies how the entire system of social care should respond to the challenges of providing choice and control on the front line. This is promoted by providing services for service users, practitioners and carers. The following key implications are arrived at.

1. Personalisation and adult safeguarding: The examination of the barriers and risks identified that, despite the person centered and empowering nature of personalisation, there is a mismatch between personalisation and safeguarding. Research findings in Chapter Four indicate that systems of social care and health care are not integrated and that the presence of fragmented guidelines creates obstacles and negative risks towards implementation of effective personal budgets.

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2. Systems barriers and risk averse practices: The study findings provide evidence of the promotion of risk avoidant defensive practices among practioners and mental health professionals. This is carried out in order to protect the organisation from risks related to financial factors and reputational factors. This has resulted in a decrease in attention given to the promotion of choice and control.

3. Organisational systems change: The results also provide empirical evidences that the organisational culture is still dependent on brokerage and monopoly of power. This, accompanied by the increasing focus on accountability and limited support for streamlined processes, has affected the degree of choice and control given to mental health service users.

From the above implications, the following recommendations, which can be implemented at a systems level, are identified:

- Firming up of protection policies for the mentally ill.
- Identification of risk factors of abuse and measures to overcome the same.
- Integrated approach including assessment of knowledge, technical and financial barriers as well as risk assessment to promote safeguarding.
- Promote leadership and management across all local and national mental health service organisations

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5.2.2. Social Worker/Mental Health Professional Level

The mental health professional level relates to how front line employees manage the provision of choice and control for service users afflicted with mental illness. This includes measures of decision making with respect to overcoming barriers and understanding associated risks.

1. Empowerment and intervention: From the research findings it is clear that there is a lack of awareness and understanding of measures to manage obstacles and overcome risks. It is understood that the mental health professionals do not possess the necessary training to assess the needs of the mental health users. Despite their best intentions in relation to the willingness and ability of the individuals, mental health professionals are often unable to identify the correct balance between empowerment and intervention. There is increased conflict between accountability of resources and professional advocacy, resulting in these healthcare professionals finding themselves as frontline gatekeepers.

2. Relationship based working: The increased use of personalisation can lead to the risk of a decrease in activity between the professional and the service user. It is understood that the relationship between the worker and the service user is most important in improving the health status of mental health patients. A number of professionals feel that this may become eroded due to the increased use of personalisation.

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3. Training and awareness: The research findings indicate that there is limited training and awareness among staff with respect to the personalisation schemes. There are risks of systemic abuse of mental health service users, which may be due to lack of knowledge on unsafe practices.

4. Definition of risk: Mental health professionals face difficulties with respect to the definition of risk and danger. It is understood that there are no separate definitions of risk promoted for separate groups of mental health users. This indicates a lack of awareness on a systemic level about the unique and individual nature of these service users.

From the above implications the following recommendations, which can be implemented at a professional level, are identified:

- Promote training and organisation across all levels of social and health services on personalisation measures.
- Ensure that risks associated with personalisation are defined for service users who suffer from mental health issues.
- Ensure that awareness is promoted with respect to unsafe practices.
- Identify measures to promote interaction between the professional and the service user even after the personalisation process is implemented.

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5.2.3. Service user level

These implications relate to how people use mental health social care services and experience choice and control related to the personalisation process.

1. Lack of knowledge: The results have shown that a number of mental health service users are unaware of the benefits, barriers and challenges of personalisation. In relation to promoting safety, there are limited efforts undertaken that ensure that dignity, autonomy and independence are promoted.

2. Empowerment and feeling safe: The deployment of social care and support by mental health service users can affect the vulnerability of the group. The research indicates the need to ensure consistent channels of communication in order to provide information about various measures which can be undertaken to improve their quality of life.

From the above implications, the following recommendations, which can be implemented at a service user level, are identified:

- Ensure that information, options and mediations are provided.
- Ensure that the service users/carers are given the choice to take their own decisions.
- Discuss the associated risks and obstacles by presenting all options in care management.

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- Ensure that the safety of the service users is a priority and safeguard their interests

*(Space reduced)*The following framework is suggested by the researcher to overcome the risks and obstacles of personalisation.

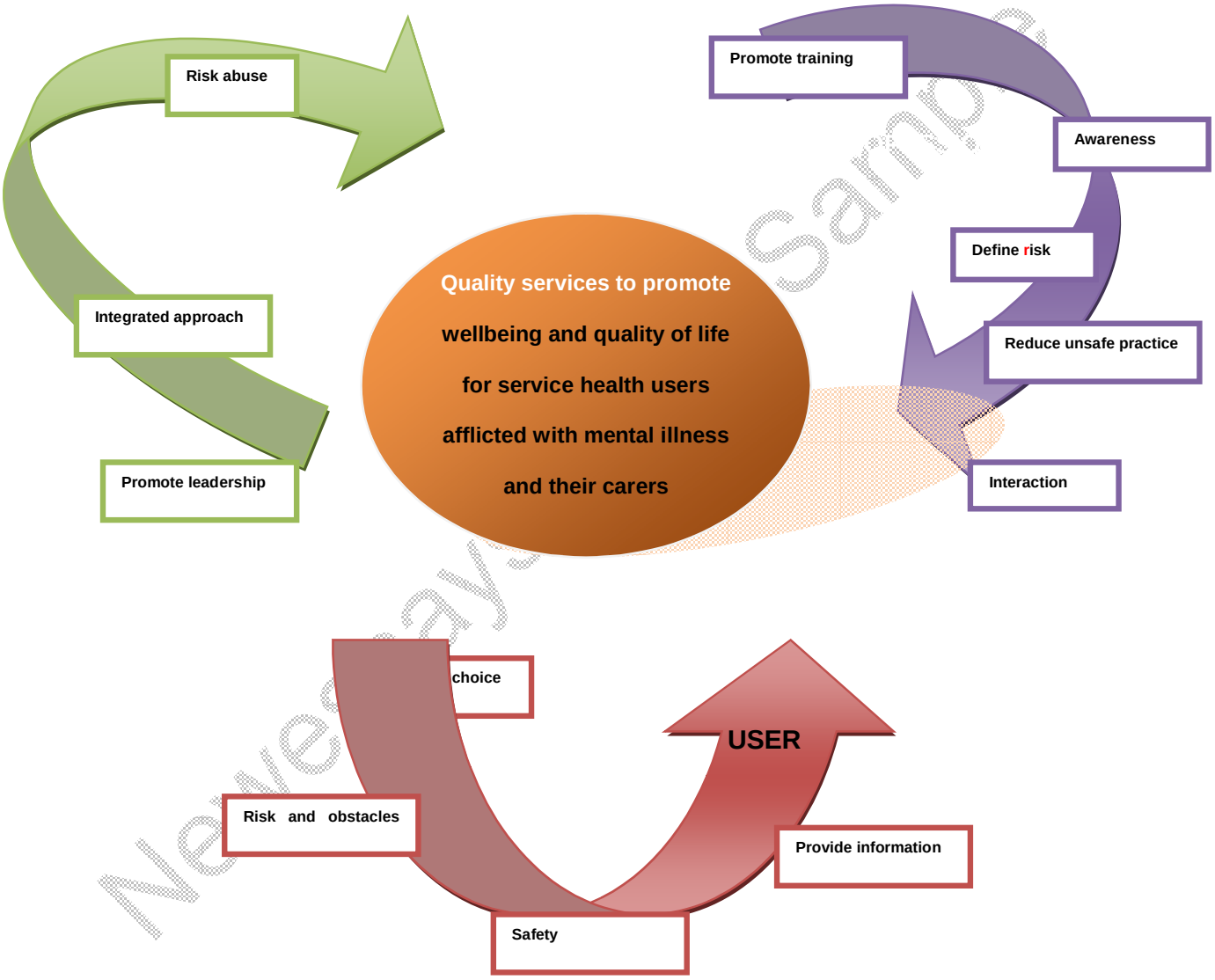

Figure 5: Recommendations to Promote Personalisation in Mental Health (Source: Author, Current Study)

5.3. Limitations of the Study

This study has adopted a purely qualitative approach wherein literature on personalisation and its impact on service users afflicted with mental health issues has been examined. It is acknowledged that the quantitative approach examining statistical trends with respect to knowledge, risk, accountability and safeguarding may help understand the growth of personalisation as a policy measure.

The study has examined only secondary published data to arrive at the implications of personalisation for mental health. It is to be acknowledged that a personal data collection measure (e.g., a semi-structured interview) will provide information on the current views of different stakeholders and thereby provide a different set of implications.

5.4. Conclusion: The Future of Personalisation and Mental Health

It can be concluded that the challenges associated with the promotion of the "personalisation agenda" in the mental health framework should not be underestimated. The future of personalisation in this field requires a visionary approach, which promotes practical and energetic measures across different segments of the social and health care system, in order to ensure that beneficial outcomes are identified for service users afflicted with mental disorders. The future of personalisation measures holds the need for a paradigm shift in theory and practice at a systemic, professional and service user level. Personalisation is truly a radical measure in UK social care policy, which, if provided with careful consideration, will help in the recovery of service users with mental afflictions.

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It is expected that the promotion of effective risk management measures along with a strategic and operational leadership will slowly create new collaborations to promote personalisation. These measures will overcome obstacles and will be grounded in the building of relationships, development of shared values and collective inputs towards the empowerment of people with mental health issues.

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References

Alakeson, V. (2008). Let patients control the purse strings. British Medical Journal, 336 (7648), 807-809.

Bartnik, E., Coulson, S., & Cox, J. (2007). *Co-production and personalisation in social care: changing relationships in the provision of social care* (Vol. 49). S. Hunter, & P. Ritchie (Eds.). Jessica Kingsley Publishers.

Beresford, P. (2008). Whose personalisation. *Soundings*, *40*(1), 8-17.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK Systematic review. *The British Journal of Psychiatry*,*182*(2), 105-116.

Bird, A., & Wooster, E. (2008, September – October). Personalise this! Openmind, 153, 6-9.

Bovaird, T., & Davies, R. (2011). Outcome-Based Service Commissioning and Delivery: Does it make a Difference?. *Research in Public Policy Analysis and Management*, *21*, 93-114.

Boxall, K., Dowson, S., & Beresford, P. (2009). Selling individual budgets, choice and control: Local and global influences on UK social care policy for people with learning difficulties. *Policy & Politics*, *37*(4), 499-515.

Braye, S., & Preston-Shoot, M. (2010). *Practising social work law*. Palgrave Macmillan.

Bryman, A. (2012). *Social research methods*. OUP Oxford.

Bryman, A., and Bell, E. (2007). *Business research methods*. Oxford University Press: USA.

Bryman, A., and Cramer, D. (2011). *Quantitative data analysis with IBM SPSS Statistics 17, 18 and 19: A guide for social scientists.* Routledge. New York.

Cambridge, P., Forrester-Jones, R., Carpenter, J., Tate, A., Knapp, M., Beecham, J., & Hallam, A. (2005). The state of care management in learning disability and mental health services 12 years into community care. *British Journal of Social Work*, *35*(7), 1039-1062.

Campbell, J. and Oliver, M. (1996). *Disability Politics: Understanding Our Past, Shaping Our Future.* London: Routledge.

Carr, S. (2010). *Personalisation: a rough guide (revised edition*). London: Social Care Institute for Excellence.

Cestari, L., Munroe, M., Evans, S., Smith, A., & Huxley, P. (2006). Fair access to care services (FACS): implementation in the mental health context of the UK. *Health & Social Care in the Community*, *14*(6), 474-481.

Chang, C. K., Hayes, R. D., Perera, G., Broadbent, M. T., Fernandes, A. C., Lee, W. E., ... & Stewart, R. (2011). Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. *PloS one*, *6*(5), e19590.

Clark, D., Field, S., & Layard, R. (2012). Mental health loses out in the National Health Service. *The Lancet*, *379*(9834), 2315-2316.

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R., Daar, A. S., ... & Walport, M. (2011). Grand challenges in global mental health. *Nature*,*475*(7354), 27-30.

Collins, S. (2008). Statutory social workers: stress, job satisfaction, coping, social support and individual differences. *British Journal of Social Work*,*38*(6), 1173-1193.

Commission for Social Care Inspection (CSCI) (2008). *The State of Social Care in England 2006–2007*. London: CSCI.

Cooper, H., Hedges, L. V., & Valentine, J. C. (2009). *Handbook of research synthesis and meta-analysis*. Russell Sage Foundation.

Coppock V, & Dunn. J. (2010) Understanding Social Work Practice in Mental Health. Sage: London.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, *30*(3), 481-491.

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: SAGE Publications, Incorporated.

Dahlgren, G. (2008). Neoliberal Reforms in Swedish Primary Health Care: For Whom and for What Purpose?. *International Journal of Health Services*,*38*(4), 697-715.

Danis, M.Z., Karatas, K., Sahin, M.C. (2008). Reflections of neoliberal policies on healthcare field and social work practices. *World Applied Sciences Journal*, 5(2), 224-235.

Newessays.co.uk Sample

Davey, V., Fernández, J. L., Knapp, M., Vick, N., Jolly, D., Swift, P., ... & Priestley, M. (2007). Direct payments: a national survey of direct payments policy and practice.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The SAGE handbook of qualitative research*. SAGE Publications, Incorporated.

Department of Health. (2005). *Independence, well-being and choice*. London: Author.

Department of Health. (2006). *Our health, our care, our say: A new direction for community services*. London: Author.

Department of Health (2007) *Putting People First: A shared vision and commitment to the transformation of adult social care.* London: DH.

Department of Health (2008) *Code of practice, Mental Health Act 1983 – REVISED 2008*. London: The Stationery Office.

Dixon, J. (2004). Payment by results—new financial flows in the NHS: The risks are large but may be worth while because of potential gains. *BMJ: British Medical Journal*, *328*(7446), 969.

Duffy, S. (2007). Care management and self-directed support. *Journal of Integrated Care*, 15(5), 3-14.

Duffy, S. (2010). Personalisation in Mental Health. *Sheffield, The Centre for Welfare Reform*.

Duffy, S. (2011). Personalisation in social care–what does it really mean?.*Social Care and Neurodisability*, *2*(4), 186-194.

Newessays.co.uk Sample

Dunston, R., Lee, A., Boud, D., Brodie, P., & Chiarella, M. (2009). Co-Production and Health System Reform–From Re-Imagining To Re-Making.*Australian Journal of Public Administration*, *68*(1), 39-52.

Eaton J., McCay L., Semrau M., Chatterjee S., Baingana F., Araya R.,. . . Saxena S.(2011). Scale up of services for mental health in low-income and middle-income countries. Lancet, 378, 1592–1603.

Ezeonu, I. (2008). Crimes of globalization: health care, HIV and the poverty of neoliberalism in Sub-Saharan Africa. *International Journal of Social Inquiry*, 1(2), 113-134.

Ferguson, I. (2007). Increasing user choice or privatizing risk? The antinomies of personalization. *British Journal of Social Work*, *37*(3), 387-403.

Ferguson, I. (2012). Personalisation, social justice and social work: a reply to Simon Duffy. *Journal of Social Work Practice*, *26*(1), 55-73.

Fisher, J., Rayner, M., & Baines, S. (2011). Personalisation of social care and health: a co-operative solution. *Manchester: MMU, Faculty of Health, Psychology and Social Change*.

Fledderus, M., Bohlmeijer, E. T., Smit, F., & Westerhof, G. J. (2010). Mental health promotion as a new goal in public mental health care: A randomized controlled trial of an intervention enhancing psychological flexibility.*American journal of public health*, *100*(12), 2372.

Fulford, B. K., & Woodbridge, K. (2007). Values-based practice: help and healing within a shared theology of diversity. *Spirituality, Values and Mental Health: Jewels for the Journey*, 45.

Fulford, K. W. M. (2011). Bringing together values-based and evidence-based medicine: UK Department of Health Initiatives in the 'Personalization'of Care. *Journal of evaluation in clinical practice*, *17*(2), 341-343.

Garrett, D., & Garrett, R. (2012). Personalisation: why is personalisation important in health and social care?. *Nursing older people*, *24*(9), 12.

Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*,*8*(1), 92.

Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., ... & Wilberforce, M. (2008). Evaluation of the individual budgets pilot programme. *Final Report. York: Social Policy Research Unit, University of York*.

Gould, N. (2006). An inclusive approach to knowledge for mental health social work practice and policy. *British Journal of Social Work*, *36*(1), 109-125.

Graham, H. L. (2010). Severe mental health and substance use: developing integrated services–a UK perspective. *Developing Mental Health-Substance Use*, 62.

Green, G., Hayes, C., DICKINSON, D., Whittaker, A., & Gilheany, B. (2003). A mental health service users perspective to stigmatisation. *Journal of Mental Health*, *12*(3), 223-234.

Henwood, M., & Hudson, B. (2008). Individual Budgets and Personalisation: A New Model for Integration?. *Journal of Integrated Care*,*16*(3), 8-16.

Heslop P. (2007). *Direct Payments for Mental Health Service Users and Survivors* (revised edition). NCIL.

Heslop Pauline, Williams Val & Spandler Helen(2009). Personalisation in mental health:A review of the evidence. MIND Report. [Online], Available at, http://www.mind.org.uk/assets/0000/2164/putting_us_first_personalisation.pdf

(Accessed on 23rd May, 2013)

Holloway, F. (2012). The Health and Social Care Act 2012: what will it mean for mental health services in England?. *The Psychiatrist*, *36*(11), 401-403.

Hurstfield, J., Parashar, U., & Schofield, K. (2007). *The costs and benefits of independent living*. Office for Disability Issues.

Institute of Medicine. (2010). *Promoting cardiovascular health in the developing world: A critical challenge to achieve global health*. Washington, DC: National Academies Press.

Janes, C. R., Chuluundorj, O., Hilliard, C. E., Rak, K., Janchiv, K. (2006). Poor medicine for poor people? Assessing the impact of neoliberal reform on health care equity in a post-socialist context. *Glob Public Health*, 1(1), 5-30.

Johnson, F., Hogg, J., & Daniel, B. (2010). Abuse and protection issues across the lifespan: reviewing the literature. Social Policy and Society, 9(2), 291-304.

Knapp, M, McDaid, D and Parsonage, M (2011) *Mental health promotion and mental illness prevention: the economic case.* 15972. Department of Health, London, UK.

www.essays.co.uk Sample

Kobau, R., Seligman, M. E., Peterson, C., Diener, E., Zack, M. M., Chapman, D., & Thompson, W. (2011). Mental health promotion in public health: Perspectives and strategies from positive psychology. *Journal Information*,*101*(8).

Larsen, J., Ainsworth, E., Harrop, C., Patterson, S., Hamilton, S., Szymczynska, P., ... & Pinfold, V. (2013). Implementing personalisation for people with mental health problems: A comparative case study of four local authorities in England. *Journal of Mental Health*, 1-9.

Levin, E. (2004). *Involving service users and carers in social work education*. London: SCIE.

Littlechild, R. (2009). *Direct payments and personal budgets: putting personalisation into practice*. Policy Pr.

Lymbery, M. (2012). Social work and personalisation. British Journal of Social Work, 42(4), 783-792.

Lyon, J. (2005). A systems approach to direct payments: a response to 'Friend or foe? Towards a critical assessment of direct payments'. *Critical Social Policy*, *25*(2), 240-252.

Manthorpe, J., Moriarty, J., Stevens, M., Hussein, S., & Sharif, N. (2012). Promoting the mental well-being of older people from black and minority ethnic communities in United Kingdom rural areas: Findings from an interview study. *Journal of Rural Studies*, *28*(4), 406-411.

Manthorpe, J., Stevens, M., Rapaport, J., Harris, J., Jacobs, S., Challis, D., ... & Glendinning, C. (2009). Safeguarding and system change: Early perceptions of the

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implications for adult protection services of the English individual budgets pilots—a qualitative study. *British Journal of Social Work*,*39*(8), 1465-1480.

Manthorpe, J., Stevens, M., Rapaport, J., Jacobs, S., Challis, D., Wilberforce, M., ... & Glendinning, C. (2010). Gearing up for personalisation: training activities commissioned in the English pilot individual budgets sites 2006–2008. *Social work education*, *29*(3), 319-331.

Marlow, C. (2010). *Research methods for generalist social work*. Brooks/Cole.

Martinez, E. & Garcia, A. (2001). What is neoliberalism? [Online] Available at: www.corpwatch.org/article.php [Accessed 25th April 2013].

Minkler, M., & Wallerstein, N. (Eds.). (2010). *Community-based participatory research for health: From process to outcomes*. Jossey-Bass.

Mitchell, W. and Glendinning, C. (2007) *A review of the research evidence surrounding risk perceptions, risk management strategies and their consequences in adult social care for different groups of service users*. Working Paper No DHR 2180 01.07, York: Social Policy Research Unit, University of York

Needham, C. (2009). SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation. *policing*, *8*, 11.

Needham, C., & Tizard, J. (2010). Commissioning for personalization: from the fringes to the mainstream. *London: Public Management and Policy Association*.

Newbigging K. and Lowe J. (2005). *Direct payments and mental health: New directions*. JRF and Pavilion. [Online], Available at,

www.jrf.org.uk/publications/implementing-direct-payments-mentalhealth (Accessed on 23rd May, 2013)

Newbronner, L., Chamberlain, R., Bosanquet, K., Bartlett, C., Sass, B., & Glendinning, C. (2011). Keeping Personal Budgets Personal: Learning from the experiences of older people, people with mental health problems and their carers. Research Report. Adults' Services Report, 40 . Social Care Institute for Excellence , London.

Newman, J., Glendinning, C., & Hughes, M. (2008). Beyond modernisation? Social care and the transformation of welfare governance. *Journal of Social Policy*, *37*(4), 531-557.

NIMHE (2006). Community Engagement Project: Mental Health Programme. [Online], Available at,

http://webarchive.nationalarchives.gov.uk/20120505024741/http://www.help.northwest.nhs.uk/storage/library/community_engagement_Big_Life_Liverpool.pdf

(Accessed on 23rd May, 2013)

Priebe, S., & Slade, M. (2012). *Evidence in mental health care*. Routledge.

Pritchard, C. (2006). *Mental health social work: evidence-based practice*. Psychology Press.

Reeves W. C., Strine T. W., Pratt L. A., Thompson W., Ahluwalia I.,Dhingra S. S., . . . Safran M. A. (2011). Mental illness surveillance among adults in the United States. *Morbidity and Mortality Weekly Report*, 60, 1–32

Renshaw, C. (2008). Do self-assessment and self-directed support undermine traditional social work with disabled people?. *Disability & Society*, *23*(3), 283-286.

Richardson, A., & Cotton, R. (2011). No health without mental health: developing an outcomes based approach. *NHS Confederation, Mental Health Network, December, available at: www. nhsconfed. org/Publications/briefings/Pages/outcomes-based-approach. aspx (accessed 3 January 2012)*.

Ridley J. and Jones L. (2002). '*Direct what': a study of direct payments to mental health service users*. Scottish Executive Central Research Unit, Edinburgh

Roulstone, A., & Morgan, H. (2009). Neo-liberal individualism or self-directed support: Are we all speaking the same language on modernising adult social care. *Social Policy and Society*, *8*(3), 333-345.

Rubin, A., & Babbie, E. R. (2012). *Essential research methods for social work*. Brooks/Cole.

Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Service user, patient, client, user or survivor: describing recipients of mental health services. *The Psychiatrist*, *34*(1), 20-23.

Skuse, D. (2010). Mental health services in primary care. *International Psychiatry*, *7*(3).

Smith, J., Wood, J., & Elias, J. (2009). *Beyond Practice-based Commissioning: The local clinical partnership*. Nuffield Trust for Research and Policy Studies in Health Services.

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Spandler, H. (2007). From social exclusion to inclusion? A critique of the inclusion imperative in mental health. *Medical Sociology Online*, *2*(2), 3-16.

Spandler H. and Vick N. (2004) *Direct Payments, independent living and mental health.* Health and Social Care Advisory Service. [Online], Available at, www.hascas.org.uk/pdf_files/HASCAS%20Executive%20Summary2.pdf (Accessed on 23rd May, 2013)

Spandler H. and Vick N. (2005). Enabling access to direct payments: an exploration of care coordinators' decisionmaking practices. *Journal of Mental Health*, 14 (2): 145–55

Spandler, H., & Vick, N. (2006). Opportunities for independent living using direct payments in mental health. *Health & social care in the community*,*14*(2), 107-115.

Spencer, R., Phillips, M., & Williams, B. (2012). 7 Mental health and older people. *Practical Care Planning For Personalised Mental Health Care*, 130.

Stalker, K. (2003). Managing risk and uncertainty in social work a literature review. *Journal of Social Work*, *3*(2), 211-233.

Taylor, N. S. (2008). Obstacles and dilemmas in the delivery of direct payments to service users with poor mental health. *Practice*, *20*(1), 43-55.

The Social Exclusion Unit (2004). *Mental Health and Social Exclusion***.** Office of the Deputy Prime Minister, London

Thornicroft, G., Leff, J., Warner, R., Sartorius, N., & Schulze, H. (2009). Shunned: Discrimination against people with mental illness. *J Occup Psychol Employ Disabil*, *11*, 56-8.

Tyson, A. (2008). Self-Directed Support, Social Workers' Contribution.

Waitzkin, H., Jasso-Aguilar, R., & Iriart, C. (2007). Privatization of health services in less developed countries: an empirical response to the proposals of the World Bank and Wharton School. *International Journal of Health Services*, *37*(2), 205-227.

Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *Journal Information*, *100*(S1).

While, D., Bickley, H., Roscoe, A., Windfuhr, K., Rahman, S., Shaw, J., ... & Kapur, N. (2012). Implementation of mental health service recommendations in England and Wales and suicide rates, 1997–2006: a cross-sectional and before-and-after observational study. *The Lancet*,*379*(9820), 1005-1012.

Willis, M., & Bovaird, T. (2012). Commissioning for quality and outcomes.*Commissioning for Health and Well-Being: An Introduction*, 145.

World Health Organization. (2005, January). *Mental health: Facing the challenges, building solutions*. *Paper presented at the WHO European Ministerial Conference*,Helsinki, Finland.

World Health Organization. (2010). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. Geneva, Switzerland:Author.

World Health Organization. (2011). *Scaling up action against non-communicable diseases: How much will it cost?* Geneva, Switzerland: Author.


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