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How social work can contribute in the shift to personalised, recovery-oriented psycho-social disability support services

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Title: How social work can contribute in the shift to personalised, recovery oriented psychosocial disability support services

Abstract: This paper presents the findings from an Australian study in which forty-one people, who self-identified as having a psychosocial disability as a result of mental health problems, spoke about their priorities for treatment, care and support within a personalised funding context. The research enabled an improved understanding of the choices about support that people with psychosocial disabilities would make if offered individualised funding packages. Participant's prioritised specific supports to improve their health, financial situation, social connection, housing and personal relationships. A relationship with a support worker with a range of skills was identified as a key facilitator of these life goals, but people with psychosocial disabilities also valued opportunities to have discretionary funds to directly address the major problems they face including stigma, discrimination and poverty. The paper argues that social workers can potentially fill a range of roles and are well placed to work in partnership with people with psychosocial disabilities, having skills in co-production of services, negotiation and advocacy that are required if individual funding is to be maximised for user control, social justice and personal recovery outcomes.

Key words: psychosocial disability, personalisation, recovery, adult social work

Introduction:

This paper describes a research project that sought to enhance the understanding of the support needs and preferences of people with a psychosocial disability in the context of the significant changes to how mental health support services will be offered in the future in Australia. This field of research has become particularly important given the emerging emphasis on recovery orientation in service delivery and the shift to individualised, person-centred and consumer-directed approaches (or personalisation). The research supported a recovery oriented perspective that acknowledged people with psychosocial disability as being experts through lived experience and, therefore, needing a voice as mental health services prepare for individualised funding packages available

under the new Australian National Disability Insurance Scheme (NDIS). The findings indicate that people with psychosocial disability would allocate funding to a range of life goals related to health, finances, social connection, housing and personal relationships, as well as to the purchase of a range of support roles to assist them achieve these (Brophy, et al.2014). Social workers have the potential to fulfil a wide range of roles, including being directly employed by people with psychosocial disability, which well match their fundamental skill and knowledge base in working with people with psychosocial disability and their families and carers. The intersection between recovery, personalisation and social work are well identified. However, despite this theoretical and practice alignment there is little explicit discussion of the role of social workers in Australia's NDIS. This paper explores what this might be from the viewpoint of people with psychosocial disability. Valuing the perspective of people with lived experience will enhance the capacity of Social Workers to facilitate people with psychosocial disability benefiting from this significant transformation of non-clinical mental health support services in Australia.

Policy and practice contexts

People with psychosocial disabilities in Australia experience high levels of social isolation (Harvey and Brophy, 2011), poor physical health and decreased life expectancy (Fels, 2012) and greater disadvantage on measures of income, employment and housing when compared with those with physical or sensory disability (Kavanagh, *et al.*, 2015). Current service delivery is failing people with psychosocial disability and policy change toward a focus on personalisation and recovery is now occurring in Australia, following the lead of other countries.

There is emerging evidence to suggest that personalisation, or individualised allocations of government resources controlled by service users, delivers cost effective outcomes for people experiencing mental health problems (Webber, *et al.*, 2014), though the comparative cost effectiveness of personalisation approaches remains contested (Slasberg, *et al.*, 2012). However, to date, a focus on the outcomes and uses of individualised funding for people with psychosocial

disability has been minimal. An early evaluation of the introduction of Individual Budgets (IB) in the UK included a cohort of IB recipients with mental health problems (131 participants) and identified that this cohort achieved higher overall well-being outcomes than other cohorts, with authors noting that 'IBs offered a greater range and flexibility of support arrangements than were available for this group through standard services' (Glendinning, *et al.*, 2008a, p. 236). Similarly, a study of Individual Recovery Budgets with a small sample of people with mental health problems in England identified that funding was utilised for a wide range of recreational, leisure, educational and personal supports (Coyle, 2011). In this context, individual budgets are seen as a 'lever for change', providing creative and flexible opportunities for individuals where other funding sources were unavailable (Coyle, 2011, p.799).

In Australia, changes to mental health and disability policy are underpinned by the themes of recovery and personalisation. In particular, the National Disability Insurance Scheme (NDIS) Act (2013) has affirmed Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (United Nations, 2008) which requires action towards the independence and social and economic participation of people with disabilities. Like the CRPD, the NDIS shares a commitment to promoting and realising the human rights of people with disability, a key component of which is the removal of barriers to participating fully in social, economic and political spheres of life, including stigma and discrimination. The CRPD encourages law and policy that adopts a 'presumption of capacity' and increased opportunities for choice and control (McSherry, 2012).

The NDIS is an insurance scheme that provides three tiers of intervention offering all Australians reassurance that they would have access to disability support on a no fault basis (Fawcett and Plath, 2014). Bigby (2013) summarises the rationale for the NDIS as follows:

By offering an insurance model, the proposed reforms emphasised that early intervention, lifelong support matched to individual needs, and improved coordination across areas of the

life, as well as over the life course would be a more efficient and cost effective way to support people with disability. (p.1)

Tier Three is where most resources will be focused and this will enable individual budgets, for those eligible, to fund 'reasonable and necessary' supports (NDIS Act, 2013). It is estimated that this will include 60,000 people with psychosocial disability (Quinlan, 2014). Currently in Australia, most psychosocial disability support is provided by non-clinical community mental health support services (CMHSS) that are generally 'block funded' by the States; these include services such as individual outreach, centre based programs and residential services. While this varies across the States in Australia, in Victoria, the second largest state (where the present study took place), all current psychosocial disability, rehabilitation and support services in the non-clinical sector will be absorbed into the NDIS over the next few years leading to an end to block funding of programs and a shift to services relying on contributions from individual packages to operate. Hence there is an imperative to engage in service development and improvement that responds to the implications of consumer choice and control, and for mental health social workers, who form a large component of this workforce, to consider what they have to offer such a scheme (Fawcett and Plath, 2014).

This funding shift is one of a number of important current influences on service delivery in CMHSS in Australia. Another intersecting influence is the shift to recovery-oriented practice (Leamy, *et al.*, 2011). Personal recovery can be distinguished from clinical recovery in that its emphasis is on hope, empowerment and 'living with' mental illness rather than a sole focus on the relief from symptoms of illness (Slade, 2009). This change in emphasis has been supported by service users, social activists, mental health practitioners and policy makers who identify this approach as offering the potential for positive change in mental health service delivery

It has been argued that there is a positive intersection between the concepts of recovery and personalisation (Davidson, *et al.*, 2010; Coyle, 2011), recovery and social work (Carpenter, 2002) and

social work and personalisation (Lymbery, 2014; Ellis, 2014; Duffy, 2010). Duffy (2010) points out the important role that social work can play in such processes:

The technologies of personalisation simply are social work, social work in action; for what is social work if it is not the effort to develop, share and implement practices that promote social justice for people whose citizenship is threatened? (p.265)

Similarly, Glendinning *et al.* (2008b) identify that the significant changes to 'working culture, roles and responsibilities' required by the implementation of individual budgets are understood by many practitioners as a 'reinvigoration' of social work roles and values, '... the opportunity to work with people to identify a wider range of goals and aspirations, and to develop support plans to achieve them' (p. 35). Duffy (2010) also concurs that social workers are well equipped to engage positively with personalisation:

Social workers cannot afford to be cynics. Social workers have a better understanding than most of the enormous difficulties that assail millions in our society today. Social workers also have to believe in the power of people to bring about positive change in their own lives and in the lives of those they love. Social workers must, in order to live up to their responsibilities, embrace the technologies of personalisation and find ways to make them work — and improve them when they break. (p.265-266)

However, beyond the broad rhetoric of alignment between social work values and skills with the intent of personalisation, more explicit discussion of the role of social workers within the NDIS is required. As in the UK, social workers may find themselves in the role of 'care co-ordinators', resource allocators, planners and advocates. Glendinning *et al.* (2008)'s study identifies a range of issues and concerns from and about social workers within the personalisation pilot sites, including a concern that their role would contract to 'crisis work, safeguarding and high-end complex casework' (Glendinning *et al.*, 2008b, p.35). Within Australia, social workers represent at least 24% of the

CMHSS workforce in Australia and this is likely to be an underestimation because many are also in management and other leadership roles (National Health Workforce Planning and Research Collaboration, 2011). Also many social workers are employed in clinical mental health services and their roles intersect with those in the CMHSS. With the absorption of non clinical mental health funding into the NDIS, many of these roles will necessarily change, even cease. This set of issues poses many opportunities and challenges for social workers, not least understanding the possibilities of their role in this new system. This study offers the perspectives of people with psychosocial disability about the uses to which they would put their individual budget, and the types of support and support personnel they value. This information offers social workers ways to shape and orient their roles within the NDIS or other personalisation and recovery contexts.

Methodology

Personalisation and recovery oriented practice both begin with respect for lived experience of service users and fundamental principles that include empowerment (Leamy *et al.*, 2011). These notions, and particularly the recovery paradigm, are also influencing mental health research (Davidson *et al.*, 2010; Slade, 2009). According to Davidson *et al.* (2010):

These methods require a collaborative approach to involving people with experience of the phenomena of focus to participate as partners throughout all stages of a study. (p.101-102)

The current study sought to implement recovery focused principles through its research design. In particular, the research included community engagement and participatory research methods and tools to enable the active role of people likely to be impacted by the research and its findings. This research also involved two of the paper authors as consumer (or service user) co-researchers. The consumer co-researchers actively participated at different points in the life of the project. Initially they contributed to the development of the project, the research questions and project design. They

also participated in interviews with participants, assisted in data analysis and in the dissemination of research findings, including presentations at two consumer reference groups.

The project was conducted in the Barwon region of Victoria, a launch site for the NDIS. It is estimated that 691 persons aged 18 to 65 years in this region have a severe and persistent mental illness with complex needs (Department of Health, 2012). Convenience sampling was used across a number of CMHSS within the Barwon region to assist in increasing the scope and range of participants with varying levels of need. It was expected that convenience sampling would allow recruitment of approximately five to ten participants per service, or approximately 50 participants. Although this sampling method was not designed for the recruitment of a representative sample it was anticipated that those who did participate would reflect the range of people with psychosocial disability currently accessing mental health services that were likely to be eligible for NDIS in the Barwon region. Participants were required to be residents of the Barwon region, aged 26-65 years (the age range for adult tier three services in the NDIS), agree they had psychosocial disability and accessing local mental health service providers because of these issues. To enable recruitment, the research team members visited the participating services and their activities, such as community meetings, to build rapport with service users and staff over a two-month period in 2013. Service users were provided with an information flyer and the opportunity to ask the researcher any questions they had about the research before opting in to participate. Dual contact with both staff and service users enabled the potential participant to be assisted by, but not dependent on, their support personnel in making their decision to participate. A final 41 people who met the criteria consented to participate in the project.

The research utilised a mixed method approach that enabled the integration of quantitative and qualitative data collection and analysis (Creswell, *et al.*, 2004). Individual interviews were audio recorded and incorporated a survey method that used closed questions to provide numerical data that could be subject to basic statistical analysis, as well as open ended questions to provide text

data that, via a process of thematic analysis, enabled greater insight into patterns in the data and how participants think about their priorities for a good life and supports needed to achieve these.

The interview involved:

- Demographic questions
- Questions related to having a psychosocial disability, its impact, and forecast fluctuations
- Exploring participants' good life goals and aspirations
- Exploring preferences for allocating individualised funding to identified supports and how they would prioritise these supports
- Identifying what (if any) decision-making assistance might be needed.

The schedule used in the interviews was collaboratively developed through the input of a local advisory group and consultations with consumer reference groups. Talking to people about what having a good life means to them is linked to helping people use their imagination, not just their past experience, to think about what is important to them and, subsequently, their formal and informal support needs and preferences (Felder, 2013). Asking about a good life facilitates discussion about what people want. This contrasts with having conversations about needs and goals structured around current service provision. Participatory research tools were also used, including prompt cards that had visual images and small amounts of text to help people think about their 'top' life goals. Fourteen good life areas were used and based on concepts identified in recovery literature (Leamy, *et al.*, 2011; Onken, *et al.*, 2007; Provencher and Keyes, 2011; Davidson *et al.*, 2010) and in the flourishing life and positive psychology literature (Keyes and Haidt, 2007). After providing a general response about what a good life meant to them, participants were asked to identify their top five life areas or goals/aspirations. Also a 'ten seeds' technique was used that allowed people to have a visual and hands-on approach to how they might allocate a funding package across the life goals they prioritised in the early part of the interview (Jayakaran, 2002).

Data was sorted into two main data sets: 1. data from all 41 participants; 2. data from a sub-set of 15 participants. Both data sets underwent targeted analysis. Data set 1 (n = 41) was used to quantitatively analyse all suitable data across the whole cohort to present descriptive statistics on all appropriate items, particularly focusing on demographic items, frequency analysis of good life areas prioritised by participants, and percentage of funding allocated to these areas. These are presented as percentages. Data set 2 (n = 15) purposively selected fifteen participant interviews for in-depth thematic analysis. Interviews were selected (from data set 1) for gender balance, age range and to include the two types of interviewer (both consumer co-researcher and academic researcher led interviews). The primary purpose of the targeted analysis of data set 2 was to enable exploration of meanings and patterns within the data about the core phenomena of interest such as the elements of a good life, the nature of supports to be purchased, and views on the need for support with decision making. These multiple data sources and mixed methods allowed for triangulation of data analysis (Ostlund, *et al.*, 2011). The fifteen selected interviews were transcribed in full and managed in Nvivo 10 (QSR International, 2013). A general inductive approach was taken to the analysis (Thomas, 2006). This involved developing an initial coding frame using *a priori* codes for qualitative analysis based on the top five life goals as nominated by all 41 participants. Using this initial coding frame, analysis was conducted by two researchers, including one consumer co-researcher, of five interviews with a focus on developing a more in depth understanding of meaning attached to codes such as “health”. The same interviews were also analysed using an open coding approach by the chief investigator and the other consumer co-researcher. This enabled team reflection and discussion and further development of the coding frame. Finally, the chief investigator coded the remaining 10 transcribed interviews utilising the final coding frame. This qualitative analysis process enabled themes to emerge and to be contextualised by their supporting sub-themes. Use of multiple researchers enabled cross-checking of coding and themes to ensure the analysis was credible and reliable.

Ethics approval was sought and obtained from the University of Melbourne Human Research Ethics Committee and the Barwon Health Human Research Ethics Committee. All participants provided written consent.

Research Findings

Demographics

Overall, participants in this project broadly reflected many of the common characteristics of people living with psychosocial disability (Table 1). Participants were aged between 27 and 63 years. A large proportion of participants lived either alone or in supported residential services, in poverty and experienced social isolation. Around half had been excluded from completing high school. Although around one third had a post-school certificate or diploma, many participants reported that they had completed this higher training through supported employment agencies, but not all participants were using these new skills, particularly as demonstrated by a sizeable level of unemployment among the participants (56%). The vast majority were reliant on the Disability Support Pension (over 90%) as their main source of income, suggesting that any paid employment was minimal. Most reported difficulties in managing on very low incomes:

I have shortcomings related to the years that I had schizophrenia and especially lack of work experience which in this country is very difficult...I'm still suffering the effects of a lack of experience in the professional work force and poverty, relative poverty by Australian standards. (Participant 25)

The impact of psychosocial disability

The majority of the 41 participants reported the expectation of continuing impact of psychosocial disability over time, including ongoing impact in the same way (32%), fluctuating impact (29%) or a gradual reduction of impact over time (27%). The domain that was most frequently rated as being 'extremely' impacted was lifelong learning activities, followed by social interaction, and then

employment. When asked if there were any other areas that they would like to comment on as impacting on their life activities, almost 30% of participants reported stigma (and/or discrimination).

Eligibility for the NDIS

Only 36.5% of the 41 participants believed their psychosocial disability meant they were eligible for NDIS given the criteria of having a 'permanent' psychosocial disability, even though all were currently accessing mental health services in the region:

You see with this NDIS that I don't know a lot about, I'm [hoping] that I can keep some of them [paid support staff]. I don't know if I'll be eligible. I don't know enough to know. I hope I am eligible... But it scares me when they're gone. That's something I really fear. Because then I'll be back to where I was and I'm not quite ready for that. (Participant 5).

Good life goals and preferred supports

The top five good life goals that all 41 participants nominated were: Health (68%); Economic (61%); Social connection (58%); Housing (34%); and Personal relationships (31%).

The qualitative analysis found that when discussing improving their health, participants focused on both physical and mental health needs and recognised the connection between the two for wellbeing. In relation to economic security, generally participants wanted assistance related to achieving economic stability and increasing incomes through assistance with training and education, employment, and financial security. Social connection was described by most as connecting with potential friends and other individuals and/or with social groups and the community. Participants appeared to prioritise housing in the main to enable more stability, safety and independence. Getting assistance to build personal relationships was valued as a way of helping to meet people and therefore have opportunities to develop intimate relationships. This was also strongly related to repairing, sustaining or improving relationships with families.

Participants identified a wide range of activities, services and supports to which to allocate individual funds in order to achieve each of these top life goals (Table 2). A considerable element was the purchase of better targeted ‘mainstream’ supports such as a psychologist or doctor of their choice, targeted education or employment supports, and housing. Participants saw this as resulting from inadequate or inappropriate services and supports provided via public services, combined with significant financial disadvantage that restricted their current options. A list of common supports to which participants anticipated allocating funding is provided in Table Two.

The importance of a support person

Participants spoke about the value of a support person in the context of a variety of goals, roles and functions, and many of these were interconnected with one another. In this sense, a support person emerged as a form of purchased support that could facilitate outcomes through access to other forms of support, both publicly and privately funded. ‘Support person’ was originally presented to the research participants as one of the good life areas. However, qualitative analysis revealed that participants did not view it in this way, but rather as a key enabler and as highly valuable to achieving other life goals, as discussed by the participant below:

[W]ell, a support person because they could help me achieve all the rest. If you had that one they would help you get all the rest. (Participant 2)

Participants clearly identified the desired roles of a support person they would fund including: someone to talk to and provide social connection; a motivator, encourager and coach; an advocate in a range of settings; a navigator of the system; and someone to work with family members and friends. Support persons were seen to need a set of core skills and knowledge including having a good understanding of the impact of mental illness and psychosocial disability. Also participants valued a personalised approach that requires discussing the person’s values, needs and preferences.

A caseworker, yeah. ...at the moment that's what I think I really need ...because I'm so much on my own and there's no-one really I can open up to. You know, I would like to be able to have a full on conversation for at least once a week with somebody or once a fortnight.

(Participant 6)

Peer support workers potentially have an important role in this context:

...just connecting with people is probably the main thing. When you connect with someone else who understands you and you look in their eye "You know what I'm talking about right now", it's great. But you go and talk to other people and they just go "You should do this, you should do that". You're not even going to listen to them because they're just doing it from what they've learnt in books and all that, so that's why I reckon peer support is the way to go. (Participant 33)

In summary, whether formal or informal, a peer worker or other mental health professional, a support person needed to display the attributes of responsiveness and continuity, respect and flexibility, compassion, acceptance, and personalised care.

Decision making

In this study participants indicated that they would purchase support with decision making through their individualised funding package if they could be influential in determining the nature and provider of this support. Participants indicated they might choose support for decision making to assist them in deciding the optimal way to expend their personalised funding package. The preferred support could include family and friends, professionals, independent mental health advocates and those who were employed by CMHSS.

I think it is good to have somebody because they see things differently and if you could talk about that together, the two or three of you or however many, you actually get a better result. I'm probably actually better than back then, back then I had no clue. (Participant 5).

When asked why decision-making assistance was needed, participants reported that they faced internal conflict about confidence in their decision-making abilities even with respect to smaller decisions and would find it difficult to make decisions about their individualised or personalised funding package.

I've lost all confidence and sometimes I get to the extreme – I go to the supermarket and all of a sudden I don't know what to buy, I can't make up my mind. I have a very difficult time making decisions. (Participant 6)

Even when experience and confidence were present, participants were concerned about whether their choices would provide the optimal opportunity for them to have their good life.

Well I'm usually the one person making the decisions by myself. But then, like I said, my decision is probably not 100% [correct]. So I'm usually only making a decision that's not appropriate, so how do I make the right decision if I don't know what the outcome of my decision will be? (Participant 18)

Discussion of findings

Study participants living with psychosocial disabilities were likely to have fluctuating needs. Many were concerned that there is a significant risk that they may not be deemed eligible for personalised funding under the NDIS simply because the fluctuations in their condition are not understood. For example, some participants theorised they would be judged as 'too well' to be eligible. This has potential to make initial assessment complex, and requires flexibility in adjusting plans and service provision to meet changing needs. Concerns about fluctuating needs has already been raised as a problem for the integration of mental health into the NDIS and is particularly apparent in the tension between the emphasis on personal recovery in mental health policy and the need to demonstrate permanent impairment in NDIS eligibility (Mental Health Council of Australia, 2013).

This research adds to understandings about what people value in recovery focused support. In particular participants prioritised specific supports to improve their health and well-being, financial situation, social connection, housing and personal relationships. This is broadly consistent with research in the UK (Glendinning *et al.*, 2008a; Coyle, 2011). Poverty is a key issue for these participants which was seen to significantly affect the extent to which they can self-fund or make a financial contribution to meeting their recovery goals. At this stage the degree to which discretionary funds will be available and to what extent under the NDIS is unknown but this research highlights the importance of this option to people with psychosocial disability. Additionally, participant needs are not well met by current 'mainstream' service provision, including government services related to health, housing and education. As indicated by Williams and Smith (2014) this means some mental health service users are likely to require assistance with care co-ordination and advocating improved access to the health and welfare services they require that are outside the jurisdiction of the NDIS. People with psychosocial disability also value opportunities to have discretionary funds that can assist directly with the major problems many face in relation to recovery, social inclusion and well-being (Table 2). However, the interface between disability support and health is likely to be a challenging aspect of NDIS implementation, as the NDIS resists substituting for deficits in health care. The UK is also tackling the difficulties resulting from separation of health and social care needs, noting the particular impediment for people with mental health issues in uptake of the scheme, where social and health care are best integrated in mental health service delivery but remain separate in funding (Larsen *et al.*, 2013).

People in this study often lacked access to informal supports although many talked about the value and importance of family, intimate and other social relationships in their lives. A major barrier to a productive and healthy life is loneliness and isolation (Tew, *et al.*, 2012). and, consistent with this, participants described needing support to reconnect with family as well as direct family support and counselling, transport costs and recreational activity costs.

While most participants expressed confidence that they could make decisions about their life goals without the need for support, this contrasted with their willingness to purchase decision making support. Participants preferred a person who is independent, perhaps specially qualified and, most importantly, someone they choose to support them in decisions about funding allocations.

Participants valued having support from others with lived experience and it appears that many of their expectations of a support worker are consistent with how the peer support worker role is evolving (Davidson, *et al.*, 2012). Thus the future of mental health community support work is strongly linked to the inclusion of peer support workers and establishing a shared vision for the value of lived experience in practice. While peer support was a valued option, these mental health service users also indicated a preference for formal support persons with a diverse range of skills and attributes. Whilst data is not generalisable to the broader sector, the participant support preferences here indicate a strong match, as Duffy (2010) observed, between service user preferences and the required attributes of mental health social workers. It also suggests that social workers in this context may need to work alongside peer support workers and informal support persons to form part of a personalised support network.

Implications for social workers

Despite the intersection between recovery, personalisation and social work being well identified there is little explicit discussion of the role of social workers in Australia's NDIS. Within the rapid shift to personalisation in mental health service delivery in Australia, social workers have the potential to occupy multiple roles both within the infrastructure of resource allocation and service delivery as well as roles purchased through use of individual funding packages. Roles include ensuring that fair and holistic assessments are made for eligibility for individual service packages, assisting people to exercise choice and control, supporting decision making, and as direct service providers in a recovery oriented service delivery environment. According to this data set, potential roles for social workers which could be 'purchased' by the service user, using their individual funding

allocations, include: social connector, motivator, encourager, coach, advocate, system navigator, decision making support and family counsellor. Such roles may sit (if guidelines are viewed flexibly) within the identified list of support items related to social work that can be purchased in participant plans. Individual social work services are described as “Individual social work to empower participants and improve interactions between participants and their social networks. Assistance to engage effectively in broader community, achieve goals, gain insight into their lives and make informed decisions” (National Disability Insurance Agency, 2014, p. 43). Whilst this very general description of what is included under therapeutic supports may enable a broad range of activities and include those preferred by participants, it is restricted by not being directed toward improving a participant’s health as well as being required to demonstrate value for money (a complex and ill-defined task).

Social workers in all roles should be skilled in working in partnership with people with psychosocial disability and their families and carers to find new and innovative ways to help them envisage a good life, and develop creative and evidence informed supports that are flexible and respond to individualised planning and service delivery. As Glendinning *et al.* (2008a) describe it, personalisation offers social workers the potential of ‘actually forming relationships with people and working with them in a much more meaningful way’ (p.189). This includes enabling opportunities for direct funding of formal and informal community based resources, supports and activities. In the context of recovery and the valuable role of peer support, social workers can draw on their longstanding commitment to empowerment and self determination to support this approach and work collaboratively with peer support workers (Carpenter, 2002).

However, as Ellis (2014) indicates, there are numerous challenges that may spoil this vision. Developments in the United Kingdom have seen social workers being increasingly required to gate-keep due to eligibility requirements, increased sources of demand and the need to manage scarce resources (Ellis 2014; Lymbery, 2014). The continued pressure to manage risk may threaten the

ability of social workers to enable service users greater choice and control and form trusting relationships and person centred approaches that are creative and innovative (Ellis, 2014).

Participants in this study indicated the importance of having access to workers who are highly skilled but inadequate pricing of services may compromise the quality of service delivery. In this context, social workers may need to advocate for adequate price recognition of their specialist skills and the legitimacy of service users choosing such workers, over cheaper less skilled ones, to undertake a range of, what may be misunderstood as, generic support roles (Ellis 2014; Lymbery, 2014).

Finally, there is a risk of poor uptake of packages and the potential that, without attention to the adjustments that may be required, people with psychosocial disabilities may 'miss out' on the opportunities provided (Larsen *et al.*, 2013; Williams and Smith, 2014). There are many examples of people with complex needs who are already excluded or poorly resourced in the current disability support system. There is potential that an insurance scheme that emphasises individual responsibility may further alienate marginalised groups such as many of the participants in this study who recognised their problems with motivation and engagement (Fawcett and Plath, 2014). Even so, Duffy (2010) mounts a strong case that social workers have an opportunity, in the shift to personalisation, to engage in efforts to use this new mechanism to promote social justice and full citizenship for people with disability. Social workers offer advanced skills in assessment, negotiation and advocacy skills that may enhance responses to individual circumstances (Fawcett and Plath, 2014). This is particularly pressing given the needs of people with psychosocial disability. As this research has demonstrated, the ideals of the recovery movement, where people with mental illness have opportunities for hope, empowerment and improved wellbeing, may be lost if the structural and collective forces of stigma and discrimination, poverty and social isolation are not recognised and addressed alongside individually tailored interventions (Duffy, 2010; Fawcett and Plath, 2014).

Limitations

There are two main limitations of this study. One is that this was a small and potentially not representative sample. However, it was valuable in lending important insight to the poorly researched area of service user support preferences in an individualised funding system. The second limitation was asking participants to anticipate choices they would make in an, as yet, unfamiliar system.

Conclusions

The study discussed in this paper indicates that service users valued improvements in health, financial stability, housing, social connection and personal relationships, within a context of support for decision making and the enablement of choice and control to achieve a good life. This is consistent with the other few studies that have also investigated this question (Davidson *et al.*, 2010; Glendinning *et al.*, 2008a; Coyle, 2011). The recovery movement has been at the forefront of recognising these aspirations and challenges the current limitations of the technological paradigm of modern psychiatry (Carpenter, 2002). Similarly, the CRPD and system changes that are facilitating greater personalisation of support, such as Australia's NDIS, are trying to create a culture that puts full citizenship and social participation at the forefront of the purpose of service delivery to people with disability (Duffy, 2010). Social workers in mental health have long shared these aspirations (Renouf and Bland, 2005) but they now need to negotiate what they have to offer in a new environment. Critical to this is to redefine the way they work with service users as one of partnership, shared expertise and relationships that are recovery oriented. Hence for social workers there are "new opportunities and well as new risks" in the shift to consumer directed care that may require major adjustments (Laragy and Allen, 2015, p.225). They have an opportunity to demonstrate capacity to undertake a range of roles that are of value to people with psychosocial disability. However, social workers engaged with schemes such as Australia's new NDIS also need to confirm that they offer value for money, can achieve the outcomes people with psychosocial disability want and are open to the innovation this requires.

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References:

Harvey, C., & Brophy, L. (2011). Social isolation in people with mental illness. *Medicine Today*, 12(10), 73-78

Bigby, C. (2013). A National Disability Insurance Scheme—Challenges for Social Work. *Australian Social Work*, 66(1), 1-6

Brophy, L., Bruxner, A., Wilson, E., Cocks, N., Stylianou, M. and Mitchell, P. (2014). People making choices: the support needs and preferences of people with psychosocial disability. *Mind Australia*.

Carpenter, J. (2002). Mental Health Recovery Paradigm: Implications for Social Work. *Health & Social Work*, 27(2), 86-94

Coyle, D. (2011). Impact of person-centred thinking and personal budgets in mental health services: reporting a UK pilot. *Journal of Psychiatric and Mental Health Nursing*, 18, 796-803.

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, 11(2), 123-128.

Davidson, L., Shaw, J., Welborn, S., Mahon, B., Sirota, M., Gilbo, P., . . . Pelletier, J.-F. (2010). "I don't know how to find my way in the world": contributions of user-led research to transforming mental health practice. *Psychiatry Interpersonal & Biological Processes*, 73(2), 101-113

Duffy, S. (2010). The citizenship theory of social justice: exploring the meaning of personalisation for social workers. *Journal of Social Work Practice*, 24(3), 253-267.

Ellis, K. (2014). Professional discretion and adult social work: exploring its nature and scope on the front line of personalisation. *British Journal of Social Work*, 44(8), 2272-2289.

Fawcett, B., & Plath, D. (2014). A National Disability Insurance Scheme: What Social Work Has to Offer. *British Journal of Social Work*, 44(3), 747-762

Felder, F. (2013). Inclusion and the good human life. In J. Bickenbach, F. Felder & B. Schmitz (Eds.), *Disability and the good human life* (1st ed., pp. 300-322). Cambridge: Cambridge University Press.

Fels, A. (2012). Mental health report card: it's time to address quality of life.

<http://theconversation.com/mental-health-report-card-its-time-to-address-quality-of-life-11001>
(accessed 17th February 2014)

Glendinning, C., Challis, D., Fernandez, J-L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. & Wilberforce, M. (2008a). *Evaluation of the Individual Budgets Pilot Programme Final Report*. Social Policy Research Unit, University of York, York.

Glendinning, C., Challis, D., Fernandez, J-L., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. & Wilberforce, M. (2008b). *Evaluation of the Individual Budgets Pilot Programme Summary Report*. Social Policy Research Unit, University of York, York.

Jayakaran, R. (2002). The ten seed technique. People's Republic of China: World Vision China.

<http://ravijayakaran.com/books.htm> (accessed 19th August 2015)

Kavanagh, A. M., Krnjacki, L., Aitken, Z., LaMontagne, A. D., Beer, A., Baker, E., & Bentley, R. (2015). Intersections between disability, type of impairment, gender and socio-economic disadvantage in a nationally representative sample of 33,101 working-aged Australians. *Disability and health journal*, 8(2), 191-199.

Keyes, C. M. L., & Haidt, J. (Eds.). (2007). *Flourishing: positive psychology and the life well lived*.

Washington, D.C.: American Psychological Association

- Laragy, C., & Allen, J. (2015). Community aged care case managers transitioning to consumer directed care: More than procedural change required. *Australian Social Work*, 68(2), 212-227.
- 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*, 22(2), 174-182.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445-452
- Lymbery, M. (2014). Social Work and Personalisation: Fracturing the Bureau-Professional Compact? *British Journal of Social Work*, 44(4), 795-811
- McSherry, B. (2012). Legal capacity under the Convention on the Rights of Persons with Disabilities. *Journal of Law and Medicine*, 20(1), 22-7.
- Mental Health Council of Australia (2013) Mental Health and the National Disability Insurance Scheme: Position Paper. <http://waamh.org.au/assets/documents/media-releases/mhca-position-paper.pdf> (accessed 21 November 2014)
- National Disability Insurance Agency (2014) Support Clusters Definitions and Pricing for Victoria. (p.43). <http://www.ndis.gov.au/document/880> (accessed 23rd July 2015)
- National Health Workforce Planning and Research Collaboration (2011). *Mental Health Non-Government Organisation Workforce Project Final Report*. Health Workforce Australia.
- Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, 31(1), 9-22.

Ostlund, U., Kidd, L., Wengstrom, Y., & Roosa-Dewar, N. (2011). Combining qualitative and quantitative research within mixed method research designs: a methodological review. *International Journal of Nursing Studies*, 48(3), 369-383.

Provencher, H., & Keyes, C. L. M. (2011). Complete mental health recovery: bridging mental illness with positive mental health. *Journal of Public Mental Health*, 11(1), 57-69

Renouf, N., & Bland, R. (2005). Navigating Stormy Waters: Challenges and Opportunities for Social Work in Mental Health. *Australian Social Work*, 58(4), 419-430. QSR International. (2013). NVivo10 (Version 10): QSR International

Quinlan, F. (2014) Getting the NDIS right for people with psychosocial disability. Mental Health Australia. <http://mhaustralia.org/general/getting-ndis-right-people-psychosocial-disability> (accessed on 24th July 2015)

Slasberg, C., Beresford, P. & Schofield, P. (2012). Can personal budgets really deliver better outcome for all at no cost? Reviewing the evidence, costs and quality. *Disability & Society*, 27, (7), 1029-1034.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *British Journal of Social Work*, 42(3), 443-460

Thomas, D.R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27 (2), 237-246

United Nations (2008) The United Nations Convention on the Rights of Persons with Disabilities (entered into force 3 May 2008; ratified by the Australian Government on the 17 July 2008)

Webber, M., Treacy, S., Carr, S. Clark, M. & Parker, G. (2014). The effectiveness of personal budgets for people with mental health problems: a systematic review. *Journal of Mental Health*, 23, (3), 146-155.

Williams, T. M., & Smith, G. P. (2014). Can the National Disability Insurance Scheme work for mental health? *Australian and New Zealand Journal of Psychiatry*, 48(5), 391-394