Professional issues in clinical psychology

With one in four people in the UK experiencing mental health problems at some point in their lives (Mental Health Statistics, n. d.), how easily people can access treatment in the NHS becomes a very important subject, with serious socio and economic implications. In his recent article in The Guarding, Rob Greig (“ Why are personal budgets not used more in mental health?”, January 2015) raised a very important dilemma directed at the NHS and the new wave of personalising treatment, that of personal budgets for people with mental health problems. Greig is making an excellent case in favour of personal budgets, accentuating that personalisation of treatment empowers clients and lets them take control over their lives.

In the Community Mental Health Survey (2014) two-thirds of the respondents rated their overall experience of the mental health services received as a seven or above on a scale from zero to ten. However, an important recurrent issue in several surveys, including this one is that of involvement in the treatment. Only 57% of the respondents felt involved in planning and reviewing the care they received. Seeing that lack of control over the therapy has become a common criticism attributed to the NHS, involvement and personalisation of treatment should become common practices in the healthcare system. In “ Personal Budgets and Health: a review of the evidence”, Wirrmann Gadsby (2012) explains that implementing personalised treatments should improve people’s management of long term conditions and, moreover, the patient’s experience, and outcomes through choice and flexibility.

Greig states in his article that results from the national POET survey (2014) showed that people reported better mental health as a result of personal

budgets. The same pattern of results appears in the evaluation conducted by Davidsone et al. (2012), with improvement in confidence and social life. Furthermore, some clients reported more motivation to increase their wellbeing now that they had access to goods and services not available in the NHS or alternative therapies. And these results are consistent with those from other countries that have implemented personal budgets. For example, evaluations of personal budget programmes in the US and Australia, showed that patients using personal budgets for their care arrangements expressed a higher level of satisfaction than those who receive an agency-directed care (Gordon et al. 2012; Alakeson, 2010).

Evaluations of personal budgets in Florida, US reported patients spending significantly more days in the community and were more likely to be enrolled in education and training than before entering the programme (Cook et al., 2008). Furthermore, Sullivan (2006) found the same results in Oregon, with an 83% increase in number of clients who were enrolled in education and training after receiving personal budgets and an increase of 80% in the number of clients employed after the first year. The evaluations conducted in Australia showed comparable findings, with personal budgets being associated with higher levels of satisfaction of client’s various aspects of their life, for example their competency to participate in social activities, their ability to travel, and their perceived health (Gordon et al., 2012). Therefore, a similar pattern of results seems to emerge from all literature, highlighting psychological benefits for clients, coming from having control over their choices. All clients appear to improve their confidence levels, become more optimistic and positive and increase their levels of

independence and motivation to explore new opportunities (Arksey et al., 2008).

The reason why personal budgets seem to affect in a positive way the lives of patients who suffer from mental health problems is that the programme is tailored around the individual, giving control on how much involvement in managing the personal budget they are willing to assign. If the client in eligible (already in the system as suffering from a mental health problem and is treated by a specialist mental health team in the hospital or in the community), then an individual budget is calculated. Within this personal budget, with the help of a broker or care planner, the client identifies his or her needs and desires and then presents this plan towards the local authority. After the plan is approved, the client has a choice of how the budget will be managed- either direct payment towards the client or passed on to a third party, which then takes responsibility for paying the services.

Although the literature around personal budgets has shown results in terms of increasing the client’s psychological wellbeing and mental health, implementing them is not regarded as favourable just yet due to a number of critiques. One of the criticisms attributed to the personal budget programme was related to what kind of goods and services the clients will choose to spend the budgets on and whether those services were different than the ones NHS already provides? An analysis of the Department of Health documents conducted by the NDTI showed that people usually spend the budget on personal assistants, leisure activities, gym memberships, education, travel and so forth (Greig, 2014). Furthermore, as Greig stated in his article, 80% of personal budget is spent outside the public sector,

whereas 80% of the traditional treatment is directed towards NHS services. Therefore, the goods and services are very different than those obtained through traditional treatment and furthermore, they are regulated so that budgets don’t end up being spent on tobacco, alcohol or anything illegal (Murray- Neill, 2012).

Another concern attributed to the programme relates to economical concerns is whether the programme will cost NHS more than the traditional treatment, at a time of healthcare cost increases and growing pressure on the health services inflamed by the increasing number of people suffering from mental health problems since the recession (Withworth, 2014). The Evaluation of the Individual Personal Budgets Pilot Programme, Glendinning et al. (2008) showed that in terms of social care, clients receiving personal budgets had better outcomes. Overall, clients accessing personal budgets received £149 per week compared to £152 per week for the control group. However, when breaking down the costs per week, the overall difference between the two systems was not significant, leading to a neutral cost. Another study comparing the costs of care packages before and after the personal budget showed that personal budgets cost about 10% less than the traditional services (Leadbeater et al., 2008). Glendinning et al. (2008) also found that individual budgets are more cost-effective in achieving the social care outcomes. However, these results should be carefully considered because there is no evidence at the moment that personal budgets will bring cost savings to the NHS on long term. Although literature is not yet able to look at the difference of cost between traditional service and the private budget, the IBSEN (2008) showed that the personal budget programme for

mental health was significantly more cost-effective than the traditional services, with clients spending less time in hospital and more time in the community.

Nonetheless, the personal budget programme still needs to answer a few other criticisms with a not so clear implementation system and problematic funding. How do we get to a reliable and fair way of calculating budgets? How well prepared are the brokers who help clients finding ways of spending their budgets and how do we make sure that the services are actually helping the client? Furthermore, the most important question, when do clients stop receiving personal budgets?

In conclusion, although the programme still needs to address real concerns and make its regulations slightly harsher, I believe it’s a good alternative to the overcrowded traditional system. With a programme that improves general well-being and empowers the clients to choose for themselves, the NHS budget won’t be the only sector where improvements will be seen. We will see benefits in general physical health, reduction in health-damaging behaviours, greater educational achievement, higher incomes, reduction of absenteeism, less crime and reduced mortality (Keyes, 2007; Barry & Friedli, 2008). I strongly support Rob Greig’s point of view and I want to raise a few other important questions: When will people stop being treated as simple numbers in annual reports and the system will understand that they are a combination of wishes and strengths? More importantly, when will the policy makers understand that tailoring a treatment that takes into consideration the client’s expectations and wishes will actually save them money on the long term?

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