

Personalisation through Individual Budgets: Does It Work and for Whom?

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Abstract

In England, 'personal budgets' are being implemented at a time of financial austerity. They are part of a growing trend internationally to give users of publicly funded social care and support more choice and control. In the individual budgets' (IB) pilot, people were allocated and had control over the way their IB was managed and spent, offering the opportunity to explore the potential of IBs to deliver better outcomes for people than conventional services and support. We describe the way we measured outcomes, the effects we found and how they varied between and within service user groups. For some groups, there were clear benefits from IBs. However, it should not be a 'one-size-fits-all' approach, and, in taking personal budgets forward, it is important to consider how best to address the particular challenges for older people, effects on social work practice and resource implications if the potential benefits are to be achieved. Social workers may find themselves implementing a policy with considerable potential, but which may prove very difficult to achieve in the current financial climate.

Keywords: Outcomes of social care, personal budgets, personalisation, social work role

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Introduction

Social workers could be forgiven for thinking themselves caught between a rock and a hard place in a policy climate that emphasises improvements in outcomes (Department of Health, 2010) and a financial climate that necessitates cuts in expenditure on social care (Audit Commission, 2010b). Are personal budgets the 'magic bullet' that delivers improved outcomes at lower costs? What are the implications for social work practice?

Personal budgets are a reflection of moves internationally towards personalisation to enable people eligible for publicly funded social care (community care or home health care support) to have more control over the resources used in their care and support (Ungerson and Yeandle, 2007; Pavolini and Ranci, 2008; Timonen *et al.*, 2006; Da Roit and Le Bihan, 2010). While control and empowerment are important ends in themselves, a key rationale is that people are best able to identify

what will support them most effectively, and can potentially draw on informal networks, so complementing formal resources to achieve desired outcomes.

The roots of moving decision making closer to individuals and facilitating flexible use of resources can be traced back in the UK to early social work case management experiments (Challis and Davies, 1986). The means by which people are given more direct control over resources for their care and support were extended from care managers acting as proxy or third-party purchasers to providing monetary transfers, or cash for care, which increasingly allowed eligible people to employ personal assistants or care workers and sometimes family members. However, more recently, cash payments may combine with in-kind services (Pavolini and Ranci, 2008). Direct payments (DPs) were introduced in 1996 in England but with variable use geographically and by different groups of people (Ellis, 2007; Priestley *et al.*, 2007). In England, younger adults with physical or sensory impairments (PDSI) have been most likely, and people with a mental health (MH) problem least likely, to use DPs (Fernandez *et al.*, 2007). Barriers to their use include concerns about managing payments (Davey *et al.*, 2007), social workers' attitudes to and expectations of people with MH problems (Spandler and Vick, 2006) and older people (Ellis, 2007; Leece and Leece, 2006), and problems in recruiting personal assistants (Davey *et al.*, 2007).

Individual budgets (IBs) were first proposed for England in the report *Improving the Life Chances of Disabled People* (Cabinet Office Strategy Unit, 2005). This aspiration of personalisation has continued to be emphasised, most recently in the coalition government's *Vision for Social Care* (Department of Health, 2010).

Individual budget pilots

IBs were intended to build on the successes of DPs, but address some of the problems. People could have their IB as a cash DP or combination, which could be provided and managed in different ways. The approach built on the In Control model in which people plan and, if they want, manage their support, knowing the level of resources available to them (Poll and Duffy, 2006). Funding depended on an assessment of the person's financial contribution (if any) to the costs of support. Overall, the intention was that IBs would be 'resource neutral' (Department of Health, 2005), although whether this was to the public purse as a whole or for adult social services departments specifically was unclear.

Once the amount of the IB was agreed, social workers or care managers undertook a support planning process to elicit individuals' priorities and goals and how to meet them. Help with planning support might come from a social worker or care manager, an in-house or external support

planner or broker, the person's family and friends, or (unusually) a service provider. A team leader or senior manager approved ('signed off') the support plan and also considered risk and possible safeguarding concerns (Manthorpe *et al.*, 2009).

Projects piloting IBs ran in 13 sites across England from November 2005 to December 2007. Prior to the end of the pilots, the government announced that, in England, a system-wide transformation would include 'personal budgets for everyone eligible for publicly funded adult social care support' (Department of Health, 2008, p. 3). These personal budgets differed from IBs in being limited to social care expenditure, rather than drawing in additional funding streams. The new coalition government has supported this policy but emphasises that DPs are to be the main form of personal budgets (Department of Health, 2010).

A key objective of an evaluation of the pilots commissioned by the Department of Health was to identify whether the approach improved people's outcomes. This paper describes how we measured outcomes, the effects we found and how they varied between and within service user groups. We examine the factors associated with outcomes, and end by discussing the implications of our findings for social work practice. Further findings covering the impact of IBs on care management have been published elsewhere (Jacobs *et al.*, 2011).

Method

In order to establish whether IBs delivered better outcomes for people, we needed to ensure we had a sound basis for comparison and measures likely to reflect the impact of IBs. A randomised controlled trial (RCT) design was used to ensure like-with-like comparisons between the new and standard care and support arrangements.

Design

The pilot sites varied in the ways in which they introduced IBs in terms of service user group. A target number of IB holders was calculated for each site in order to achieve an adequate sample. All eligible individuals were randomly assigned to the IB or comparison group with the objective of achieving an overall sample of 1,000 individuals (see Glendinning *et al.*, 2008, for details).

Baseline data on demographic characteristics, household circumstances, service user group, abilities in activities of daily living (ADLs) and instrumental ADLs (IADLs) were provided by the pilot sites. People were interviewed six months after the offer of the IB or, in the comparison group, a review or assessment had been conducted.

Interviews

Interviews covered people's experiences of the IB process, service receipt, self-perceived health and functional abilities, and a variety of outcome and process measures designed to reflect the intentions of IBs. Over-arching aspects of well-being were reflected through two global indicators: the General Health Questionnaire (GHQ-12; [Goldberg, 1992](#)) to reflect psychological well-being (or absence of ill-being) and a single quality-of-life question using a seven-point scale ([Bowling, 1995](#)). In order to pick up key areas of people's lives that are specifically relevant to social care, an early version of the Adult Social Care Outcome Toolkit (ASCOT) measure was used ([Netten et al., 2010](#)). This measure of 'social care related quality of life' (SCRQoL) is applicable across all user groups, with seven domains ranging from basic areas of need such as personal cleanliness and safety to more aspirational aspects such as social participation and involvement and control over daily life. To create an overall SCRQoL 'score', responses were weighted to reflect the relative importance of each domain and level of need, drawing on work on population preferences ([Burge et al., 2010](#)). Measures of satisfaction and quality of care were based on indicators used in national surveys of service user experiences ([Jones et al., 2007](#); [Malley et al., 2006](#)).

As far as possible, individuals were interviewed directly but, in a quarter (24 per cent) of cases, we sought proxy views when people were unable fully to communicate (the study took place before the 2005 Mental Capacity Act was implemented). In addition, we recorded when people had others with them during the interview and responded on their behalf if there were problems in communicating or understanding a question. When we report the results, we have included proxy responses but, as proxies may respond differently from individual service users ([Elliott et al., 2008](#)), we also explored the impact of excluding them.

Analysis

The study was designed with the aim that there should be no systematic difference between the IB and comparison groups at baseline, so that any differences in our outcome measures could be attributed to IBs. Baseline data were used to compare the groups to ensure this and to investigate whether the sample was representative of the wider service user populations. For discrete variables, a chi-square test was used and, for continuous variables, a *t*-test.

Multivariate analyses were used to control for potential influences and distinguish sources of variation from a range of baseline characteristics (such as age, gender and need). Ordered logit models were used when

the dependent variable was categorical and ordinary least squares when it was continuous. Multiple-imputation (MI) methods were used to fill in missing values in the data-set (Glendinning *et al.*, 2008).

Ethics

The proposal was reviewed by a NHS multi-site research ethics committee and received research governance approval in each site. An advisory group of service users and carers met regularly and provided advice throughout the evaluation.

Results

The sample

A total of 2,521 service users were approached by the pilot sites to participate in the research, of whom 1,594 (63 per cent) agreed to take part. The final sample for the analysis was 959, of whom half (53 per cent, $n = 510$) were in the IB group (see Glendinning *et al.*, 2008, for details about sample recruitment).

As expected, baseline characteristics varied by user group (Table 1), with higher proportions of women among older and PDSI groups. A slightly higher proportion of the sample than would be expected was from black and minority ethnic (BME) groups (8 per cent compared with 6 per cent of service users nationally and 5 per cent in the pilot sites) (Department of Health, 2007). There was a significantly lower proportion of people from BME groups among MH service users than would be expected: 5 per cent compared with 12 per cent nationally (Department of Health, 2007).

Table 1 shows the mean and range of Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) problems. Approximately three-quarters of the total sample needed regular help with shopping and housework and two-thirds needed help cooking. A small minority required assistance with eating, and a little over a quarter needed regular help with toileting and washing their face and/or hands. There were no significant differences between the two groups.

In addition to personal characteristics, we had information about previous social services support for 683 (71 per cent) of the whole sample, so less than a third of people in the study were new to social services. Overall, 26 per cent had previously had a DP. This compared with just 4 per cent nationally at the time of the study (Department of Health, 2007). A higher percentage of people with PDSI (43 per cent) had previously received DPs compared with only 13 per cent nationally. A third (34 per cent) of those receiving services previously had been receiving intensive

Table 1 Characteristics of the sample

	User Groups				Total
	PD	LD	MH	OP	
Total sample	327	235	131	263	959
IB group	180	119	66	142	510
Comparison group	147	116	65	121	449
Mean age	55	35	49	82	57
Per cent female	63%	42%	46%	66%	57%
Per cent BME	10%	11%	5%	5%	8%
Has identified informal carer	145	162	46	156	509
Lives alone	132	41	64	134	371
Employment status					
Employed	10	19	6	0	35
Student	9	57	2	0	68
Retired	96	5	13	223	337
Private household	271	185	103	205	764
Care home	1	7	3	3	14
Sheltered/extra care	29	22	10	27	88
Other	0	1	0	0	1
Mean number of abilities underlying ADL activities	5	6	8	6	6
% previously receiving DP	43%	21%	20%	4%	26%
% receiving intensive home care	34%	43%	11%	36%	26%

homecare. Older people in our sample were more likely to receive ‘intensive’ homecare than nationally: 36 per cent had received over ten hours per week, compared with 26 per cent nationally.

No statistically significant differences were found between the IB and comparison groups in terms of personal characteristics, household circumstances, service use, employment status or benefit receipt at baseline (Glendinning *et al.*, 2008).

Progress through the IB process at the time of the interview

Around 10 per cent of the IB group (fifty-two service users) refused the offer of an IB (but still wished to take part in the research). Of the IB refusers, there was some evidence that those who were aware of the level of funding of their previous support arrangements (because they had received DPs) were more likely to refuse an IB, particularly those who had been receiving higher levels of DPs (Glendinning *et al.*, 2008).

The original design anticipated that all IB holders would be using their IB at the time of the six-month follow-up interview. However, of the 458 who agreed to an IB, only 371 had reached the IB assessment stage, and only 280 had support plans in place after six months. Just 231—less than half of the 510 allocated into the IB group—had IB-funded support in place at the time of the follow-up interview. Of those with IB-funded support in place, a fifth (21 per cent) reported that it was not yet all in place or had been in place

Table 2. Quality of life, well-being and social care outcome states

	IB group	Comparison group
<i>Quality of life</i>	<i>N</i> = 504	<i>N</i> = 439
So good, it could not be better	3%	3%
Very good	15%	18%
Good	27%	28%
Alright	38%	31%
Bad	8%	9%
Very bad	7%	7%
So bad, it could not be worse	2%	5%
<i>GHQ-12</i>	<i>N</i> = 448	<i>N</i> = 380
Mean score ¹ (sd)	13.83 (6.74)	13.80 (6.85)
Percentage ² scoring 4 +	36	33
<i>ASCOT</i> ³	<i>N</i> = 457	<i>N</i> = 385
Social care outcome state (sd)	3.55 (0.79)	3.48 (0.89)

¹ GHQ item scoring 0–3; higher GHQ scores indicate poorer outcomes.

² Using GHQ12 item scoring 0–1. Psychological distress is identified when the score of 4 or more (Goldberg, 1992).

³ Higher scores indicate lower levels of need.

less than a month. People with DPs were more likely to have had their IB in place at the point of their six-month interview, and for longer.

Outcomes

Tables 2 and 3 show overall measures of quality of life and well-being at six months for the whole sample. At this global level, there were no statistically significant differences between the IB and comparison groups, although overall SCRQoL, measured by the ASCOT score, appears slightly higher among people in the IB group. However, when individual aspects of SCRQoL were examined, people in the IB group were more likely to report feeling in control of their daily lives (48 per cent, $p < 0.05$) compared with those in the comparison group (41 per cent).

Tables 4 and 5 show summarised measures of outcome by user group. Self-reported quality of life for people with MH problems was significantly higher for the IB group than for the comparison group ($p < 0.05$). In contrast, older people in the IB group reported significantly lower well-being on the GHQ-12 ($p < 0.05$). However, when proxy responses were excluded, both differences ceased to be statistically significant.

While there were some apparent differences between the IB and comparison PD and MH groups in the individual SCRQoL domains, none reached statistical significance and there was very little difference at all for older people. The results did suggest, however, that people with LD in the IB group were more likely than those in the comparison group to feel they had control over their daily lives (46 per cent reporting they felt in control of their lives compared with 35 per cent in the comparison

Table 3. ASCOT social care outcome state domains

	IB group % (N)	Comparison group % (N)	Overall % (N)
<i>Personal cleanliness</i>			
No needs	82 (408)	78 (334)	80 (742)
Low needs	15 (75)	19 (80)	17 (155)
High needs	2 (12)	4 (15)	3 (27)
<i>Social participation</i>			
No needs	35 (169)	38 (159)	36 (328)
Low needs	43 (207)	39 (159)	41 (366)
High needs	22 (106)	24 (101)	23 (207)
<i>Control over daily life*</i>			
No needs	48 (235)	41 (179)	45 (414)
Low needs	43 (212)	44 (194)	44 (406)
High needs	9 (46)	15 (64)	12 (110)
<i>Food and nutrition</i>			
No needs	74 (363)	67 (291)	71 (654)
Low needs	21 (102)	26 (112)	23 (214)
High needs	5 (26)	7 (30)	6 (56)
<i>Safety</i>			
No needs	47 (232)	45 (195)	46 (427)
Low needs	43 (212)	43 (184)	43 (396)
High needs	10 (49)	12 (51)	11 (100)
<i>Accommodation</i>			
No needs	87 (429)	83 (106)	85 (793)
Low needs	11 (56)	15 (65)	13 (121)
High needs	2 (9)	2 (9)	2 (18)
<i>Occupation</i>			
No needs	45 (219)	46 (195)	45 (414)
Low needs	41 (198)	42 (177)	41 (375)
High needs	14 (70)	13 (54)	14 (124)

* Significance level: $p < 0.05$.

group; $p = 0.054$). Once those who refused the IB were excluded, this difference grew, with 47 per cent reporting no needs and 9 per cent reporting high needs ($p < 0.05$).

On a less positive note, people with LD who accepted the offer of an IB (and their proxies) were significantly less likely to report being fully occupied in activities of their choice (51 per cent compared with 61 per cent: $p < 0.05$). However, this may reflect the proxy perspective and/or the type of individual with a proxy respondent: when we excluded proxy responses, users with an IB were *more* likely to report being fully occupied in activities of their choice (69 per cent, eighteen people), although the small numbers meant this difference did not reach statistical significance.

Factors associated with outcomes

The lack of impact of IBs reported above may be due to the low level of implementation at the time of the interviews, the effect of proxy informants and the combined implications of the two on effective sample size. We used

Table 4. Quality of life,¹ well-being and social care outcome states by service user group

	IB group Mean (N)	Comparison group Mean (N)	Mean
<i>PDSI</i>			
Quality of life	3.93 (178)	3.83 (146)	3.88 (224)
GHQ 12	14.73 (164)	15.01 (134)	14.86 (308)
ASCOT	3.53 (169)	3.39 (138)	3.47 (311)
<i>LD</i>			
Quality of life	2.99 (118)	2.92 (110)	2.94 (234)
GHQ 12	10.25 (96)	9.59 (82)	10.00 (184)
ASCOT	3.80 (106)	3.81 (93)	3.81 (205)
<i>MH</i>			
Quality of life	3.78* (65)	4.31 (64)	4.04 (135)
GHQ 12	15.68 (56)	18.05 (57)	16.69 (119)
ASCOT	3.16 (54)	2.97 (57)	3.06 (115)
<i>OP</i>			
Quality of life	3.71 (140)	3.70 (119)	3.71 (268)
GHQ 12	14.63 (129)	13.24 (107)	14.04 (245)
ASCOT	3.53 (126)	3.57 (97)	3.54 (232)

* Significance level: $p < 0.05$.

¹ Mean of seven-point score based on levels shown in Table 2.

multivariate analyses to explore these and other potential factors affecting outcomes for the full sample (see [Glendinning *et al.*, 2008](#), for details of the methods). Factors explored included baseline needs and other characteristics, as well as some operational measures such as the support received (measured by cost of support package).

Table 6 shows the results for our three main outcome indicators and, because of its central relevance to the objectives of IBs, the outcome dimension in ASCOT that measured ‘control over daily life’. Positive signs indicate positive associations with outcome, except for the GHQ, which is coded as a negative outcome indicator, so that *negative* coefficients denote improvements in psychological well-being.

Not surprisingly, all outcomes were significantly associated with physical and mental health needs at baseline. The relationship between age and outcome varied. Older people generally reported better quality of life, SCRQoL and control. However, among individuals aged up to forty-eight, greater age was associated with *lower* psychological well-being. Beyond this age, the association is reversed and older individuals reported better psychological well-being. This U-shaped effect of age on well-being has been identified in studies of general populations ([Blanchflower and Oswald, 2004](#)). People in full- or part-time employment reported higher quality of life and better SCRQoL. Those in education also reported better quality of life. The only other contextual characteristic associated with outcome was that people living with a partner reported lower levels of control.

Turning to formal support, higher levels of weekly expenditure led to improvements in most outcomes, whether through IBs or conventional

Table 5. ASCOT social care outcome state domains by service user group

	IB group % no needs (N)	Comparison group % no needs (N)	Overall % no needs (N)
<i>PDSI</i>			
Personal cleanliness	84 (148)	77 (111)	81 (259)
Food and nutrition	73 (129)	62 (90)	68 (219)
Safety	42 (73)	36 (52)	39 (125)
Accommodation	84 (149)	82 (121)	83 (270)
Social participation	29 (51)	35 (50)	32 (101)
Control over daily life	51 (91)	44 (65)	48 (156)
Occupation	47 (82)	47 (67)	47 (149)
<i>LD</i>			
Personal cleanliness	89 (103)	90 (95)	89 (198)
Food and nutrition	77 (89)	79 (85)	78 (174)
Safety	59 (68)	57 (60)	58 (128)
Accommodation	96 (110)	93 (102)	94 (212)
Social participation	50 (57)	58 (59)	54 (116)
Control over daily life	46 (52)*	35 (38)	41 (90)
Occupation	51 (60)	61 (66)	56 (126)
<i>MH</i>			
Personal cleanliness	62 (38)	58 (37)	60 (75)
Food and nutrition	70 (42)	52 (33)	61 (75)
Safety	35 (21)	31 (20)	33 (41)
Accommodation	66 (40)	56 (37)	61 (77)
Social participation	22 (13)	12 (8)	17 (21)
Control over daily life	49 (30)	41 (26)	45 (56)
Occupation	41 (24)	25 (15)	33 (39)
<i>OP</i>			
Personal cleanliness	84 (116)	79 (91)	82 (207)
Food and nutrition	74 (101)	72 (83)	73 (184)
Safety	50 (69)	55 (63)	52 (132)
Accommodation	93 (127)	90 (104)	91 (231)
Social participation	36 (47)	39 (42)	37 (89)
Control over daily life	42 (59)	43 (50)	43 (109)
Occupation	38 (51)	41 (47)	40 (98)

* Significance level: $p < 0.05$.

services. For both quality of life and SCRQoL, the marginal effect was reduced as the intensity of provision increased. In contrast, levels of expenditure were not associated with feeling in control.

Once these factors were allowed for, those in the IB group reported better SCRQoL and control. As we might expect, IBs were only associated with better SCRQoL among IB users whose support plan had been implemented by the time of the interview. Sense of control was less influenced by whether the plan was in place, but it was important to allow for the impact of proxy responses.

We tested for interactions between pilot site approaches to introducing IBs and their impact; none was significant. We also examined whether the high proportion of DP users in the comparison group influenced the effect associated with IBs, given the similarities in these types of

Table 6. Factors associated with variations in outcome

	Quality of life ¹	GHQ ²	ASCOT ¹	Control ³
IB group	0.006 ^{ns}	-0.164 ^{ns}	0.158**	0.537***
Count of abilities undertaking ADL activities		0.323**		
Count of abilities undertaking ADL activities (squared)		-0.007**	2.5E-04**	0.001***
Ability to move outdoors independently	0.112*			
Ability to transfer from and to bed/chair independently			-0.121**	
Evidence of cognitive impairment			0.174**	0.656***
LD user group	0.971***	-2.567***	0.622***	0.716**
MH problems user group		1.306**	-0.305***	
PDSI user group				0.444**
Age		0.066*	0.005***	0.009*
Age (squared)	5.8E-05**	-0.001**		
Student	0.550***			
Employed	0.545**		0.499***	
Lives with partner				0.709***
Weekly expenditure on support	8.5E-04***	-0.001**	3.4E-04*	-1.4E-07 ^{ns}
Weekly expenditure on support (squared)	-5.0E-07***		-1.4E-07 ^{ns}	
Support plan not yet agreed	0.008 ^{ns}	0.131 ^{ns}	-0.102 ^{ns}	-0.235 ^{ns}
Proxy involved in answering outcome questions	-0.236**	-0.009 ^{ns}	-0.027**	0.706***
Declined IB	-0.099 ^{ns}			
Constant	-4.391***	0.328 ^{ns}	3.248***	
R ²	0.12	0.13	0.09	0.08

¹ Positive effects denote improvements in outcome. Model estimated using OLS.

² Outcome is GHQ total score using a 0/1 coding with negative effects denoting improvements in outcome. Model estimated using OLS.

³ Positive effects denote improvements in outcome. Model estimated using ordered logit. ns, not significant; * $p < 0.1$; ** $p < 0.05$; *** $p < 0.01$.

self-directed support; again, there was no effect. There was no evidence of outcome differences between new referrals and current service users.

Discussion

The study was conducted at the very early stages of the introduction of the policy of personalisation and the numbers who actually experienced an IB for any length of time were limited, but the findings remain highly relevant, as later small-scale studies confirm (Lambkin *et al.*, 2010). At the time of the study, resource neutrality was a key policy aim, although, elsewhere, cost reduction was an explicit objective of the equivalent of personal budgets (Arntz and Thomsen, 2008, 2011). At the time of the study, social workers were aware of cost tensions (Jacobs *et al.*, 2011), which have become a central concern of English local councils. Service user researchers have further noted the difficulty for practitioners of translating the values of person-centred support

into organisational priorities and systems (Beresford *et al.*, 2011) and others that a significant shift in the culture would be required (Cunningham and Nickson, 2011). Indeed, rather than a ‘magic bullet’, delivering both better outcomes and lower costs, the results suggest a complex set of messages, with important implications for social work practice.

Perhaps the most important message is that there was evidence that individual or personal budgets can deliver improved outcomes. A key finding was the greater sense of control expressed by members of the IB group, which was not dependent on the plan being in place, or level of resources allocated to the individual. This suggests that the IB and support planning processes may have had a positive impact on people’s perceptions of their own role, which extended beyond the care planning process. When we allow for the impact of level of resources and degree to which support plans were implemented, IBs had a positive impact on SCRQoL for the sample as a whole.

However, looking at the effects in more depth, impacts are dependent on user group. Because these subsamples were smaller, some ‘real’ effects may not reach statistical significance. Analysis of the different measures and dimensions of outcome, reflected in the ASCOT measure, however, is instructive.

For people with MH problems, the impact of IBs appeared to be very positive. Although we could not identify separate statistically significant effects, in all domains of SCRQoL, the direction of effect suggested lower levels of need for those with IBs. They also reported better overall quality of life. Given the limited sample size of this particular user group, the effect must be substantial to reach statistical significance. The circumstances and characteristics of people with MH problems vary widely and we did not have information about individuals’ more specific mental health needs, so the effect may be limited to a particular subgroup. Further, many services for many people with MH problems are provided by integrated health and social care services and teams, who were excluded from this pilot. Nevertheless, our finding is encouraging for a group who do not seem to have been served well by mainstream services and DPs in the past (Manthorpe *et al.*, 2008). The key challenge with this group for practitioners may be in terms of trust and risk taking.

The flexibility and control provided by personal budgets appear well suited to working-age adults with PDSI, who also reported significantly higher levels of overall satisfaction with their support (Glendinning *et al.*, 2008). However, it was notable that, although the directions of effect suggested IB users felt more in control and better able to meet their needs in more ‘basic’ aspects of SCRQoL—such as personal cleanliness, food and safety—these differences were not extended to the ‘higher order’ domains of social participation and occupation. These may be particularly challenging domains to address for this group, suggesting the importance of social work and peer support to assist people

who, while able and willing to act as their own care managers, encounter significant problems in socialising and accessing activities that they value and enjoy.

For people with LD, the effect of IBs was consistently positive with respect to control, but our interpretation of effects was hampered by the high proportion of proxy responses. As with working-age adults with PDSI, people using mainstream services appeared to fare better in terms of social participation and occupation. However, the statistically significant negative effect on occupation was *reversed* once proxy responses were excluded. The small sample size suggests caution in interpretation, but the ‘proxy effect’ may reflect differences in perceptions between the proxy respondent and service user, and/or differences in the types of individuals who needed a proxy respondent. Particularly in these ‘higher order’ aspects of outcome for people with LD using personal budgets, social workers may need to continue to play an active advocacy role in the context of family relationships, some of which may be conflictual or disempowering.

For the largest group of service users nationally—older people—there clearly are important challenges to be met if personal budgets are to prove an effective means of personalisation. IBs appeared to have a negative impact on psychological well-being, at least in the ways the new arrangements were introduced and implemented during the pilot (often taking the form of a direct payment). Use of proxies complicates the picture, but the results suggested that, while lower levels of well-being or higher anxiety levels might be only slightly more prevalent among those older people able to participate in the interview, higher levels of anxiety appear to have been systematically attributed by their proxy respondents. We cannot distinguish whether this is due to the concerns of more vulnerable older people, less able to respond on their own behalf, or of their relatives (the most frequent proxy). Whatever the reason, in addition to this finding, older people did not appear to experience a higher level of control with IBs, unlike younger age groups. It may be that, rather than a sense of control, older people experienced higher levels of anxiety in the process of both planning and managing support—concerns raised by some providers, social workers and care workers interviewed (Glendinning *et al.*, 2008).

Of the ‘basic’ SCRQoL domains, personal cleanliness and accommodation, there were indications of a positive IB effect for older people. However, older IB users seemed to feel less safe than those receiving mainstream services, and, like other groups, tended to report more needs in the ‘higher order’ domains of social participation and occupation.

The lack of a positive effect on control, and possibly associated higher levels of anxiety for older people, may be partly a cohort effect, but clearly it has implications for the pursuit of a ‘personalisation’ policy built on personal budgets, especially direct payments. More support for

users, carers and practitioners will be needed to allay anxiety. Whether this is a role for social workers or can be managed (and at what cost) by third-sector groups is an open question but, as [Arksey and Baxter \(2011\)](#) suggest, such support may require continuity and the ability to respond to frequent changes in circumstances and levels of need.

Whatever the type of support, once we allowed for levels of impairment, level of expenditure was a significant predictor of quality of life, SCRQoL and overall well-being, showing similar patterns of decreasing marginal effects of services to those receiving mainstream services in England in the 1990s ([Davies and Fernandez, 2000](#)). In Germany, an RCT demonstrated that better outcomes were achieved through personal budgets but were also associated with much *higher* formal care expenditure ([Arntz and Thomsen, 2011](#)).

Per capita social care funding for older people is lower than for equivalent levels of impairment in younger age groups ([Forder, 2008](#)). This raises the question of whether, when funding is comparatively low for the level of need, it is simply not possible to take advantage of the potential flexibilities of IBs. It was certainly observed that older people tended to make less use of innovative approaches to support and deployment options ([Glendinning et al., 2008](#)). This might help explain the lack of a positive impact of IBs on older people and, if so, challenge the potential for achieving better outcomes through personalisation at a time of financial austerity ([Audit Commission, 2010a](#); [Dunning, 2011](#)). In terms of equalities, overall equity in levels of resources between age groups might be addressed through savings achieved from support of younger adults, but such shifts are never easily achieved and would be ethically hard to pursue by social workers.

Conclusion

Personal budgets are seen as a cornerstone to achieving the policy aim of enabling service users and their carers to take control over their care and support in England. Given that IBs took significantly longer to be put in place than was anticipated, the effects found in this study are encouraging. However, to achieve these benefits, social workers and other professionals may need to adopt a variety of approaches to supporting people in the process of planning and management, particularly older people (see [Newbrunner et al., 2011](#)). While some have seen personalisation as a threat to the social work profession ([Cunningham and Nickson, 2011](#)), our study also identified that personalisation might require higher levels of support at set-up and planning stages ([Jacobs et al., 2011](#)). The question remains: will sufficient resources be available for adequate personal budgets and to employ professionals who can sustain the flexible and creative approaches needed to support different groups in achieving their desired

outcomes? Social workers may well find themselves at the forefront of implementing a policy with potential for considerable improvements in people's lives in a context that undermines its capacity for success.

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