

Personalised care is the current cornerstone of social care policy across the UK. The shift away from local authority and healthcare professionals controlling provision is set to bring about a dramatic cultural change in the way that organisations operate. Choice and control are two of the key outcomes outlined within the policy direction (DH, 2006). For mental health care, in particular, this represents a significant departure from what has sometimes been perceived as a paternalistic and risk-averse sector.

The balance between empowerment and risk has been the subject of a constant debate within mental health provision for many years, despite the rhetoric regarding recovery-orientated and person-centred approaches. The stigma and prejudice associated with mental health issues, both within services and within society as a whole, as well as the dominance of the medical model within services, has made progress towards the implementation of choice and control slow, with many barriers that have yet to be overcome.

The social model of disability states that it is society that reinforces any impairment that an individual may have – and by addressing social, economic and environmental factors the individual's functioning is improved and they are empowered to participate within the wider community. However, the nature of psychiatric care over the last century has been to focus on diagnosis and symptoms, with the wider public often seeing mental health in a context of fear, misconception and sensationalist media coverage. The impact of risk (perceived or actual) is both an important factor, and a considerable barrier, in the achievement of true user-led provision within mental health care. Perceptions of what constitutes choice and control differ greatly between the users of services, the wider community and the professionals that work within services, and the power relationships inherent within the system need careful consideration.

Over recent years the concept of positive risk-taking has been an area of debate in mental health service provision (Brewis, 2007). The potential consequences of 'getting it wrong' are huge and in some cases fatal. As a result, mental health services are not proactive in promoting user control or positive risk-taking with those who experience mental distress, and in many cases are reluctant to even engage with the process.

In addition, the historic dominance of the medical model in mental health care has created a culture of 'the professional knows best', and the individual is rarely considered the expert in their own situation. The aim of mental health care within the medical context is to return the individual to their pre-morbid personality via treatment and ultimately cure, a perspective that is largely incompatible with self-direction and the personalisation agenda.

Power and powerlessness are aspects that are relevant to all social care services, which by their very nature exist to support those individuals that require additional assistance to live their lives. However, given the legal sanctions within mental health and the imbalance of power it creates, it is often difficult to identify where personalised care is evident. Individuals subject to provisions under the Mental Health Act are not able to exercise control in the same way as other service users, and while it can be argued that they are offered a degree of choice over which services best provide for certain types of needs, there are often limited community options available, which can restrict that choice.

In conclusion, the way that services are organised in the current climate is not wholly conducive to service user control. Although involvement is promoted, this is a very different proposition to that of the individual directing their own care. The potential for individuals experiencing mental distress to have treatment forced upon them, regardless of whether this is in the best interests of them or the community, creates a situation in which the professionals retain the power, and while this may be necessary in terms of health and wellbeing, it also skews the potential for self-direction of care and support within mental health service provision.

Personalisation was discussed at a recent study day organised by the Social Perspectives Network. A further study day, sponsored by Pavilion Publishing, is being planned for December 2008. The aim of these events is to bring together service users, carers, professionals, academics and policy makers in an attempt to resolve some of these areas and make personalisation a reality in mental health service provision. ■

Brewis R (2007) *A Choice & A Voice: Self-Directed Support for People with Mental Health Problems*. London: CSIP.

Department of Health (2006) *Our Health, Our Care, Our Say*. London: TSO.

Perceived risk is a barrier to user-led provision, says Daisy Bogg

the bigger picture

Daisy Bogg is a consultant in social care with Bedfordshire and Luton Partnership NHS Trust and a member of the Social Perspectives Network (SPN). SPN is a coalition of service users/survivors, carers, policy makers, academics, students and practitioners interested in how social factors contribute to people becoming distressed. See www.spn.org.uk