

Chapter 6

Individual Funding for People With Mental Health Issues: Opportunities, Tensions, and Outcomes

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ABSTRACT

This chapter outlines the key features of individual funding programs and examines their suitability for people with mental illness. This is a contested area with some writers concerned that mental illness is different from other types of disability and unsuitable for individual funding. The recovery model and the episodic nature of mental illness are seen as conflicting with individual funding eligibility criteria for consistent and permanent disability. The counter view is that flexible individual funding is ideally suited to meeting the fluctuating needs of people with mental illness: its key principles of empowerment and self-direction being consistent with the recovery paradigm. Evidence from Australian and international studies is reviewed, suggesting that successful outcomes can be achieved if the necessary supports and resources are available to meet people's needs.

INTRODUCTION

The past four decades have seen a marked increase in individual funding models internationally and in Australia, particularly in disability and aged care. Individual funding aims to shift choice and control to people using services through flexible budgets in a services market, with the option to self-direct arrangements if preferred. This chapter explores the implications of these approaches for people with mental illness. Factors influencing choice, control and access to services will be considered, given the

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episodic nature of mental illness and principles of the recovery paradigm. The authors consider key debates, opportunities and risks for people with mental illness and the ensuing challenges for individual funding policy, implementation, and practice. These challenges have been scrutinised in Australia as the National Disability Insurance Scheme (NDIS) rolls out and grapples with ways to respond to the needs of people with mental illness. This major reform offers important lessons for Australia and elsewhere regarding mental health service and support systems. The chapter concludes with recommendations for policy, practice and further research.

BACKGROUND

Individual funding is linked to the broader personalisation agenda in disability and aged care, seeking to promote greater choice and control for people using services in a competitive market model. Individual funding has emerged in response to the shortcomings of previous block funding models where service users were tied to one provider, restricted to services the provider offered, and did not know the budget allocated for their support. From a government's perspective, the previous model provided limited accountability for public funds, as service providers had discretion to distribute funds between running costs and participants' supports.

Individual funding was seen as a mechanism for overcoming these limitations; giving people with disability more choice and control over services, and therefore in their lives. Disability advocates, particularly from the field of physical disability, lobbied for its introduction, as did western governments interested in potential cost savings and finding a way of meeting their obligations to give rights to people living with disability (Dickinson, 2017). Individual funding was seen as a mechanism to encourage creative planning and provide a wider range of supports to meet individual needs and preferences. People with reduced decision-making capacity would be assisted by family or professionals as appropriate. Importantly, individual funding was to place the person at the centre of the decision-making process: to choose their supports and give them greater independence and improved quality of life (Alakeson, 2008; Croft & Parish, 2016).

Individual funding programs reportedly commenced in the 1960s and 1970s when parents of children with disabilities in Canada (Hutchison, Lord, & Salisbury, 2006), and Vietnam veterans with disabilities in the US (Yeandle & Ungerson, 2007) lobbied for community living. Subsequently an array of individual funding programs has emerged in disability and aged care services, with many different structures, administrative arrangements and names. Self-directed support (SDS) has emerged as the most common name being used in Scottish legislation (2013), by the United Kingdom (UK) advocacy group *In Control* (2017), and by the *Cash and Counseling* program in the US (RWJF 2010). Under the umbrella term of self-directed support, the UK has personal budgets and direct payments (Hamilton, Tew, Szymczynska, Clewett, Manthorpe, Larsen, & Pinfold, 2016). Other terms are used elsewhere with some European countries referring to 'cash-for-care' (Da Roit & Le Bihan, 2010) and Australian aged care using the term 'consumer directed care' (CDC).

These programs have core features in common despite their various names and configurations. An assessment of personal needs is undertaken, a budget is allocated to purchase services and supports, and the person has a degree of control over what is purchased. There is an important difference between programs that expect the person with individual funding to self-direct their budget by arranging their supports, employing staff and managing their accounts, and programs that offer support to assist or

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