



Swedish Science Pioneers
Developing World Journal Series

Journal of Clinical Research & Governance

www.jcrg.sciencepub.se



Research Article

Analysis of the Payment by Results Policy for Mental Health in England

Paula Murphy

St Andrew's Healthcare, Billing Road, Northampton, England.

Correspondence

Dr Paula Murphy,
Visiting researcher, Institute of
Psychiatry, 16 De Crespigny Park, London
SE5 8AF
Email: PMMurphy@standrew.co.uk

Keywords:

Health economics
Payment by Results
Mental health
PbR
Funding

Received: 2013-09-22

Accepted: 2014-01-19

DOI: [10.13183/jcrg.v3i1.80](https://doi.org/10.13183/jcrg.v3i1.80)

Abstract

Purpose: To analyse the Mental Health Payment by Results policy with an emphasis placed on exploring the perceptions of Providers involved in implementation, to identify any barriers to implementing the policy and provide recommendations to improve implementation.

Methods: This report follows the structure of the Walt and Gilson policy analysis framework addressing each area of context, content and processes with a focus on actors who are involved in the implementation process to inform how this policy is being implemented in practice. Results from the primary interview data were triangulated with the literature. The data collected was subsequently analysed and barriers to implementation were identified.

Results: The following barriers to implementation were identified: 1) Inadequate time frame 2) Inaccurate data arising from (i) staff not being trained adequately (ii) the Mental Health Clustering Tool (reliability and variability, issues of clarity, difference in thresholds) clustering at the correct times (iii) clustering at the correct times (iii) defining care packages (iv) costing clusters 3) Lack of guidance from central government 4) Insufficient IT systems which do not support the policy 5) Lack of preparation of providers and commissioners 6) Changes in commissioning structure.

Conclusion: On the basis of the barriers identified and the literature review, recommendations to policy makers were made to assist them with improving the implementation of Mental Health Payment by Results.

©2014 Swedish Science Pioneers, All rights reserved.

Introduction

In 2004 in England a new system of financing hospitals was introduced by the Department of Health (DH) called Payment by Results (PbR)[1]. It replaced the previous system of block contract which paid fixed sums for defined levels of service[2]. Whilst administrative costs were low under the block contract, there was no incentive to improve financial efficiency[2].

Under PbR, payment is linked to activity and adjusted for case mix to try and ensure a fair and consistent basis for funding[3]. Hospitals are paid for operations or treatments only when they have done them, with the price fixed by a national tariff for specific procedures. Prices are defined under Healthcare Resource Group (HRG) 'spells' of stay in hospital where a spell of activity is 'a hospital stay from admission to discharge and is a measure of hospital output. An HRG code is assigned to each spell of activity'[1].

When PbR was first introduced into the acute sector the intention was always for it to be extended out into other services[4]. Darzi's *High Quality Care for All* (2008)[5] outlined

the need for PbR to cover mental health services.

Mental health care is more complex than acute care however and transferring this system into mental health funding is challenging. In acute care payment is linked to activity, for example, the number of operations performed, where the cost of one operation can be calculated fairly easily[6]. This does not translate easily into an acute episode of mental illness however. The reason for this is that in many cases diagnosis and severity of the illness do not predict resource use accurately. Factors such as social support, accommodation, area of residence, marital status,[7] drugs, criminality and physical health[6] also impact on cost. In addition treatment is often shared between different agencies, leading to complicated care pathways[6].

Due to the belief that a standardised HRG approach would be difficult to apply uniformly to mental health services[8] a different system for classifying patients was designed. The new system proposed 'currencies' and 'clustering'. Currencies relate to the groupings of similar treatments or patient groups. Clustering involves assessing each patient based on their need and assigning each patient to a cluster. Each cluster is linked to

a tariff using local prices agreed between commissioners and providers[9].

England is not the first country to adopt PbR for financing health care in the acute sector and follows on from other countries such as the USA, Canada and Australia. Whilst no other country in the world uses PbR for mental health funding, Australia and New Zealand have tested mental health classification systems but neither adopted it as a means of funding[9]. This was due to the fact that it was found in both cases that case-mix did not particularly drive cost and '*cost variations were better explained by differences in providers' treatment of similar patients*[9]. England will therefore be leading pioneers in this area and its development and success will no doubt be of interest to many other countries over the succeeding years.

A number of potential risks have been highlighted with Mental Health PbR (MH-PbR) particularly financial risks[10]. In 2005 the Audit Commission warned of the challenges that mental health would face in light of the fact that data quality was generally poor[11].

Why then has this policy come about? What are the perceptions of those involved in implementation and have they been sufficiently prepared in order to ensure its success? This study aimed to answer these questions by interviewing the providers involved in implementing the policy and triangulating the results with the literature.

Methods

Data Sources:

Literature review

A literature review was undertaken to examine the existing literature on the Mental Health Payment by Results policy in England.

Documents were collected and reviewed using multiple database searches, which included:

1. Journal articles identified via Medline, PubMed, PsychInfo, Embase, Ovid.
2. Reports by Department of Health (DH), Kings Fund, Audit Commission, Centre for Health Economics
3. Web resources included DH, National Audit Commission, NHS Confederation
4. Local resources within South London and Maudsley NHS Foundation Trust, the library at the Institute of Psychiatry and library at London School of Hygiene and Tropical Medicine.

Search terms used were: payment by results; mental health; commissioning; diagnosis related group; health resource group; activity-based payments; funding; policy formulation; policy implementation; stakeholders; providers; commissioners; opinions; perceptions; views.

Primary Data Collection: In-depth Interviews

Primary qualitative data was collected from providers of Mental Health Trusts across London who were involved in the policy implementation process. Through collecting and analysing qualitative data it was possible to gain an in-depth understanding of the providers opinions and attitudes towards the new policy. In-depth interviews were conducted in person using an open-ended semi-structured questionnaire. Open-ended questions allowed actors to fully express their viewpoints and experiences.

The semi-structured questionnaire was based on the Walt & Gilson framework which is a simple policy framework designed specifically for health and addresses the context, content, processes and actors involved in the policy as a means of understanding how they interact and influence health policy[12]. The first part evaluated knowledge on the background to the

policy and why it was introduced (context), the policy itself (content) and their views on the policy formulation (process). The second part explored their experiences of implementing the policy (process). The third part gathered information around how prepared they were for MH-PbR and their perceptions on how successful the policy would be.

Care was taken to ensure that the questions were phrased in such a way that they were non-directive towards any perspective.

To ensure operational functioning of the questionnaire plus relevance and understanding of the questions, it was piloted with two participants prior to use on study participants. These were not included in the analysis.

Sampling Strategy

A non-probability purposive sampling technique was used to select participants in a non-random and deliberate manner. Recruitment of participants was voluntary and based on their role as a provider of a mental health trust in London. The medical director of each trust was contacted initially via email and invited to take part in the research. In some instances the medical director nominated another employee within the trust whom they felt would be more appropriate to be interviewed. Following initial contact participants were e-mailed an information sheet describing the study and how they would be involved.

There are 10 Mental Health Trusts providing mental health services in London and all agreed to take part in the study however one trust did not respond to emails or telephone calls to arrange an interview following initial contact and therefore a total of nine interviews were conducted.

Data Collection

Data collection occurred from June to September 2012 in London.

Interviews were conducted in the work place of the participant. In one case it was not possible to meet in person and instead a telephone interview took place. Interviews lasted approximately 60 minutes.

During the interviews, notes were taken and electronically recorded. Over the course of the interviews, interviewees were allowed to talk freely on their knowledge and opinion of MH-PbR and their own experiences of implementation. Interviewees were prompted on the title of each sub-section if the discussion was not flowing easily. The aim in so doing was to saturate the key themes.

Participants were interviewed in private to ensure confidentiality and to encourage them to give open and honest views of their opinions and experiences.

Data Analysis

Deductive analysis was applied using a thematic framework approach based on the three areas of context, content and processes as per the Walt & Gilson framework[13]. As specific themes emerged a detailed coding system was developed which helped to retrieve similar information from a number of the transcripts. The main themes were indexed and coded following which they were cut and pasted into a table using the Walt & Gilson framework areas as headings which were sub-divided further into themes.

To ensure the reliability and validity of information, the interviews were conducted with providers actively involved in the policy implementation process in each trust. Data was triangulated to establish the validity of information which involved cross-checking information by using two or more sources, either from literature or interviews.

Results

Due to provide better readability, the results are summarized in a table format as follows.

Walt & Gilson Framework	Key Areas	Literature Review	Interview themes /quotes
Context	<p>Health system reform</p> <p>Improve services</p> <p>Political changes</p>	<p>Natural progression as part of NHS reforms plan[4,5,14]</p> <p>Block contracts were considered insensitive to volume or nature of services, lacking incentives for efficiency[5,15]</p> <p>The new coalition government emphasized commitment to PbR in mental health[14]</p>	<p><i>"it's already there for the acute sector so it's coming in now for mental health trusts"</i></p> <p><i>"so that you have transparency and know what is being commissioned"</i></p> <p><i>"it is the direction of the successive governments"</i></p> <p><i>"Pushed through by new coalition government in wake of economic crisis"</i></p>
Content	<p>Purpose of MH-PbR</p> <p>Processes involved</p> <p>Method of clustering patients</p> <p>Care packages and Tariffs</p> <p>Frequency of clustering</p>	<p>The intention of the Mental Health Payment by Results (MH-PbR) policy is to develop a system which:[16]</p> <ul style="list-style-type: none"> -facilitates understanding of clinical processes between commissioners and providers, and between clinicians and service managers -distribute the burden of financial risk fairly between commissioners and providers, including financial risks arising from demand for services, service activities, service quality, and service efficiency - incentivises both commissioners and providers to deliver effective, efficient and equitable models of treatment and care. <p>Achievement of these principles requires a series of processes:[17]</p> <ul style="list-style-type: none"> -identification of a currency -identification of a tariff: the price to be paid for each unit of service activity <p>-agreement of a contract structure, containing not only currencies and tariffs, but also specifications of service models, care pathways, volumes (and volume thresholds) and outcome / performance incentive arrangements.</p> <p>Patients are clustered using an assessment tool called the Mental Health Clustering Tool. This tool has 18 scales (e.g. depressed mood), the first 12 of which are the Health of the Nation Outcome Scales (HoNOS). Each scale is given a rating from 0 (no problem) to 4 (severe to very severe problem).[16]</p> <p>It is intended that the clusters and the assessment tool will develop over time as the NHS tests and refines them. Whilst there should be national consistency in the use of clusters and the assessment tool, the service response is not being nationally defined and a menu of care options available to individuals will need to be developed locally.[18]</p> <p>Each cluster has a defined care package and is linked to a tariff[18]</p> <p>Clustering of patients should occur at three points[18]</p> <ul style="list-style-type: none"> -initial assessment; -scheduled reassessment; and -any reassessment following a significant change in need that cannot be met by the continuation of the current cluster 	<p>All providers had very good knowledge of the intention behind Mental Health Payment by Results</p> <p>All providers were aware of the processes involved</p> <p>All providers were knowledgeable of the method by which patients were clustered</p> <p>All providers were aware that clusters were associated with care packages and a tariff</p> <p>All providers were aware of the frequency of clustering patients.</p>

		care package	
Policy Formulation	<p>Top down process</p> <p>Stake-holders</p> <p>Currencies</p> <p>Mental Health Clustering Tool (MHCT)</p> <p>Care packages and Tariffs</p>	<p>Government led on formulating the policy via ‘a central co-ordinating role with much of the development being done through the testing of approaches locally’[16]</p> <p>Stakeholders consulted included Mental Health Providers and their regulatory bodies, commissioners, service users, Professional clinical bodies, Information Centre for Health and Social Care, NHS Connecting for Health, Audit Commission Healthcare Commission, NHS Confederation[16]</p> <p>A model, originally designed to improve the quality and consistency of services within South West Yorkshire Mental Health Trust, was tested and ultimately accepted as a classification system which would provide the basis for currencies within mental health[19]</p> <p>Service users are grouped into one of 21 clusters, organised under three super classes ‘non-psychotic’, ‘psychotic’ and ‘organic’, using a tool, shown below in Figure 1.[19]</p> <p>The Department of Health commissioned the Health and Social Care Information Centre (HSCIC) with the remit of developing the tariffs or currencies.[20] The HSCIC then set up the Care Packages and Pathways Project (CPPP) involving six mental health provider trusts in North East England.[21] The ‘Quality and Outcomes’ group was then established between the DH and CPPP[9]</p> <p>The DH created a web based tool to provide guidance on the content of care packages for each of the clusters.[16]</p>	<p>Viewed overwhelmingly as a top down process “with grass roots contributing”</p> <p>Overall the formulation of the policy was viewed as being controlled centrally. “Not enough front line workers” “Only very senior staff involved”.</p> <p>Clustering widely supported as it improved transparency Also viewed as a rational system for allocating resources</p> <p>There was general ambivalence towards the tool used to cluster (MHCT) “not fit for purpose” “was never designed as a commissioning tool”</p> <p>Care packages widely supported “care packages will provide more consistency”</p> <p>Most of the providers did not find the information on the web site informative enough</p>
Policy Implementation	<p>Time frame</p> <p>Communi-cations</p> <p>Barriers to Implemen-tation</p>	<p>On 1 April 2010 the DH informed providers:[22] By 2010/11 clusters available for use By 2011/12 tariffs agreed By 2012/13 clusters with prices mandatory for contracting and payment purposes.</p> <p>These dates have all been pushed back and currently block contracts are still being used for commissioning purposes</p> <p>The government communications were distributed externally through fact sheets on DH website[16].</p> <p>A Mental Health Readiness Review by Mental Health Network NHS Confederation (2011)[17] identified 9 barriers to implementation:</p> <ol style="list-style-type: none"> 1.Clustering service users 2.Defining packages of care associated with each cluster 3.Local tariffs 4.Contracting arrangements for 2012/13 5.IT infrastructure 6.Commissioning 7.Social care 8.Independent sector 9.Support in implementing PbR <p>The readiness review (2011) revealed concerns about the tool being used to cluster. ‘Significant concerns were raised about the quality of the clustering data. Inter-rater reliability was raised as an issue as part of the national development</p>	<p>Time frame in which to implement was felt to be too short by most apart from 2 providers who said it was 2 slow. Frustration related to deadlines being pushed back or changed. “They keep changing the dates”</p> <p>It was generally considered that there had been poor communication from the DH</p> <p>Barriers identified in interviews have been split into 6 themes:</p> <p>1.Inaccurate data</p> <p>Participants described many potential sources of inaccurate data which impinged upon effective implementation of the policy</p> <p>These have been sub-divided according to theme:</p> <p>1a) The Tool used to cluster patients was viewed negatively “We have done some reliability and validity testing by peer reviews and the results have been variable.” 1b) Not having all staff trained or staff not understanding the tool even after training</p> <p>1c) Clustering and re-clustering at the correct times was described as “a real uphill struggle”</p> <p>1d) Difference in thresholds. Many providers commented on the possibility of there being a</p>

	<p><i>work and has not been satisfactorily resolved</i>.[17]</p> <p>Jacques (2008), <i>'even if tariffs are accurate, there may still be problems applying them. Some service users may become more 'attractive' to treat than others – for example, they could see themselves 'up coded' by trusts to a more expensive tariff so that service providers could charge more from those commissioning the service. This is known in the acute hospital sector as 'diagnosis-related group (DRG) creep'</i>:[21]</p> <p>Guidance from the DH in October 2011[22] outlined that <i>'commissioners should work constructively with providers to ensure a smooth transition to the new system in 2012-13. Providers must share relevant information with commissioners on cluster activity, cluster packages of care, and cluster costs, following the principles contained in the PbR Code of Conduct. Such information exchange can also form of a Memorandum of Understanding (MOU). Commissioners should work with their local clinical commissioning groups in 2012-13 to ensure that they understand the new approach to funding mental health services.'</i></p> <p>Mental Health Payment by Results Survey Report (2012)[23] by Healthcare Financial Management Association identified 6 barriers to implementation:</p> <ol style="list-style-type: none"> 1. Poor data quality/collection 2. Poor information systems 3. Difficulties in developing a robust costing model 4. Clinical engagement 5. Competing priorities 	<p>different threshold for admitting people in different parts of the country and even in different parts of London due to complexities such as homelessness, drugs and disengagement and that the thresholds for admitting patients in their trust were different to the thresholds suggested by the clustering tool.</p> <p>1e) Defining the care package for each cluster. Some providers were not sure how they should approach it and said that the guidance provided was not adequate.</p> <p>1f) Calculating tariffs. This was raised by all providers as being the most problematic process in the implementation. "rough costs for clusters have been done but they are not worth the paper they are written on because data quality is poor"</p> <p>2.Changes to commissioning All providers commented on the structural changes taking place in the NHS and there was wide spread concern around the commissioning of services in the future under the CCG arrangements led by GPs.</p> <p>3.Lack of guidance "We need better statements and guidance from central government." "Guidelines on how to cost are non-existent"</p> <p>4.Insufficient IT systems All providers commented that their IT systems were not sufficient.</p> <p>5.Lack of funding "We have had to employ financial analysts, buy software, build IT systems and employ someone to do that, plus someone to do project management and all the costs have been absorbed by ourselves"</p> <p>6.Level of preparedness Most providers did not feel adequately prepared for the policy although a couple felt that they were.</p>
--	--	--

Discussion

The implementation of PbR into mental health trusts is complex. Part of the difficulty lies in the fact that it has been and continues to be an iterative process. Different approaches to the implementation process between trusts could lead to failure of some to achieve the policies objectives. This was predicted by Jacques in 2008, *'Some trusts will do well as others struggle and it is likely that the trusts that benefit and thrive with payment by results, will already have robust and organised information and cost management systems, and work with high-quality and efficient service providers'*[21].

In this study the results of both the HFMA survey and the readiness review were compared and contrasted to the results from the primary interview data and were generally found to be complementary. Both the HMFA survey and the readiness review were conducted roughly one year prior to the interviews in this study. The readiness review which involved a much broader group of stakeholders, made reference to the fact that interviews were conducted prior to the publication of additional national guidance published in October 2011 stating *'we are conscious comments and views may already have changed in the light of the additional guidance'*[17]. However the issues raised in this study, conducted after the additional guidance was issued, echo the issues raised in the readiness review.

The main concern of providers was the local tariff and how meaningful costs would be under this system thus reflecting the initial warnings surrounding the potential financial risks.

Implementation challenges were predicted years ago alongside warnings to ensure adequate preparation however this continued to be a concern of providers. Many of the providers commented on a lack of 'clinician buy in' mainly due to the many uncertainties surrounding inaccuracies in the data. In particular the MHCT was often questioned. Such concerns are perhaps not unfounded. Whilst there is no published research yet on the reliability and validity of the MHCT, there have been many studies looking at such properties of HoNOS, which forms the basis of the MHCT. Results have found *'at best moderate interrater reliabilities and its validity is under question. As such, it is concluded that the psychometric properties of the HoNOS do not warrant its use as a routine measure'*[24]. One way therefore to get 'clinician buy in' would be to address these issues through a rigorous research approach aimed at providing answers to the many questions raised allowing for a tried and tested structured approach to implementation.

In a report by the Sainsbury Centre for Mental Health in 2006 it was speculated, *'the very concept of payment by results arouses degrees of pessimism and perhaps resentment among mental health services'*[21]. It was apparent from the primary and secondary sources of data that policy implementers are very supportive of PbR in mental health however and there was a palpable enthusiasm and energy during interviews from providers who were fully invested in this policy. It is essential that this energy is channelled effectively by policy makers as success relies on the continued dedication of the entire mental health workforce.

PbR in mental health is an innovative system and one in which will make England international pioneers of a new funding mechanism for mental health services however failure of this policy could have catastrophic outcomes for the mental health economy and ultimately mental health patients.

The success of this policy is dependent on how good local systems are developed and implemented. Given that most providers feel they have not had adequate guidance on how to do this it will invariably lead to variation in its approach and therefore in its quality, somewhat ironically as the objective of MH-PbR is to improve quality. The government need to provide robust detailed guidance based on rigorous research strategies on each and every step of implementation if this policy is to succeed.

Limitations of the Research

1. The policy for PbR in mental health is still in the process of implementation and as such remains a dynamic policy undergoing changes. Full policy

implementation has not yet occurred thereby limiting the ability to analyse the policy on its finer technical details.

2. Research was only conducted in the London area and this is a national policy. It would be useful to be able to compare other parts of the country.
3. Due to the transitional stage of commissioning arrangements, interviews with commissioners could not take place as the new commissioners had not been appointed and current commissioners were doubtful of their jobs and not keen to be interviewed therefore commissioners experiences could not be sought. This was seen as a major limitation as commissioners are a vital part of the process.
4. Another major limitation was the small sample size. Whilst nine out of the ten Trusts were represented, this amounted to only nine individuals and it would have been more meaningful to have wider viewpoints from each Trust.

The viewpoint of top level stakeholders involved in the policy formulation were not sought nor the views of service users.

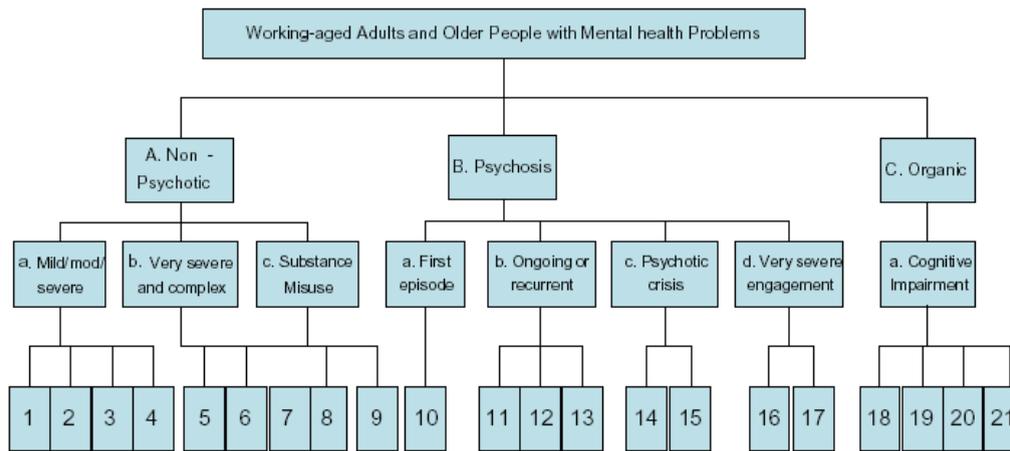


Figure 1. The Mental Health Clustering Tool which is used to cluster patients. Each cluster is associated with a structured care pathway and care package alongside a particular tariff and expected time frame for admission.[19]

Recommendations

1. The government needs to provide clear and detailed guidance for each stage of the implementation phase. In particular more guidance should be available on care packages and costing.
2. Improve communications to allow regular communication on developments from the government, more opportunity for front line staff to provide feedback and a means of sharing information with other stakeholders, such as an online forum or website.
3. A longer period of implementation is required with mechanisms in place to check that the systems which have been developed locally by trusts are adequate and appropriate.
4. Transitional funding should be made available to assist trusts in implementing this policy.
5. Rigorous research should be undertaken to address each quality issue i.e. training of staff, the MHCT (inter-rater reliability, intra-rater reliability, validity, complexity issues, threshold issues), differences in care packages and the validity of the costing process.
2. Greun R, Howarth A: *Managing Health Services Finance*. Berkshire: Open University Press; 2005.
3. Richard L, Jennifer D: *NHS market future: exploring the impact of health service market reforms*. London: Kings Fund; 2005.

This is essential not only to ensure clinician buy in but also to ensure the feasibility of this funding mechanism for mental health.

6. The IT requirements for this policy need to be established. A standardised electronic system for reminding staff when to cluster and re-cluster should be developed.

There needs to be an intensive programme of teaching for commissioners in particular and provider/commissioner links should be strengthened through joint workings.

Conflict of interests: The author declares no conflict of interest.

References

1. Farrer S, Sussex J, Yi D, Sutton M, Chalkely M, Scott T, et al: *National Evaluation of Payment by Results*. Health Economics Research Unit. HERU, University of Aberdeen; 2007.
4. Department of Health: *Reforming NHS Financial Flows. Introducing Payment by Results*. London: DOH; 2002.
5. Darzi A: *Our NHS our future: NHS next stage review Interim report*. London: Department of Health; 2007.

6. The Sainsbury Centre for Mental Health: Policy Paper 4: Payment by results: what does it mean for mental health? London: SCMH;2004.
7. Oyeboode F, Cumella S, Garden G, et al: Diagnosis-related groups: implications for Psychiatry. *Psychiatric Bulletin* 1990,14: 1– 3.
8. Department of Health: *Mental Health, Payment By Results, Care Packages And Pathways Project*. London;2007.
9. Mason A, Goddard M: Payment by Results in Mental Health: A Review of the International Literature and an Economic Assessment of the Approach in the English NHS. CHE Research paper 50. Centre for Health Economics, University of York;2009.
10. *Audit Commission Review of the NHS Financial Management and Accounting Regime, A report to the Secretary of State for Health*. London: Audit Commission; 2006.
11. *Audit Commission Early Lessons from Payment by Results*. London: Audit Commission; 2005.
12. Buse K, Mays N, Walt G: *Making Health Policy*. Maidenhead: Open University Press; 2005.
13. Walt G, Gilson L: Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning* 1994, 9(4): 353- 370.
14. Department of Health: *Equity and excellence: liberating the NHS*. London; 2010.
15. Department of Health: *The Power of Information*. London; 2012.
16. Department of Health: *Project Initiation document, Mental Health Payment by Results development project*. London;2008.
17. Mental Health Network NHS Confederation. *Mental Health Readiness Review*. [http://www.nhsconfed.org/Publications/Documents/PBR_241111.pdf]
18. Department of Health: *Practical guide to preparing for PBR in mental health*. London; 2009.
19. Department of Health: *A report on the development of a mental health currency model: Care Packages and Pathways Project*. London;2008.
20. Fairbairn A: Payment by Results in mental health: the current state of play in England. *Advances in Psychiatric Treatment* 2007,13: 3-6.
21. Jacques J: Payment by Results and Mental Health Services. *Psychiatric Bulletin* 2008, 32 (10):361-363. doi: 10.1192/pb.bp.108.020370.
22. Department of Health: *Payment by Results draft 2012-13 Mental Health Guidance*. London: 2011.
23. Healthcare Financial Management Association: *Mental Health Payment by Results Survey Report*. London; 2011.[<http://www.londonhp.nhs.uk/wp-content/uploads/2011/08/survey-report.pdf>]
24. Brooks B: The reliability and validity of the Health of the Nation Outcome Scales: validation in relation to patient derived measures. *Australian and New Zealand Journal of Psychiatry* 2000,34 (3):504-11.