Journal of Mental Health
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713432595

A census study of independent mental health sector usage across seven Strategic Health Authorities

To cite this Article: , 'A census study of independent mental health sector usage across seven Strategic Health Authorities', Journal of Mental Health, 16:2, 243 - 253
To link to this article: DOI: 10.1080/09638230701279824
URL: http://dx.doi.org/10.1080/09638230701279824

Journal of Mental Health,
April 2007; 16(2): 243–253

informa
healthcare

REVIEW

A census study of independent mental health sector usage across seven Strategic Health Authorities

TONY RYAN[1,2], BARBARA HATFIELD[1], INDHU SHARMA[1], VICKY SIMPSON[1], & ALASTAIR McINTYRE[3]

[1]*Mental Health Social Work Research Unit, Department of Psychiatry, University of Manchester,* [2]*Health and Social Care Advisory Service, and* [3]*Care Services Improvement Partnership, National Institute for Mental Health in England, West Midlands Development Centre, UK*

Abstract

Background: Private and voluntary organizations are significant providers of mental health and social care in England. Limited strategic information is available on the range of people placed into independent sector care.

Aim: To describe independent sector usage by NHS and local authority commissioners through examining secondary mental health care placements for adults of working age, types of service provision, linkage between agencies and associated costs.

Method: A census day study was undertaken across all agencies commissioning mental health services within seven Strategic Health Authority areas ($n = 127$). A 100% response rate was obtained from data providers consisting of 82 Primary Care Trusts, 42 Local Authority Social Services Departments and three specialist commissioning agencies. Data was obtained for 3,510 cases.

Results: A weekly expenditure of over £2.98 M was identified with considerable variation in costs across and within client groups. All illness groups were being supported across the full range of service models. Many people were placed at distance and links with CPA care co-ordinators and commissioners were frequently not robust.

Conclusions: Private providers dominate the independent sector and require strategic engagement. Improved co-ordination between the independent sector, NHS provider trusts, CPA care co-ordinators and service commissioners would more effectively utilize this significant resource.

Declaration of interest: This work was part of a wider programme of work that was funded through grants from Care Services Improvement Partnership National Institute for Mental Health in England Development Centres in the North West and West Midlands and the County Durham and Tees Valley Strategic Heath Authority.

Keywords: *Mental health providers, independent sector, CPA care co-ordinators, service commissioners*

Background

The involvement of the independent provider sector in Europe and the USA is a longstanding feature of the system of healthcare delivery (Blank & Burau, 2004; Blomqvist, 2004; Elkan, 2003; Ham, 2005; Harrison, 2004; Maio & Manzoli, 2002). In relation to the

Correspondence: Dr Tony Ryan, Tony Ryan Associates, 26 Sergeants Lane, Whitefield, Manchester M45 7TS, UK.
Tel: +44 (0)7968 031 087. E-mail: info@tonyryan.org

ISSN 0963-8237 print/ISSN 1360-0567 online
DOI: 10.1080/09638230701279824

provision of mental health care specifically, the relative merits of who should be providing services would seem to be less of a concern elsewhere than it is currently in the UK (Becker & Vazquez-Barquero, 2001).

In the US Rosenau and Linder (2003) found substantial performance differences between private and not-for-profit mental health providers across the country since 1980. In all but one of 17 national studies not-for-profit organizations were found to have performed as well or better than their for-profit counterparts in the provision of in-patient care in the areas of access, quality, cost-effectiveness and charitable care (the provision of care to bad debt patients or those with histories of unpaid care). Dorwart et al. (1991) found the increase in private psychiatric hospitals widened the availability and choice for privately funded patients but did nothing for those reliant upon public funding. At the start of the 20th century psychiatric care was largely provided by the charitable sector, however, the 1980s saw the market being dominated by for-profit organizations (Dorwart & Schlesinger, 1988) who were "highly motivated by commercial concern" (Hall & McGuire, 1987). The end of the 20th century saw a reversal of this with provision being largely delivered through the not-for-profit sector. Rosenau and Linder (2003) suggest the primary reason for this shift is due to the poorer performance of for-profit providers in relation to their not-for-profit counterparts.

In England mental health placements of people into independent sector services is significant and of increasingly concern to many who are responsible for funding services. The independent sector in England consists of voluntary (not-for-profit) and private (for profit) organisations. The sector has been a key part in the provision of mental health care in England in recent years and is set to become more so in the near future (Department of Health (DoH), 2005a, DoH, 2006). However, concerns have been raised in respect of quality, cost, appropriateness, case monitoring and service regulation, ability to return to the area of origin and the distance of some placements from relatives (Brindle, 2004; Cooke & Carpenter, 2002; Jaydeokar & Piachaud, 2004; Poole et al., 2002; Royal College of Psychiatrists, 2005; Ryan et al., 2004; Ryan et al., 2005a; Ryan et al., 2005b; Ryan et al., 2005c).

The last 10 years have seen the independent sector grow and develop considerably whilst provision of mental illness beds in the National Health Service (NHS) and local authorities has declined. Between 1994/5 and 2004/5 the number of NHS beds fell by 23.5% from 41,380 to 31,645 while between 1994/5 and 2000/1 the number of private sector beds rose by 49.2% from 47,980 to 97,600 (DoH, 2005b; DoH, 2005c). The growth in independent hospitals, care homes with nursing and care homes shows no sign of abating (Mental Health Act Commission, 2006), and is supported within an increasingly sympathetic political climate. By 31 March 2005 the Healthcare Commission estimated there would be 229 private and voluntary healthcare establishments registered as independent hospitals with approximately 6,000 mental health beds, most of which would be registered to provide services to people subject to the Mental Health Act (Healthcare Commission, 2004).

At 31 March 2004 in England 2,300 patients were detained under the 1983 Mental Health Act in private and voluntary sector facilities whilst 11,700 were detained in NHS services (DoH, 2004a). Formal admissions under the 1983 Mental Health Act into independent sector facilities have risen from 601 in 1993/04 to 1,403 in 2003/4, with a further 1,933 informal admissions being subsequently detained in 2003/04 (DoH, 2004a). The number of NHS secure beds has increased by 137% from 1,080 to 2,560 between 1994/95 and 2003/04 (DoH, 2005b). A significant number of secure beds are also provided outside the NHS with 34% of beds in England in private ownership in 2000 (DoH, 2000/01).

The independent sector delivers the same range of services that are delivered by statutory providers, including continuing care services, secure services, CAMHS and acute care services. With a dispersed range of services some service users have been moved away from

their families and communities and important relationships have been lost or damaged as a result. Many have also been excluded from their home communities and from local services despite the fact the National Service Framework (DoH, 1999), Reed Report (DoH, 1992) and the Children Act (2004) all espouse the principle of placing people as close to home as possible and in the least restrictive environment.

Chisholm and Hallam (2001) have suggested that because community care may be more expensive than originally thought this is a key factor behind the high number of out of area treatments (OATS) into institutions of various forms. Macpherson et al. (2004) and Ryan (2005) have linked the issue to local whole systems and the lack of supported accommodation in the community.

In the learning disability field Forsyth and Winterbottom (2002) found a disparity and variation in spend. They found areas with larger budgets were more likely to export people through OATS. Somewhat paradoxically they also found that areas exporting clients were more likely to be smaller urban health authorities and suggested geographical size was the more likely cause than urban-ness. Several commentators have argued that exporting people results in an additional burden to the import area (Forsyth & Winterbottom, 2002; Jaydeokar & Piachaud, 2004). In one study of a new private sector learning disability service Mitra and Alexander (2003) suggested this resulted in an unplanned increase in the workload of local learning disability and mental health services.

The NHS Plan (DoH, 2000) encouraged an increased role for the private sector in health care. Moore (2001) suggests that in England specialized commissioning agencies have made progress in building relationships with the private sector service providers through dealing on behalf of many commissioners resulting in less ad hoc and more block contracts. However, there is still significant evidence of this fragmentation in many niche markets (Ryan et al., 2005a, b, c). Moore also suggests that providers have claimed they wished to have long term relationships and contracts with the NHS in specialist areas. However, the reality has been that they are happy to work in all areas. This in part could be due to the poor market management of NHS providers and not solely the profit making motives of the private sector as they have had to work opportunistically to stay in the market.

The review of the National Service Framework (NSF) indicated that £157 million was being spent annually on OATS and this was creating significant financial difficulties, with the majority being spent on high-cost low volume referrals to forensic units (DoH, 2004b). In addition to this expenditure there are considerable high-volume low-cost placements made to non-forensic services and placements made in partnership or solely by Local Authority Social Services Departments. Indeed, a recent study found that 95% of OATS for mental health and learning disabilities across one Strategic Health Authority (SHA) were into the independent sector (Ryan et al., 2005a), although this may vary elsewhere. Interestingly, despite the independent sector being an area of high growth a clear picture has not been available to date in a systematic format or on a large scale of the expenditure or the characteristics of some of the client groups.

To date a considerable focus has been upon OATS placements, i.e., placements outside the area of the commissioner or main service provider. However, the growth of the independent sector has seen placements both "within" area and "outside" take on increased significance to commissioners seeking to understand local whole systems (Ryan et al., 2005a).

Aim

To describe the use of the independent sector by NHS and Local Authority commissioners of secondary mental health care on a census date. The study examined placements for

adults of working age, nature of service provision, links between key agencies and associated costs.

Method

A census day study using a designed-for-purpose instrument was undertaken across all agencies commissioning secondary mental health services within seven SHA areas ($n = 127$). Data was collected from all PCT and social services commissioners of mental health services including secure commissioning teams. Data was collected in relation to all individuals placed in independent (private or voluntary) psychiatric hospitals, care homes with nursing and care homes on a study "census date" of 28 June 2004 in six of the SHA areas, and 7 October 2004 in the seventh.

The seven SHAs were not selected randomly. Six were encompassed within National Institute for Mental Health England (NIMHE) regional boundaries for the North West and West Midlands. The seventh was an individual SHA in the North East, where the study took place slightly later. The choice of sites reflected the interest and financial support for the study from the two NIMHE regions and the individual SHA. Although the results from the study cannot be generalized to the whole country, the population within the seven SHA areas comprises around a quarter of the population of England and it is likely the issues identified are not unique to these areas.

A standard questionnaire was developed in collaboration with commissioners in the study areas and was subject to intensive piloting before a final version was agreed. Commissioners of mental health services were asked to complete the finalized questionnaire in respect of each individual in placement on the census date. Data collected included basic demographic details, information about the placement, provider information and associated costs. Service users in all age ranges were included; although this paper only reports on adults between 16 and 65. Commissioners were requested to provide written confirmation that data on all cases placed in the independent sector on the census date had been provided. Supplementary data on providers was obtained by direct contact, from their websites or those of their regulators.

The study was approved by the North West Multi-Centre Research Ethics Committee and by the University of Manchester Senate Committee on the Ethics of Research on Human Beings.

Data was analysed using SPSS Version 12.0.1 (SPSS, 2001).

Results

A 100% response rate was obtained from the 127 data providers consisting of 82 Primary Care Trusts, 42 Local Authority Social Services Departments and three specialist commissioning agencies. Data was obtained for 3,510 cases.

Client demographic details

A total of 3,510 adults were identified as being placed in the independent sector on the census dates. Of these 2,210 (63.0%) were men, 1,280 (36.5%) women with a further 18 (0.5%) people whose sex was "not recorded". The mean age was 46.3 years (men = 45.8 years; women = 47.0 years). The majority of people were White British (2,221; 63.2%), 100 of Caribbean origin (2.8%) and a further 193 from a wide range of other ethnic groups (5.5%). The ethnicity of 1,002 people (28.5%) was not known.

A wide range of diagnoses were supported (Table I). Additionally, 332 (9.5%) people had a co-existing alcohol dependence, 153 (4.4%) a drug dependence and 340 (9.7) a learning disability, which suggests some degree of complex needs.

In respect of the 1983 Mental Health Act a total of 1,178 (33.6%) people were not detained, 736 (20.9%) were subject to Part 2 (civil provisions) of the Act or ''required to reside'' under Guardianship or Supervised Discharge requirements while a further 95 (2.7%) were subject to Part 3 of the Act (forensic provisions). The Mental Health Act status of 1,444 (41.1%) people was unknown to service commissioners.

Client information is analysed in greater detail in a companion paper (Hatfield et al., in press).

Provider information

In total 448 organizations provided placements of which 397 (88.6%) were private sector providers and the remaining 51 (11.4%) from the voluntary sector (Table II). The private sector dominated provision in each of the three types of registration with 2,754 (78.5%) placements being provided by 397 organizations in contrast to 59 voluntary sector organizations supporting 713 (20.1%). A small number of providers dominated the market with 55 (12.3%) delivering 1,827 (52.6%) of the total bed usage on the census dates. At the other end of the distribution 130 (3.7%) formed a ''long tail'' of single placements. A broad range of services were commissioned although the overwhelming majority (74.7%) were described as continuing care placements (Table III).

Service links to area of origin

On the day of the census 2,071 (59.0%) people were known to have a care co-ordinator and 1,541 (43.9%) to have a consultant psychiatrist from the area commissioning the placement.

Table I. Principal psychiatric diagnosis.

Principal diagnosis	Frequency	Percent
Pick's disease	6	0.2
Huntington's Chorea	49	1.4
Korsakoff's Syndrome	108	3.1
Early onset dementia	85	2.4
Acquired brain injury	101	2.9
Other organic condition	27	0.8
Schizophrenia	1,174	33.4
Schizo-affective disorder	101	2.9
Bi-polar disorder/affective psychosis	148	4.2
Other psychotic disorder	45	1.3
Depression	78	2.2
Anxiety disorder	20	0.6
Other neurotic disorder	11	0.3
Eating disorder	39	1.1
Personality disorder	152	4.3
Autism/Asperger's syndrome	95	2.7
Other	44	1.3
Non-specific mental illness	1,227	34.9
Total	3,510	100.0

Table II. Registration type by sector.

Type of registration	Private sector		Voluntary sector		Total
	Services	Placements	Services	Placements	Services (Placements)
Independent hospital	58	521 (77.5%)	9	151 (22.5%)	67 (672)
Care home with nursing	162	991 (86.9%)	23	150 (13.1%)	185 (1141)
Care home	288	1,198 (74.7%)	48	406 (25.3%)	366 (1604)

Table III. Type of placement.

Type of service	Frequency	Percent
Acute in-patient ward	49	1.4
PICU	33	0.9
Low secure	70	2.0
Medium secure unit	185	5.3
Rehabilitation unit	410	11.7
Continuing care service	2,622	74.7
In-patient psychotherapy service	11	0.3
Specialist eating disorder facility	24	0.7
Specialist mother & baby service	2	0.1
Women only unit	15	0.4
Other service	49	1.4
Specialist learning disability service	23	0.7
Missing	17	0.5
Total	3,510	100.0

A total of 2,065 (58.8%) people were felt to be appropriately placed with 174 (5.0%) placements regarded as inappropriate. However, in 1,271 cases (36.2%) the suitability of the placement was not known to the commissioner.

A total of 1,938 (55.1%) placements were made within the geographical boundaries covered by the commissioner. Of the remaining placements 1,205 (34.3%) were known to be outside their geographical area, although in a further 372 (10.6%) cases it was not known whether the placement was inside or outside the area.

Costs

Social services funded the greater number of placements being involved in nearly three-quarters of all cases whilst health the expenditure was greater (Tables IV & V).

The mean cost per week for independent hospital placements was £2,267 (based on 632 cases), care homes with nursing averaged £586 ($n = 1,109$) and care homes £505 ($n = 1,549$). Weekly costs by service type varied considerably and ranged from £3,520 for psychiatric intensive care unit (PICU) beds through to £548 for continuing care placements. Weekly costs by diagnosis also varied widely with eating disorder placements being the most expensive (mean = £2,847 per week) to early onset dementia (mean = £594 per week).

Considerable variation existed between the costs being paid by each of the seven SHAs with means ranging from between £1,378 to £746 per week. This variation no doubt reflects difference in local need, local economics, service supply and contracting practices. The most expensive placement during the census was one of £9,310 although this did include £5,712

Table IV. Number of placements by funding stream.

Funding stream	Frequency	Percent
Social services only	1,707	48.6
Health only	854	24.3
Joint health & social services[1]	903	25.7
Other	6	0.2
Missing	40	1.1
Total	3,510	100.0

[1]Jointly commissioned or Section 31 Health Act pooled budget.

Table V. Health and social care costs.

Cost per week	Mean (£)	Maximum (£)	Sum (£)	Cases	Missing cases
Health	532	6,550	1,813,878	3,411	99
Social services	273	3,456	934,288	3,421	89
Total	863	9,310	2,897,782	3,356	154

of additional costs, associated with high intensity nursing. The most expensive placement without additional costs for the week of the census was £6,550.

In relation to use of the 1983 Mental Health Act placements for individuals detained under Section 47/49 were the most expensive and averaged £3,653 per week with Section 117 patients being the least costly at £706.

Discussion

A considerable number of people are now placed in the independent sector, often for lengthy periods of time. The expansion of beds in this sector has taken place at a time when NHS and Local Authority beds have declined. Independent sector provision in independent hospitals, care homes with nursing and care homes is dominated by the private sector. In this study we have identified that all forms of psychiatric diagnosis are being provided for in the independent sector. They are also being provided with care and treatment in the full range of services that are delivered by the NHS. Whilst many people are placed for continuing care there are also a number who have complex needs suggesting a lack of local capacity or capability in the NHS.

At the micro level links between service providers, Care Programme Approach (CPA) care coordinators, area of origin clinicians (where the RMO responsibilities have not been transferred) and commissioners have been shown to be extremely variable (Ryan et al., 2004). Care coordination is the responsibility of the area of origin services until it has been formally transferred to services in the area of the placement, where this is appropriate. In this study less than 60% of individuals (2,071; 59%) were known to have a CPA Care Coordinator from the area of origin or provider service area. This may be explained by links between commissioners and care coordinators not being sufficiently robust to ensure that the commissioner has such information. It may also be explained however by CPA coordinators working with caseloads where crisis work is a major part of what they do and people placed in independent sector beds are not given equal priority. Additionally, some placements probably pre-date the implementation of CPA. Whilst only 1,541 (43.9%) of

placements had a named consultant psychiatrist from the commissioning area this is probably of less concern as many cases may have been transferred to the local team in the area of the placement provider. Even where there are formalized links through named CPA coordinators and consultant psychiatrists the fact that a significant number of people are placed at great distance (31 people were placed over 200 miles from their area of origin) does not improve the ability of staff to monitor the effectiveness and appropriateness of care. It also hinders the person in maintaining contact with family and friends in the area where they have originated from.

There was a considerable amount of information not known to the commissioners of services. The diagnosis was unknown in just over one third of cases (1227; 34.9%), in a further 1,002 (28.5%) cases the ethnicity was unknown and in 1,444 (41.1%) cases the legal status was not known to the commissioner. Such knowledge gaps are likely to be a failure of poorly functioning systems rather than poorly functioning commissioners. Furthermore, the commissioning resource available to provide effective monitoring is likely to have been variable across the areas covered. However, clinical knowledge of this type should be as important to commissioners as it is to clinicians as it can inform future commissioning strategies and the development of local service systems.

Lack of commissioner held information may indicate that information flows between clinicians, provider services and commissioners are not sufficiently robust. This may in part be explained by differences in local systems for managing the financial resource and placement procedures as some areas devolve budgets to NHS provider trusts to manage. However, whatever the arrangements there will be a risk of vicarious liability present that can be best managed through having core information about the people being placed, the appropriateness of their care and who is monitoring their situation. Suffice to say that during the data collection on this project one commissioner found that they were still paying for two people who had died two years earlier. There is clearly a need for care coordinators, service providers and commissioners to have strong interconnections.

In addition to needing robust review and monitoring arrangements for clinical purposes it is just as important for financial reasons as a considerable amount of money is being spent on these services. If the £2,897,782 spent across the seven SHAs during the census week is typical the expenditure for the full year would be £150,684,641. However, the true figure is likely to be greater since financial information was unavailable for 40 cases. Costs for placement were extremely variable across areas and within types of service being commissioned. This suggests there may be value in exploring more collaborative commissioning and procurement arrangements and block contracting. This would be particularly the case with high volume providers where there are often multiple commissioners. However, the way that commissioners work with the ''long tail'' of single placement providers may need to be different. Commissioners will need to develop and manage local whole systems to ensure that services are less likely to accept people from out of their locality whilst at the same time local people are not placed further afield.

Traditionally voluntary sector organizations have only been able to establish bed-based services by being directly commissioned to do so; they do not have the option of raising venture capital in the way that private companies can do. The private sector has the option of developing needs based services through requests from commissioners and responding directly to a demand that they perceive in the market. Such services are usually bought on a case-by-case or ''spot'' basis. In contrast to services commissioned through block contracts (i.e. for a number of placements where there is guaranteed income) ''spot'' funding carries with it a greater risk and consequently higher costs to accommodate this (Peck, 2005). The cost of capital schemes are often contained within the price of placements in the private

sector whereas many voluntary sector facilities are actually owned by the commissioning organizations (or their predecessors) or capital funding is not included in the placement costs. Consequently, the nature of the relationship between commissioners and the two parts of the independent sector is often quite different. Voluntary sector providers tend to have a much closer working relationship than their private sector counterparts.

As the NHS continues to separate commissioning and provision it is likely to further encourage plurality in the market (DoH, 2005a; DoH, 2006). It will be interesting to see if this brings about a more ''equal playing field'' as Foundation Trusts compete against (and also in partnership) with private and voluntary sector providers. The role of local commissioners in future is likely to include the role of systems management. Local provider arrangements will increasingly be managed as whole systems with the aim of placements outside the geographical area reduced to those required because of lack of local capability or economies of scale rather than lack of local capacity (Ryan, 2005).

Conclusions

The private sector dominates the independent sector, a market that has grown significantly over the past 10 years as statutory sector beds have declined in both the NHS and social services. Strategic engagement is being encouraged nationally (DoH, 2005a; DoH, 2006). This will require local whole system approaches to be effective whilst at the same time reducing the number of placements that are made at distance from the commissioning authority. Improved co-ordination between the independent sector, NHS trusts, care co-ordinators and service commissioners will need to be facilitated as part of this and as a result could more effectively utilize the significant resource being spent. This will need to occur at a local level for the majority of cases although collaborative commissioning and procurement is likely to be more effective where case numbers are small at local level and economies of scale would provide a more effective method of commissioning and monitoring placements.

Acknowledgements

We are indebted to the many people who participated in this study by providing data, without their support this work would not have been possible. We are grateful to the Care Services Improvement Partnership National Institute for England Development Centres in the North West and West Midlands and the County Durham and Tees Valley Strategic Heath Authority who provided the funding for this work. We are also grateful for the helpful comments received from reviewers on an earlier submission of this paper.

References

Becker, T., & Vazquez-Barquero, J. (2001). The European perspective on psychiatric reform. *Acta Psychiatrica Scandinavica*, *104* (Suppl. 410), 8–14.

Blank, R., & Burau, V. (2004). *Comparative health policy.* Basingstoke: Palgrave Macmillan.

Blomqvist, P. (2004). The choice revolution: Privatization of Swedish welfare services in the 1990s. *Social Policy and Administration*, *38*, 139–155.

Brindle, D. (2004). Private care for learning disabled people is a return to Victorian values. *The Guardian*, 4 August 2004.

Children Act. (2004). Chapter 31. London: The Stationery Office.

Chisholm, D., & Hallam, A. (2001). Changes to the hospital-community balance of mental health care: Economic evidence from two UK studies. In H. Brenner & W. Boeher (Eds.), *The treatment of schizophrenia – status and emerging trends* (pp. 210–224). Kirkland: Hogrefe & Huber.

Cooke, L. B., & Carpenter, P. (2002). No lessons learned. *British Medical Journal Rapid Response*. 23 August. (http://bmj.bmjjournals.com/cgi/eletters/325/7360/349#24874. Accessed 13th April 2006).

Department of Health and Home Office. (1992). *Review of health and social services for mentally disordered offenders and others requiring similar services: Final summary report.* London: HMSO.

Department of Health. (1999). *National Service Framework for mental health: Modern standards and service models.* London: Department of Health Publications.

Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform.* London: Department of Health Publications.

Department of Health. (2000/01). *Medium secure service map and summary reports. (Version 2)*. Manchester: AFH Research Limited.

Department of Health. (2004a). In-patients formally detained in hospitals under the Mental Health Act 1983 and other legislation, England: 1993–94 to 2003–04. *Statistical Bulletin 2004/22.* London: Department of Health.

Department of Health. (2004b). *The National Service Framework for mental health – five years on.* London: Department of Health.

Department of Health. (2005a). *Creating a patient led NHS: Delivering the NHS improvement plan.* London: Department of Health.

Department of Health. (2005b). Average daily number of available and occupied beds by sector, Strategic Health Authorities in England, 2004–05. London: Department of Health. (http://www.performance.doh.gov.uk/hospitalactivity/data_requests/beds_open_overnight.htm. Accessed 30 January 2006).

Department of Health. (2005c). Hospital beds and places in residential and nursing care homes for people with mental illness in England. London: Department of Health. (personal communication).

Department of Health. (2006). *Our health, our care, our say: A new direction for community services.* London, The Stationery Office.

Dorwart, R. A., & Schlesinger, M. (1988). Privatization of psychiatric services. *American Journal of Psychiatry*, *145*, 543–553.

Dorwart, R. A., Schlesinger, M., Davidson, H., Epstein, S., & Hoover, C. (1991). A national study of psychiatric hospital care. *American Journal of Psychiatry*, *148*, 204–210.

Elkan, W. (2003). *Healthcare: Can Britain learn from France? 4th IEA Discussion Paper.* London: Institute of Economic Affairs.

Forsyth, B., & Winterbottom, P. (2002). Beds, budgets and burdens: Learning disability expenditure v. workload across English health authorities. *British Journal of Psychiatry*, *181*, 200–207.

Hall, S., & McGuire, T. G. (1987). Ownership and performance: The case of outpatient mental health clinics. *Medical Care*, *25*, 1179–1183.

Ham, C. (2005). Lost in translation? Health systems in the US and the UK. *Social Policy and Administration*, *39*, 192–209.

Harrison, M. (2004). *Implementing change in health systems.* London: Sage Publications.

Hatfield, B., Ryan, T., Simpson, V., & Sharma, I. (in press). Independent sector mental health care: a study of private and voluntary sector placements in seven Strategic Health Authority areas. *Health and Social Care in the Community*.

Healthcare Commission. (2004). Personal communication.

Jaydeokar, S., & Piachaud, J. (2004). Out-of-borough placements for people with learning disabilities. *Advances in Psychiatric Treatment*, *10*, 116–123.

Macpherson, R., Sheperd, G., & Edwards, T. (2004). Supported accommodation for people with severe mental illness: a review. *Advances in Psychiatric Treatment*, *10*, 180–188.

Maio, V., & Manzoli, L. (2002). The Italian health care system: WHO ranking versus public perception. *Pharmacy and Therapeutics*, *27*, 301–308.

Mental Health Act Commission. (2006). *In Place of Fear? Eleventh Biennial Report 2003–2005.* London: The Stationery Office.

Mitra, I., & Alexander, R. (2003). Out-of-area placements: Implications of psychiatric. *Psychiatric Bulletin*, *27*, 382–385.

Moore, A. (2001) Hand in hand. *Health Service Journal*, 27 September 2001.

Peck, E. (2005). *Developing the public-private relationship in care services and support for adults with a mental illness or long-term disability. A response to 'Independence, Well Being and Choice' based on a private seminar held in Birmingham on July 19th and 20th.* Birmingham: Health Services Management Centre, University of Birmingham.

Poole, R., Ryan, T., & Pearsall, A. (2002). The NHS, the private sector, and the virtual asylum. *British Medical Journal*, *325*, 349–350.

Rosenau, P., & Linder, S. H. (2003). A comparison of performance of for-profit and nonprofit US psychiatric inpatient car providers since 1980. *Psychiatric Services*, *54*, 183–187.

Royal College of Psychiatrists. (2005). *Out of area treatments for working age adults with complex and severe psychiatric disorders: Review of current situation and recommendations for good practice.* London: Royal College of Psychiatrists. At: http://www.google.com/u/rcpsych?q=Out+of+Area+Treatments+for+Working+Age+Adults+with+Complex+and+Severe+Psychiatric+Disorders%3A+Review+&B1=Search (Accessed 13 April 2006).

Ryan, T., Pearsall, A., Hatfield, B., & Poole, R. (2004). A pilot study of out of area placements for serious mental illness in the private sector. *Journal of Mental Health*, *13*, 425–429.

Ryan, T. (2005). Using a whole system approach to service development in rehabilitation and continuing care services. *Mental Health Review*, *10*, 16–20.

Ryan, T., Hatfield, B., & Sharma, I. (2005a). *A census day audit of Social Services and NHS non-statutory sector placements and 'Spot purchase NHS placements' for the County Durham & Tees Valley Strategic Health Authority area.* HASCAS & University of Manchester.

Ryan, T., Hatfield, B., Sharma, I., & Simpson, V. (2005b). *A census day audit of mental health out of sector placements in the West Midlands.* HASCAS & University of Manchester.

Ryan, T., Hatfield, B., Simpson, V., & Sharma, I. (2005c). *A census day audit of mental health out of sector placements in the North West.* HASCAS & University of Manchester.

Statistical Package for Social Sciences. (2001). *Reference Guide 12.0.1.* Chicago, IL: SPSS.