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"It Made Me Feel Like I Matter and That I Have a Voice": Enhancing the Integration of Personal Health Budgets in Mental Health Services by Addressing Barriers and Optimising Outcomes

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ABSTRACT

Personal Health Budgets (PHBs) are intended to increase choice and control over care, yet their integration into mental health services remains uneven. This mixed-methods service evaluation examined the implementation and experience of PHBs within the South London Mental Health and Community Partnership between June 2023 and April 2024. Routinely collected data on 117 PHB applications were analysed descriptively and used to shape 24 in-depth interviews with 21 PHB recipients and three delivery staff, alongside three case studies and written feedback from providers. Sixty-one applications were awarded and 47 completed within the study period; 54 remained in assessment, including eight held for clinical reasons; none were refused. Recorded expenditure totalled £82,056, with expenditure per award ranging from £80 to £13,788. Funding was most often used for therapy, gym membership, information technology and educational courses. Participants described greater choice, confidence, independence and engagement with support that mattered to them. Those gains were tempered by delays between application, approval and payment, uneven practitioner awareness, uncertainty about the process and anxiety about support ending. Paired Warwick–Edinburgh Mental Well-being Scale scores were available for only 10 of 61 recipients, so well-being is reported descriptively, and no claim of effectiveness is made. Read together, the two strands indicate that the principal barriers to implementation were administrative and organisational rather than clinical. PHBs can provide valued, personalised support within community mental health care, but their potential depends on delivery systems that are accessible and proportionate to the size of the award. Services should consider streamlined approval and payment for lower-value budgets, better practitioner knowledge, monitoring co-designed with people with lived experience, clearer communication throughout the PHB journey and planned exit arrangements.

1 | Introduction

Personal Health Budgets (PHBs) represent a significant shift within the National Health Service in England, designed to give individuals greater control over their care by allowing them to direct budgets towards support of their own choosing [1]. Their integration into mental health services has nonetheless encountered numerous challenges and remains incomplete. The NHS Long Term Plan committed in January 2019 to expanding PHBs, including within mental health services, as part of an

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ambition for up to 200,000 people to benefit by 2023/2024 [2]. That ambition has not been fully realised.

A PHB is an amount of NHS money, agreed with a clinician, to meet identified health and well-being outcomes. The individual is informed of the available budget, supported to develop a plan for how it will achieve agreed outcomes, and offered a choice of deployment options [3, 4]. PHBs are not welfare benefits and are not means-tested. Adults receiving NHS Continuing Healthcare and children eligible for continuing care have held a legal right to a PHB since 2014. Since 2 December 2019, this right has also applied to people eligible for Section 117 aftercare following detention under specified provisions of the Mental Health Act [5]. Commissioners may additionally offer PHBs on a discretionary basis, including as one-off budgets to support discharge. Within the pathway examined in this study, however, identification for a PHB was individual rather than automatic.

Spending is agreed through the care and support planning process rather than determined by a fixed national list and may include therapy, personal assistance, equipment, training, exercise and support for social contact. PHBs cannot be used to fund emergency or GP care, gambling, debt repayment, alcohol, tobacco or unlawful activity [3]. Within this pathway, requests that could be met through local authority or social prescribing provision were also excluded. PHBs can be managed as a notional budget held by the NHS, through a third-party arrangement or Individual Service Fund, or as a direct payment to the individual or their nominee [6]; National Health Service [7]. In the pathway evaluated here, the process extended from identification and care planning through approval, purchase and subsequent review.

Personal budgets originated in social care and were subsequently extended into the health sector [8]. Uptake has remained lower in mental health than in physical health or learning disability services, despite the national pilot reporting improvements in quality of life and psychological well-being alongside reductions in unplanned care [9]. Studies of mental health services in England have reported benefits including greater confidence and independence, improved physical health and self-management, increased social participation, and opportunities for education and relationships [10]. Evaluations have also highlighted the importance of staff training and organisational support in enabling effective implementation [11].

International evidence on self-directed funding similarly identifies tensions between the aspiration to promote individual choice and the constraints imposed by systems and processes. Australian research, for example, has identified rigidity, procedural complexity, opacity and limited understanding of psychosocial disability as barriers to meaningful choice and control [12]. Comparable models have been developed in the Netherlands, Germany and the United States [13–15]. The English mental health context is nevertheless distinctive, particularly because Section 117 aftercare is non-chargeable and, in the pathway examined here, PHBs were generally small and time-limited.

2 | Methodology

2.1 | Study Context, Research Aims and Design

An earlier local evaluation of the same pathway focused primarily on awareness and access. Across 64 people in inpatient rehabilitation, residential care and supported accommodation, none held or had been offered a budget and none could describe what a PHB was or how to obtain one, and only 5% of the health professionals who approached to broker access had heard of the scheme. Once the concept was explained, 41 of the 64 (64%) said they would want one and 37 named a specific use. That evaluation recommended better staff knowledge, co-produced information, cross-sector training, culturally sensitive provision, advocacy, peer support and equitable, fast access in which delays in decisions and payments are avoided [16]. The present evaluation therefore moves beyond awareness to examine what happens once applications enter the pathway: progression, expenditure, implementation barriers and the experiences of recipients, staff and providers.

The aims of this evaluation were threefold: to explore recipients' experiences of PHBs and the available indicators of well-being, to draw lessons about best practice and financial implications and to build an evidence base for improving service standards. These were operationalised as three questions: how far and how quickly applications move through the pathway?; what budgets are used for and at what cost?; and what impedes or enables implementation from the perspectives of people holding budgets, staff and providers.

This evaluation used a mixed-methods design with an explanatory sequential logic [17]. Descriptive administrative and outcome data were examined first to identify patterns in application flow, expenditure and well-being, and these patterns informed qualitative questioning about delay, spending and experience. Qualitative accounts were then used to explain and contextualise the quantitative patterns, although the study was not a strictly sequential two-stage design because quantitative and qualitative data collection overlapped in time. Integration occurred during question development and again at interpretation, with priority given to the qualitative strand because outcome data were limited. Process dimensions comprised application flow, budget management and payment, and accounts of implementation. Outcomes comprised self-reported change, paired well-being scores where available and three case-study trajectories. Given the limited outcome data, the evidence is stronger for process than for outcome.

2.2 | Recruitment and Sample Size

Participants were recruited through purposive sampling within the South London Mental Health and Community Partnership. Eligible participants were adults with severe and enduring mental health conditions who had received or applied for a PHB between June 2023 and April 2024. Referrals were made by clinicians and PHB support staff; information sheets were provided; and recruitment prioritised inclusivity across age, gender, ethnicity and diagnosis. Table 1 sets out the diagnoses recorded for the 21 service user participants.

This overview of participants' diagnoses illustrates the high prevalence of severe mental health conditions. Categories are drawn from routine monitoring records, and some participants have more than one diagnosis, explaining why percentages sum to more than 100. Percentages are of the 21 service user participants and are rounded. The "Other" category comprises less frequently recorded diagnoses that are not itemised separately

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TABLE 1 | Diagnoses recorded for participants in this study.

Diagnosis ($n = 21$ service user participants)	*n*	%
Anxiety, including generalised anxiety disorder (GAD)	3	14
Bipolar affective disorder (BAD)	2	10
Complex emotional needs (CEN)	5	24
Depression	2	10
Seasonal affective disorder (SAD)	2	10
Schizophrenia	10	48
Substance misuse	5	24
Other (less frequently recorded diagnoses not itemised individually to protect anonymity)	5	24

because small cell sizes could increase the risk of re-identification.

Schizophrenia, often associated with substantial functional impairment [18], was the most frequently recorded diagnosis; anxiety, substance use and complex emotional needs were also common. The sample therefore reflects people with severe, enduring and often complex mental health needs [19–21].

The quantitative strand was a census of all 117 applications initiated in the evaluation window; no hypothesis testing or statistical inference was planned, so an a priori sample size calculation was not appropriate. Qualitative sample size was guided by information power [22], an approach that judges how many interviews are needed by how much relevant information a sample holds, rather than by counting interviews until nothing new appears or by a statistical power calculation. The narrower the aim, the more closely specified the participant group, and the stronger the interview dialogue and the more the analysis works across cases rather than within them, the fewer participants are required. Judged against those criteria: the aim and participant group were specific, interviews were in-depth and analysis was cross-case. A target of 20–25 interviews was therefore set. All eligible service users who had completed or were approaching completion of a budget were invited. Approximately one-third declined or did not attend, yielding 21 participants. All three delivery team members were interviewed.

2.3 | Data Collection

The qualitative strand consisted of 24 in-depth semistructured interviews, 21 with PHB recipients and three with staff involved in PHB delivery. Interviews were guided by a research guide drafted by the research team from a review of the PHB literature and from the findings of the earlier local evaluation [16]. The guide was reviewed by the PHB steering group, which included a service user member, and by the peer researchers, and was then piloted with two service users. It covered the application process, perceived benefits and challenges and impact on recovery and daily living. Interviews ran from June 2023 to April 2024, were conducted in person and online and lasted approximately one hour. Written feedback was also obtained from service providers supporting PHB recipients. Three narrative case studies were used to illustrate outcomes and trajectories. Cases were chosen to reflect a range of demographic and clinical backgrounds and to provide contextual insight into the lived experience of PHBs.

The quantitative strand drew on the administrative record kept by the PHB team for every application. Routine quantitative data analysed covered gender, ethnicity, diagnosis, borough, referral source, application stage/outcome and expenditure. These data were generated by the service in the course of its work rather than collected for the evaluation, which limits their completeness and explains the gaps in well-being data reported in Section 3.4.

Well-being scores were collected using the Warwick–Edinburgh Mental Well-being Scale (WEMWBS), a 14-item self-report measure scored from 14 to 70, developed to monitor mental well-being in general populations and to evaluate programmes intended to improve it [23]. The scale was completed by service users themselves, at award and again at completion. WEMWBS is copyright-protected and requires registration/licensing; at the time of this evaluation, noncommercial use was available without charge subject to registration with the University of Warwick. Its administration here formed part of routine service monitoring rather than a research protocol, which accounts for the missing data reported in Section 3.4. The instrument proved challenging for people who had been within psychiatric services for many years and whose circumstances were unsettled.

2.4 | Ethics, Consent and Capacity

The project was classified as service evaluation under Health Research Authority guidance because it assessed an existing service without randomisation or treatment change and used routinely generated service data. NHS Research Ethics Committee review was therefore not required. It was, however, reviewed and approved by the evaluating organisation's Research and Ethics Advisory Board, which includes academics, people with lived experience, carers, clinicians and safeguarding leads; its governance model is described elsewhere [24].

A psychiatric diagnosis does not remove capacity to consent. Under the Mental Capacity Act 2005, capacity is presumed unless shown otherwise, is decision-specific and cannot be inferred from diagnosis or detention history. Only participants with capacity at interview were included. Participants received an information sheet and were given time to consider taking part. The information sheet is a different document from the research guide described in Section 2.3: the sheet explained the purpose of the evaluation, what taking part involved, how information would be used and the right to withdraw, whereas the guide set out the questions asked at interview. Verbal consent was

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confirmed at interview and revisited if distress arose. Interviews were rescheduled where capacity fluctuated and clinical advice sought if doubt remained. Participants were reminded that they could withdraw without consequences for care or budget. The consent process was designed to protect participants' autonomy, dignity and right to make an informed decision about involvement. Participation was voluntary, and consent was treated as an ongoing process rather than a single decision at recruitment.

Data were anonymised, securely stored and handled in accordance with the General Data Protection Regulation and the Data Protection Act 2018. The research team, including peer researchers with lived experience, were trained in safeguarding and ethical interviewing, with protocols to manage distress, safeguarding disclosures and risk. Consent for publication of the case studies was obtained separately; all names are pseudonyms, and identifying details have been altered.

2.5 | Data Analysis, Integration and How Barriers Were Identified

Qualitative data were analysed thematically following the six-phase framework of Braun and Clarke [25]. Transcripts were coded inductively and iteratively, with codes developed into the themes reported as follows. Coding was checked by a second researcher, and peer researchers contributed to the development and naming of themes. Quantitative analysis was descriptive: counts/proportions for application flow and expenditure categories, totals/ranges for expenditure and paired well-being scores where available. No significance testing or minimal clinically important difference is claimed because paired observations were too few. The quantitative outputs are reported directly in Tables 2, 3, and 4 and in the analysis of expenditure in Section 3.5.

Integration followed mixed-methods health services guidance [26] and occurred at three points: administrative findings shaped the qualitative questions; interview and provider accounts were used to explain or contextualise quantitative patterns; and, at interpretation, findings from the different sources were compared for convergence and divergence. Divergence was retained rather than forced into agreement. Reporting follows the Good Reporting of A Mixed Methods Study framework [27].

The evaluation also had to work out what was getting in the way of people obtaining and using a budget, and to be reasonably confident that a barrier was real rather than the impression left by a single account. Each possible barrier was therefore checked against three sources: the administrative record of applications that had stalled, together with the reasons recorded for the delay; what service users said about the process and about waiting; and what staff and providers said about sign-off, payment, staffing capacity and how much referring clinicians knew about the scheme. A barrier was carried forward only where at least two of those sources pointed to it. Where a problem was raised by one source only, it is described as such in the findings and was not used to support a recommendation. Barriers were then grouped using the domains of the Consolidated Framework for Implementation Research [28], which separates features of the intervention itself from those of the people involved, the organisation and the wider system.

2.6 | Nonparticipation and Bias

Interviewers emphasised that they had no role in approving budgets and told participants that their responses could not affect care or future applications. The research guide described in Section 2.3 invited criticism as well as praise; contrary cases were sought, and coding was checked by a second researcher. Residual bias remained because participants were recruited from people who had obtained budgets and the evaluating organisation was known to deliver PHB support. An independent academic co-author and separate ethical oversight provided mitigation of this bias, although they offset rather than removed it.

Approximately one-third of those approached declined to take part, and some who agreed subsequently cancelled or did not attend. A rate of that size needs to be reported and taken seriously rather than explained away. Reasons offered included competing commitments; being too unwell to take part; and, in some cases, suspicion of the interview and of its motives. To reduce barriers to participation, interviews were available in person or online, researchers reiterated that participation was voluntary and could not affect care or PHB decisions, and interviews were rescheduled rather than proceeding where capacity fluctuated. These safeguards and practical flexibilities did not eliminate nonparticipation. No participant/nonparticipant comparison was available, so the direction of resulting bias cannot be estimated. Those most dissatisfied may have been less likely to participate, potentially biasing findings favourably. This is treated as a limitation throughout and is returned to in Section 4.6.

2.7 | Patient and Public Involvement

Patient and public involvement included a service user on the PHB steering group who contributed to the research guide, peer researchers who contributed to theme development and service-user co-design of programme information [29, 30].

3 | Results

3.1 | Application Flow and Uptake

During the evaluation period, 117 PHBs were in progress, offered or completed, distributed unevenly across the three partner trusts. South West London and St George's accounted for 65, South London and Maudsley for 31 and Oxleas for 21. Of these, 61 were awarded, and 47 completed by April 2024. Fifty-four remained in assessment, including eight applications that were on hold for clinical reasons. Assessment involved clinical teams, the local authority and social prescribing and considered whether requests could be met through another route and whether the referral was appropriate. No individual had a PHB refused, but two were offered and declined. Thus, 46% of applications remained in assessment despite no refusals. Within the evaluation window, throughput rather than recorded refusal was the principal observed constraint.

3.2 | How Budgets Were Used?

The most commonly requested uses of PHBs were therapy, gym membership, information technology equipment and educational courses. Budgets chiefly funded the practical

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TABLE 2 | Flow of PHB applications, June 2023 to April 2024.

Stage at close of evaluation window (April 2024)	*n*	% of 117
Applications in progress, offered or completed	117	100
Awarded	61	52
Of which completed	47	40
Remaining in assessment	54	46
On hold for clinical reasons	8	7
Refused by the service	0	0
Offer declined by the service user	2	2

Note: Applications on hold are a subset of those not yet awarded. Percentages are rounded.

infrastructure of daily life, exercise, study, transport and family contact, rather than clinical treatment, apart from therapy unavailable locally. This pattern accords with earlier personal-budget research [10]. Table 3 sets out the full distribution of approved or requested items.

3.3 | Experiences of the Application Process: What Worked and What Did Not?

This section reports the positive accounts first and then the criticisms, before turning to well-being scores in Section 3.4. Applications were generally experienced positively, including practical help with paperwork. One participant contrasted the team with previous experiences of promised support not materialising: *"you said it was going to happen and it did … I know I can trust you."* Providers also praised link workers' creativity and responsiveness.

Participants described PHBs as providing structure and routine, a positive focus, access to meaningful activities otherwise unavailable and a degree of control over the services they used. Many described a change in how they were seen: *"They've seen me in a different way, they trust my judgement, it's looking at things in a very different way. I had a choice and input and they listened to what I wanted to help me."* Shifts of this kind in the relationship between service users and practitioners have been identified as among the more consistent effects of personal budgets in mental health [31].

TABLE 3 | PHB services approved or requested.

Service approved or requested	*n*
Therapy	13
Gym	13
Information technology	13
Courses	12
Swimming	8
Personal assistant	6
Transport	5
Volunteering and groups	3
Cinema	2
Tennis	2

Note: Counts exceed the number of awards because some budgets covered more than one item.

TABLE 4 | WEMWBS completion and paired scores.

WEMWBS reporting	*n*
People awarded a PHB	61
Assessed on two or more occasions	13
Usable paired scores	10
Improved	8
Mean score at award ($n = 10$)	38
Mean score at completion ($n = 10$)	43
Mean increase among those improving ($n = 8$)	6.5

Participants reported trusting relationships with the PHB team and confidence that the process was right for them. Information materials had been co-designed with people using services, and a team member described the intent: "Leaflets and materials were co-designed with service users… It was really important that we embraced co-production from the start." Given that the earlier local study found effectively no awareness of PHBs in this pathway, that effort is a precondition of uptake rather than a refinement of it [16].

Reported benefits included confidence, physical health and family contact. One participant said, "It's made me feel like I matter and that I have a voice … now I go out." Exercise supported sleep and symptom management, while information technology restored family contact. Providers also described positive effects of PHBs, including reduced risk and, in one case, avoided admission where PHB-funded therapy formed part of a risk-management plan. Not all accounts were positive. One participant hardly used their gym membership, attributing this to lack of motivation. Access to an activity therefore did not guarantee behaviour change without additional support.

Delay was the consistent criticism. The time from application to approval, and from approval to money being available, was in most cases viewed as too long. One participant reported, *"Yes it was lengthy, it took a long time, I think it took about 5 months to get it sorted."* A team member described the same problem from the other side: *"Sometimes it takes months to get payments sorted. It's a complicated lengthy process which is time consuming and impacts negatively on users."* A provider noted a 3–4 month gap between assessment and implementation, which is material given that its own placements ran for 9 months. These accounts converge with Table 2, and the experience of waiting is corroborated by the volume of applications still in assessment. Two further process problems were reported. The route for making a complaint about a PHB was not always made clear, and arrangements for reviewing a budget, including whether support could continue or change, were experienced as uncertain.

3.4 | Well-being Scores

The routinely used quantitative scales intended to measure well-being were the weakest strand of this evaluation and are reported in full so that readers can judge them for themselves. Thirteen participants completed WEMWBS on two or more occasions, and usable data were available for 10. The three returns that could not be used were incomplete or internally inconsistent, reflecting

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difficulty with the questions rather than refusal to take part. Among the 10, eight recorded an increase in score, with a mean increase of 6.5 points among those eight. Average scores were 38 when PHBs were awarded, rising to 43 on completion. Table 4 sets out the completion figures and paired scores in full.

For information, WEMWBS scores range from 14 to 70, and the mean for the UK general population is approximately 51 [23]. These figures must not be read as evidence of effectiveness. With 10 paired observations from a self-selected subset of a small cohort, no comparison group and no significance testing, the available WEMWBS data are insufficient to assess effectiveness and instead demonstrate substantial limitations in routine outcome measurement within the pathway. Four of every five people awarded a budget were never assessed a second time, while those who held budgets described improvement consistently and in specific terms.

3.5 | Expenditure and Case-Based Costs

Recorded PHB expenditure across the evaluation period was £82,056, with recorded expenditure per award ranging from £80 to £13,788. Across 61 awards, this represents £1345 of recorded expenditure per award. This figure should not be interpreted as the mean final budget value, because some awards had not been fully drawn down by the end of the evaluation period. These administrative figures record expenditure drawn down during the evaluation window rather than the total value of every approved allocation; case-study allocation values may therefore be higher than the maximum recorded expenditure. Monetary values are reported as gross commissioned costs at contracted rates: that is, the amount charged to the NHS rather than an estimate of the underlying resources consumed. The counterfactual in each case study is continuation of the placement that immediately preceded the change in setting, priced at the rate recorded in the case record and held constant over the period stated. Avoided cost is therefore displaced expenditure over a defined period, not a cash-releasing saving, and each case that follows reports the prior daily rate, the period over which the comparison was made and the resulting figure.

Although these aggregate figures describe the scale of PHB expenditure, they provide limited insight into the wider care pathways within which individual budgets were used. Three case studies collected as part of the study offer an important additional perspective. Each involved a relatively small, personalised package of support introduced at a point when the individual had previously required, or was at risk of continuing to require, substantially more intensive and costly forms of inpatient or residential care. The cases are not presented as a formal economic evaluation, but as illustrations of the scale of expenditure associated with the care pathways that PHBs helped to change. All names have been changed to preserve anonymity.

Jane, in her late forties, had complex emotional needs, an eating disorder and recurrent depression and had spent several years in inpatient care, most recently in private rehabilitation charged at £446 a day from March 2019 and at £586 a day from November 2021, a gross health cost of approximately £1.34 million to her discharge in January 2023. Her PHB funded therapies that were not available locally and formed part of a package that supported discharge to live with her family. The budget cost £3907 over the following 16 months, equivalent to approximately £8 per calendar day. Continued placement at the final contracted rate of £586 a day would have costed approximately £214,000 a year, so continuation over the two years following discharge gives an estimated avoided cost of more than £400,000. She has required no local authority commissioned care and support since.

Trudy, in her twenties, had complex emotional needs, dissociative disorder, an eating disorder and chronic pain and had lived in residential care since 2018. A PHB allocation of £15,180 funded a personal assistant for 20 weeks, providing practical support during her transition to independent living in her own flat; this is a case-study allocation value and is therefore not directly comparable with the maximum expenditure drawn down in the administrative dataset during the evaluation window. The case-study record reports £594,251 for residential care from July 2018 to February 2021, £49,335 for an inpatient neuropsychiatry admission from February to May 2021 and £250,776 for subsequent residential care from May 2021 to August 2022: total recorded institutional-care expenditure of £894,362. These figures are drawn from the original commissioning records. Further information is not available to clarify the basis of the historical cost calculations. Her budget was equivalent to approximately £108 per calendar day over 20 weeks. Continued residential care at the final rate would have costed approximately £198,600 a year; she moved instead to her own flat, was discharged to the care of her general practitioner and has since required no commissioned care and support, giving an indicative avoided cost of that order for the first year following the move. In this case, the PHB represented a comparatively small component of a wider transition away from long-term residential provision.

Kathleen, in her sixties, had mixed anxiety and depression alongside neurological symptoms and had accumulated 483 inpatient bed days across four admissions before subsequently entering residential care. Her PHB funded comparatively low-cost items and activities, including a laptop, railcard and balance classes, which supported greater independence and participation after she returned home. She subsequently travelled independently and undertook voluntary work. Those admissions were charged at £400 a day, £193,200 in total, and the residential placement that followed at £121 a day, or £44,165 a year, was funded in equal shares by health and the local authority. Her budget cost £3108 over 11 months, equivalent to approximately £9 per calendar day. Comparing a further year of residential care with the year following her return home therefore gives an estimated avoided cost of more than £22,000 a year to each of the two funders.

The three cases illustrate the marked difference in scale between the cost of individual PHBs and the institutional care pathways within which they were deployed. They should not, however, be interpreted as evidence that the PHBs alone generated the observed savings. Discharge and changes in care setting were produced through wider clinical, social and family support, and the figures compare the cost of continued placement at contracted rates with the subsequent pathway rather than demonstrating cash-releasing savings to the NHS. They therefore represent indicative avoided costs rather than realised financial

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savings. With only three case studies, no system-level conclusion about cost-effectiveness can be drawn.

3.6 | Anxiety About the End of PHB Support

The scale of those figures made the question of what happens when a budget ends more pressing rather than less. Participants expressed concern about what would happen if support were withdrawn, and this was among the clearest findings of the qualitative strand. One participant asked, *"What will happen when it stops?... it worries me a lot. I'm really worried about it."* Another was explicit about the stakes: *"If it was taken away this would be very bad for me and mental health as having the therapy is really the only thing that is actually keeping me going."* A third described an ongoing need she could not fund privately, with continuation *"not clear!"* No postclosure follow-up data were available, so the evaluation cannot establish whether well-being was sustained or adverse consequences occurred. This is a monitoring gap, not evidence of absence of harm.

4 | Discussion

PHBs were valued by service users, staff and providers alike, yet significant barriers impede their integration into NHS mental health services. The dominant barriers identified were administrative and organisational rather than clinical, falling within the inner setting and process domains of the Consolidated Framework for Implementation Research [28], and the discussion takes each in turn, drawing on the three sources of evidence described in Section 2.5.

4.1 | Delay as the Dominant Barrier

Delays of up to 5 months between application, approval and payment were the dominant concern and can undermine autonomy at a fragile stage of recovery. Administrative complexity is a longstanding implementation barrier in England and internationally [12, 32–34].

Two findings make this plain. No application was refused during the evaluation period, while 46% remained in assessment. Together with participants' and staff accounts of waiting, this indicates that progression through assessment, approval and payment, rather than recorded refusal, was the principal bottleneck within the observed pathway. Recorded expenditure was £1345 per award, with the smallest award of £80. The administrative burden therefore appears disproportionate to award value, echoing concerns about overhead in the national pilot [9]. Tiered local approval for low-value budgets and simpler payment routes are indicated as ways to speed up application processes. Delay is also the one problem the pathway had already been warned about: the earlier local evaluation recommended clear eligibility criteria, pathways and decision-making processes so that delays in decisions and payments were avoided, and identified anticipated administrative burden as a reason people expected not to apply [16]. Two years on, applications were being made and approved, yet the process itself remained the barrier that had been predicted.

4.2 | Measurement as a Barrier in Its Own Right

Routine quantitative data collection did not capture the benefits reported in interviews. This is evidenced by the completion rate rather than the scores. WEMWBS was developed to monitor well-being in general populations, and some participants found its positively worded items remote from their circumstances [23]; completion also lacked clear staff ownership. A measure yielding usable paired scores for 10 of 61 people produces almost no evidence at all, and a programme that cannot demonstrate outcomes is structurally vulnerable when commissioning priorities change. That vulnerability is not hypothetical. The PHB support service described in this evaluation has since been decommissioned. No causal claim can be made about that decision, but a programme whose benefits are visible in interviews and largely invisible in its own outcome data is poorly placed to argue its case when asked to do so.

4.3 | Practitioner Awareness, Identification and Who is Offered a Budget

Many practitioners reported being unaware of what PHBs are or what the team does, and a team member argued for a system-wide awareness programme. This connects to the earlier local study, in which only 1 in 20 of the professionals expected to broker budgets had heard of them [16]. Two years into implementation, it had improved but remained uneven, suggesting that knowledge of the scheme decays without active maintenance. Where access depends on a practitioner remembering that a person has a right to a budget, uneven awareness becomes uneven access. Embedding PHB consideration into Section 117 and discharge planning could make the offer routine. Culturally sensitive information, translation and interpreting support also remain important for equitable uptake [35].

4.4 | What Budgets Buy and What It Implies for Delivery

Budgets purchased exercise, learning, transport and communication, categories sitting at the intersection of health need and material circumstance. What people bought closely resembled what people in the same pathway had said they would buy 2 years earlier, before any of them had access to a budget: gym membership and a trainer, a laptop or tablet, help with travel, a course, swimming and support to get out of the house were the most frequently named intended uses in the earlier evaluation [16]. Preferences expressed by people who had never held a budget were, in other words, a reliable guide to what budgets were later used for, which strengthens the case for asking the question routinely rather than treating stated preference as speculative. People with enduring mental health difficulties face substantial economic disadvantage, and research on self-directed care in the United States finds that one of its more significant effects is the alleviation of that disadvantage [36]. Any arrangement requiring an out-of-pocket purchase and reimbursement will therefore limit choice for precisely those least able to absorb the cost, making payment arrangements a determinant of who can use a budget at all.

Planning support was important where people were unsure how to use a budget [37]. How a budget is held matters as much as how it is planned. Where a person has to pay first and reclaim the cost, the arrangement itself excludes those with no money to lay out. Third-party arrangements merit testing for low-value awards because they can hold funds outside the approval cycle, releasing

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money on the person's behalf as it is needed; staff also valued NHS–voluntary sector collaboration.

4.5 | Implications for Practice, Commissioning and Policy

This section takes the implications together, beginning with what happens when a budget ends and with the policy changes now in train, and then setting out what follows for practice and commissioning. Anxiety about discontinuation, also reported elsewhere [11], supports a consistent exit process. Joint closing review with the care coordinator, a record of onward support and a route back if needs re-emerge all need to be considered.

The Mental Health Act 2025 includes a requirement for written notice when Section 117 aftercare ends. Because the act's provisions are being brought into force in phases rather than all at once, PHB exit planning should be aligned with the statutory aftercare process as relevant provisions take effect. The 10-Year Health Plan commits to increasing PHB offers by 2028/29, including for people with severe mental illness [38]. Scaling without process reform risks increasing, rather than reducing, delay.

Four practical implications follow from the findings, each traceable to a specific result rather than to a general principle. Approval and payment routes should be proportionate to the value of the award. Monitoring should combine a brief standardised measure with structured recording of person-defined outcomes and should be designed with people who have lived experience. Staffing should be sufficient for the volume of applications, which may mean clinic-based consultancy and paid peer worker roles. Knowledge of the scheme needs continuous maintenance through routine care planning rather than one-off launch activity. Expansion should particularly consider people stepping down from inpatient care, where case studies suggest the largest displaced costs, and younger adults, where earlier intervention may alter long trajectories.

4.6 | Strengths and Limitations of the Evaluation

The strengths and limitations set out here are those of the evaluation itself, not of PHBs as a form of support. Strengths include a census of all applications in the window; interviews with people who had held budgets; peer-researcher involvement; and triangulation across recipients, staff and providers.

Four limitations carry most weight for how the findings should be read. The evaluation covered a single metropolitan partnership over 11 months and had no comparison group, so it cannot show whether outcomes persist. Well-being data were too sparse to support any claim of effectiveness. The costings describe expenditure avoided in three cases, rather than money released, and cannot be generalised to the wider cohort. Participants were recruited from people who had obtained budgets; one-third of those approached did not take part, and the evaluation was carried out by an organisation that also delivered PHB support.

5 | Conclusion

PHBs were valued by people with complex and enduring mental health needs and supported autonomy, social connection and personally meaningful activity. Providers linked them, in individual cases, to reduced risk and to admissions avoided.

The principal constraints identified were not recorded refusals of PHBs but features of implementation and system design. No application was refused during the evaluation period, while many remained in assessment and participants and staff described delays in progression, approval and payment. The obstacles identified here therefore concern how quickly money moves, whether practitioners know the offer exists, what a service counts as evidence of its own effect and what happens when a budget ends. Each of those lies within the capacity of commissioners and providers to change, which is the practical significance of the findings.

The sums involved were small. Recorded expenditure was £82,056 across 61 awards, equivalent to £1345 of recorded expenditure per award, set against placements costing several hundred pounds a day in the case studies. These figures should not be read as mean final budget values, and the case-study comparisons represent avoided expenditure rather than cash-releasing savings. Avoided expenditure only becomes a saving when capacity is decommissioned, and a prospective evaluation with a comparison group would be needed to establish whether it does.

Two things follow for how the offer should be scaled. Access should grow in ways that preserve the relational character that recipients valued, with PHBs embedded in the pathways of people leaving high-intensity services, in provision for complex emotional needs and in early intervention for young adults, and with the exit planning that the Section 117 notice provisions of the Mental Health Act 2025 now reinforce. Success should also be measured in terms that register what people themselves say changed. The statement that gives this paper its title, that a budget made someone feel they mattered and had a voice, describes an outcome the monitoring system in place did not reliably record.

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Ethics Statement

The project was classified as a service evaluation under Health Research Authority guidance. It was reviewed and approved by the evaluating organisation's Research and Ethics Advisory Board.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Participant-level data are not publicly available because they contain sensitive mental health information and could risk re-identification. Aggregated data supporting the findings are reported in the article; further nonidentifiable information may be available from the corresponding author subject to ethical and governance restrictions.

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