

“How does your team work?” An investigation of joint working and integration within community mental health teams for older people.

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INTRODUCTION

As everybody knows, the population of the developed world is aging (United Nations, 2007). The UK is a typical example. Not only are there far more older people in the population than ever before, the older population itself is ageing, with the fastest growth in numbers being amongst the over 85s (Office for National Statistics, 2008). Whilst many older people will lead healthy, fulfilling lives, a significant minority will experience decreased quality of life associated with mental illness. More than one in ten older adults suffer from low mood, about one in twenty have dementia and still others are affected by anxiety, schizophrenia or other mental illnesses (Hofman et al., 1991; Beekman et al., 1999; DH, 2001). The increasing population of older people with mental health problems poses a considerable challenge to the public sector, for such disorders can affect every aspect of a person's functioning and cause significant personal and family distress (DH & CSIP, 2005; DH, 2009). Furthermore, their care costs constitute a substantial proportion of the health and social care budget. Studies suggest that as many as 40 per cent of older adults visiting their GP, 50 per cent of general hospital inpatients and 60 per cent of care home residents have a mental health problem (DH &

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CSIP, 2005), and that the direct costs of Alzheimer's Disease alone are greater than those for stroke, cancer and heart disease combined and are set to increase (Lowin et al., 2001; Alzheimer's Society, 2007).

Calls for specialist services for older people with mental health problems have been heard since the 1940s (Hilton, 2005). However, it was not until the early 1970s that the UK government, perhaps prompted by concerns about the 'rising tide' of this client group, showed serious interest in such provision (Hilton, 2005, 2008). Where early service development had been led by a handful of enthusiastic pioneers, there now followed a period of exponential growth in the number of consultant psychiatrists with a commitment to the elderly, culminating in the formal recognition of old age psychiatry as a speciality in the NHS in 1989 (Jolley & Arie, 1978; Wattis et al., 1981; Burns et al., 2001; Hilton, 2005). Although hospital based and doctor-led, these services were nevertheless characterised by their community orientation and, as understanding of the relationship between social factors and mental health grew, employed increasing numbers of other professional disciplines (Denning, 1992; Nolan, 1993).

Like that of many other developed nations, a key focus of UK policy for older people with mental health problems in recent years has been to move away from the provision of long-term hospital and institutional care and towards the greater support of people at home (Challis & Hughes, 2003; Howe & Kung, 2003; Knapp, 2005). Such plans, although in part stimulated by considerations of cost and efficiency, share an underlying belief that most older people with mental health problems can, and would prefer to be, cared for in their own homes (DH, 2001; Knapp, 2005; Knapp et al., 1997). The establishment of multidisciplinary community mental health teams for older people (CMHTsOP) that can provide specialist care for older adults with severe or complex mental health problems in their own homes, as well as support and advice for personnel caring for this client group in care homes, primary care and general hospitals, is central to the realisation of this ambition (DH, 2001, 2009; Lingard & Milne, 2004).

In order to fulfil this role, good practice guidance commonly agrees that CMHTsOP should employ a range of health and social care professionals, including consultants, nurses, social workers, occupational therapists and psychologists, and highlights the need for an integrated, person-centred approach (DH, 2001, Lingard & Milne, 2004; Draper & Low, 2004; DH & CSIP, 2005). However, recent surveys suggest that not all areas are able to live up to such aspirations. Whilst CMHTsOP are now in place across the country, and most contain or are able to access the multidisciplinary personnel specified, there remains much diversity in the number and mix of their 'core' staff (Audit Commission 2002; Tucker et al., 2007; Healthcare Commission, 2009). The use of certain measures to facilitate integrated practice, including common assessment documentation and electronic records, also varies considerably (Challis et al., 2002; Tucker et al., 2007, 2009; Healthcare Commission, 2009), whilst little is known about potentially important factors such as team members' roles or management arrangements.

As one strand of major programme of NIHR-funded work, we are currently undertaking a study of CMHTsOP which aims to:

- identify core features of national variation in the structure, organisation and working practices of CMHTsOP, providing a wealth of detailed information that will act as a benchmark for future service development and monitoring;
- assess progress against key policy goals in service delivery and integration, identifying factors associated with more integrated practice; and
- explore the relative costs and benefits of different CMHT models.

This paper focuses on the first two of these aims.

METHOD

A self-administered postal questionnaire was sent to the team manager of every CMHTOP in England. The questionnaire had been developed by the research team, in

collaboration with a wider steering group of experts in the field of old age psychiatry, and was refined after piloting with 6 teams from 3 mental health trusts. The questionnaire sought information on teams' organisation, structure and processes, including their referral, assessment and care planning arrangements and included a number of indicators of integration. These indicators were drawn from a range of recent UK policy documents and service development guides (DH, 2001; Lingard & Milne, 2004; DH & CSIP, 2005) as well as influential audit reports (Audit Commission, 2000, 2002; National Audit Office, 2007; Healthcare Commission, 2009) and professional standards of good practice (Royal College of Psychiatry, 2006). Although most questions had a closed format, respondents were invited to use free text boxes provided at the bottom of each page to clarify or contextualise their responses.

The prospective sample was identified using data from the 2008 'Combined Mapping Framework', a database of mental health service provision completed by all NHS Trusts¹ on an annual basis. Following preliminary contact with both Trust Chief Executives and team leaders, questionnaires were sent to all CMHTsOP on the database in November 2008. A reminder was sent to non-respondents a month later, and those teams still failing to respond were subsequently contacted by e-mail or telephone and offered the chance to complete the survey electronically or on the 'phone.

Questionnaires were originally sent to 457 CMHTsOP. However, the follow-up exercise revealed some significant errors in the sampling frame, including the presence of some teams that did not work with older people. It was clear that there had also been a significant degree of change since the mapping exercise was completed, with a number of teams subject to mergers or reorganisation. This reduced the number of teams in the final sampling frame to 429. By the close of fieldwork in March 2009, 376 of these had replied, representing a response rate of 88 per cent.

Whilst the vast majority of these teams appeared to be single CMHTs, it was clear that a small number of the returned questionnaires referred to more than one team. These

¹ See www.mhcombinedmap.org

questionnaires were typically filled in by a service manager who bore responsibility for several teams and may well have regarded them as individual units within one larger team. To complicate the picture further, a minority of respondents noted that their team took responsibility for functions which have not traditionally been part of CMHTs' remit, such as the provision of memory assessment or home treatment services. However, analysis suggested that this variation did not have a significant impact on the findings that follow, and unless stated otherwise, the following results include all teams.

FINDINGS

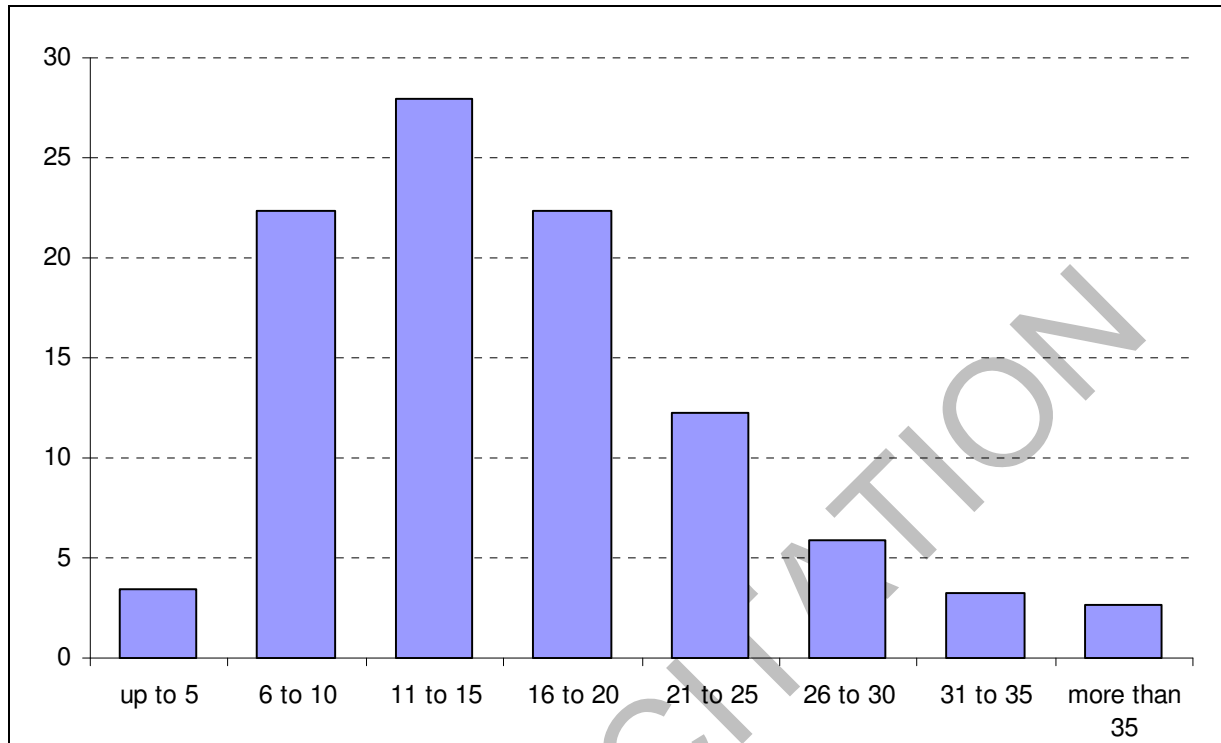
The findings are structured so that data collected on the key characteristics of teams (including important contextual data about the team's location, funding and organisation; staffing levels and professional mix; and referral patterns) are reported in section (i) that follows. Data collected on key measures of joint working and integration, and more formal modelling and hypothesis testing of an integration 'score', are then presented in section (ii).

(i) Team characteristics

Respondents were asked to provide detailed data on staffing (excluding administrators), and in particular to distinguish between 'core' members of the team (defined as those spending a large proportion of their time with the team, and/or having important operational responsibilities) and those who instead just make regular sessional contributions². The distribution of the number of core staff is shown in Figure 1. It reveals that about three quarters of CMHTsOP fall within a band of between 6 and 20 core team members. The survey also found that 26 per cent of core CMHT staff work part-time, although there is considerable variation with nearly 7 per cent of teams not employing any part-time staff and about 11 per cent having more than 50 per cent.

² A small number of respondents provided whole time equivalent figures instead of full numbers and these were rounded up but otherwise treated in the same way as all other staff figures. Administrative staff were also excluded from the data.

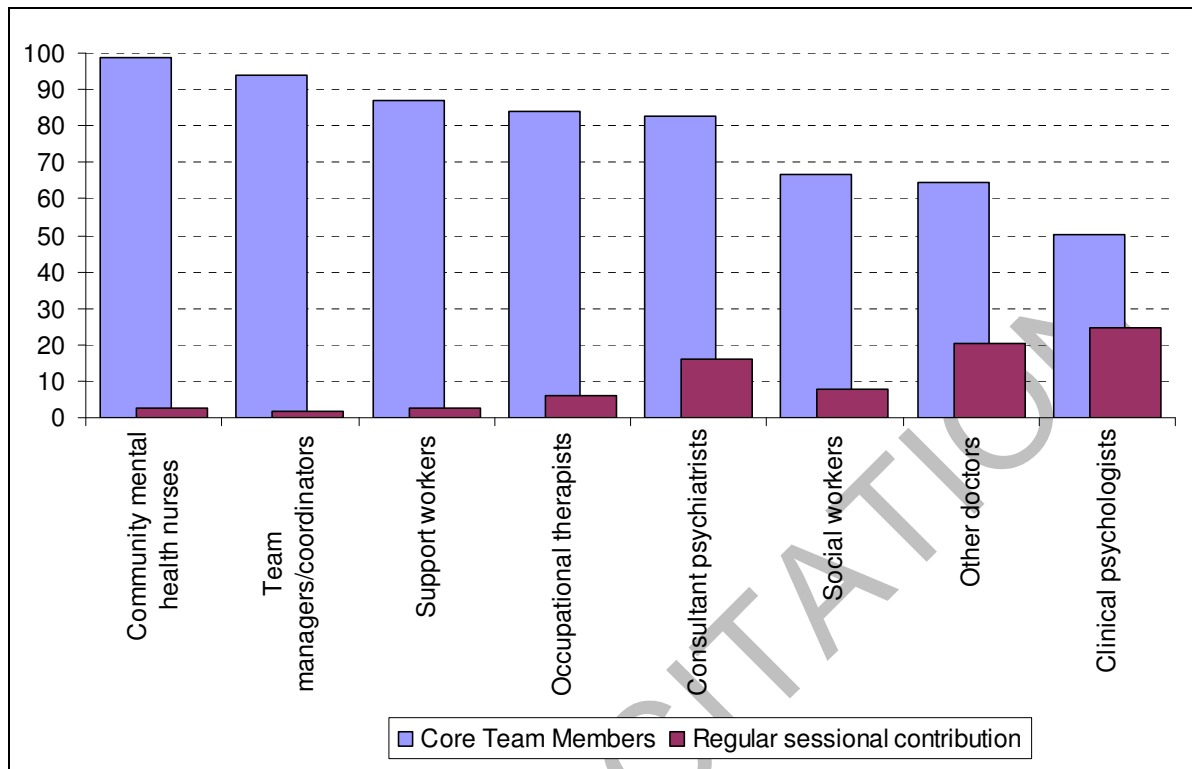
Figure 1: Distribution of the number of core team members per team (%)



Notes: n=376

We also investigated the range and proportions of different professional disciplines within teams, shown in Figure 2. Community mental health nurses are the backbone of CMHTs (forming a core part of almost all teams), while clinical psychologists are less likely than other groups to be core members, and indeed do not feature even as sessional workers in 26 per cent of teams. A similar proportion (27 per cent) of teams also do not include social workers. We also asked whether CMHTs had no access at all to certain staff groups, even from outside of the team. Nearly 10 per cent of teams report that they have no access to a psychologist, 5 per cent had no access to occupational therapists, and 4 per cent reported having no access to social workers.

Figure 2: Proportion of teams with key professional staff groups



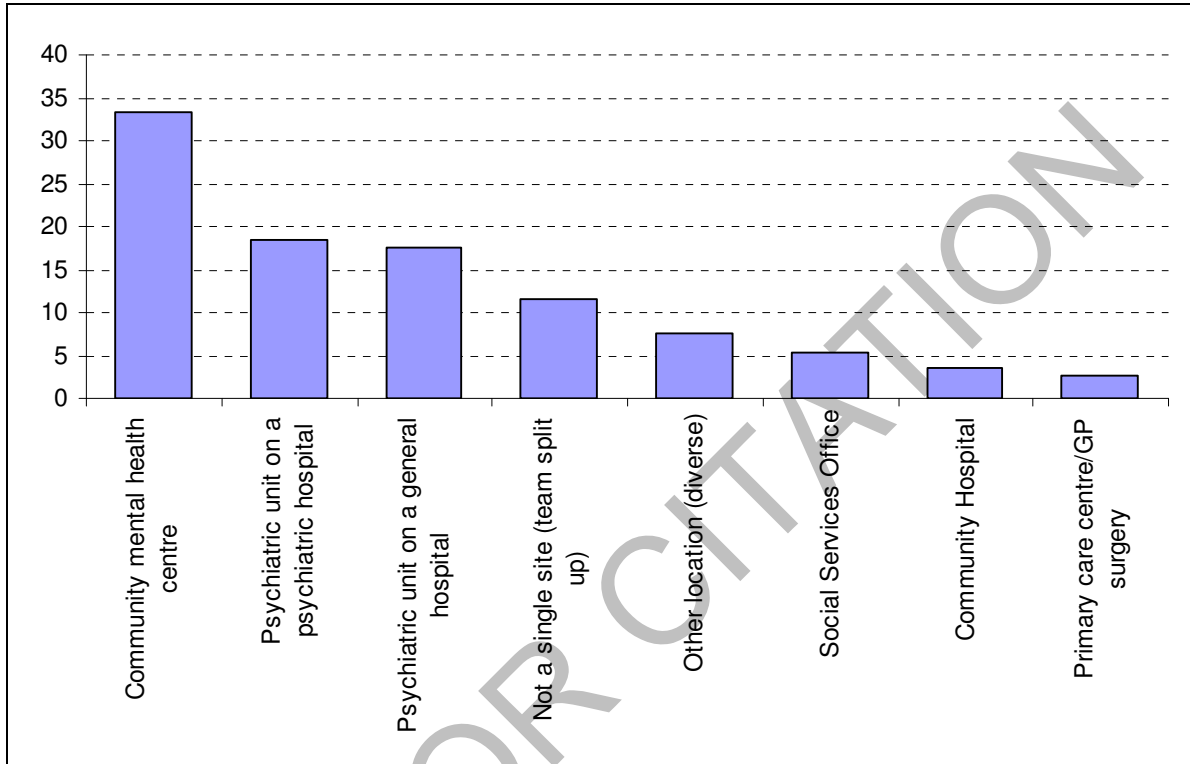
Notes: N=376

We further asked teams for the professional discipline of their team managers. In keeping with the staff mix, team leaders were mostly nurses (nearly 80 per cent), although one in five were social workers (over 20 per cent), and 6 per cent were occupational therapists. Some teams were led by managers with dual-discipline, or had more than one manager with different professional backgrounds (thus the above percentages sum to more than 100). Our data also investigate vacancy rates which display variation by staff group: a quarter of teams had at least one vacancy for community mental health nurses but very few teams were seeking consultants or other doctors.

Data on team location reveal that core staff share the same base in nearly 90 per cent of teams. Figure 3 shows that a third of teams are based in community mental health centres, units in psychiatric or general hospitals account for another third, while other sites, including local authority offices, play only a minor role. Fewer than 10 per cent are

based in 'other' locations, which encompass a diverse range of bases spanning high street units and business parks amongst others.

Figure 3: Distribution of CMHTs by location of the team base (%)

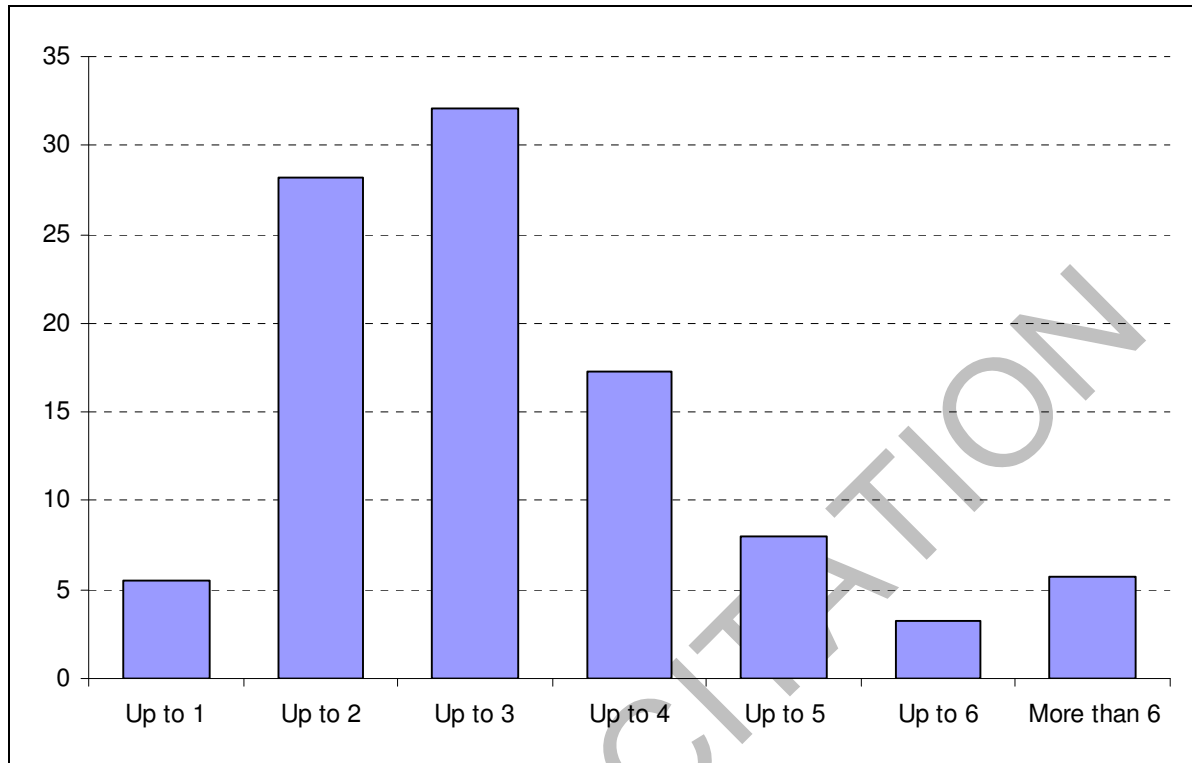


Notes: n=373

We also collected referral data and most teams accepted between 20 and 40 new referrals each month, with some considerable variation in team size and the mix of part/full-time staff. Figure 4 shows the number of new referrals per core staff member³, and whilst a majority of teams report fewer than 3 monthly referrals per team member, just under 10 per cent report more than 5. As expected, teams with more full-time staff process more referrals on average, though with substantial variation across teams.

³ Excluding support workers

Figure 4: Distribution of the number of referrals per core team member



Notes: n=365

A final set of important characteristics relate to contextual information about the team. Over 70 per cent of respondents reported that their team had been an established multidisciplinary service for 5 years or more, and just 9 per cent said the team has existed for less than 2 years. This said, nearly two-thirds of teams reported 'major' organisational change in the past year. Over 70 per cent of CMHTs work exclusively with one local authority, although a sizeable minority (11 per cent) coordinate their activities with three or more local authorities. Fifty-six per cent of teams divide their resources around geographical patches (e.g. by GP practices), and a small minority (3 per cent) are organised by whether clients had organic or functional illness. A majority (60 per cent) of teams state that they receive a combination of NHS and local authority funding, while 37 per cent state that they are funded by the NHS only (which are mostly teams that do not contain any social workers in their staff mix).

(ii) Indicators of joint working and integration

In addition to key information on team characteristics and composition, we collected data on processes and procedures, including nine measures of integration drawn from key standards of good practice as already outlined above. Table 1 shows that nearly 90 per cent of all teams have a single point of access for referrals, 80 per cent of teams have a single integrated care plan across health and social services, and that 70 per cent use a single set of assessment documentation across their professional staff. However some indicators of joint working have been achieved by a far smaller proportion of teams: fewer than a third of teams are able to access user records from their local authority (and vice versa), and fewer than one in six teams have health staff that can authorise local authority services. Using data already presented in section (i), Table 1 also shows 60 per cent of teams boast a 'core' multidisciplinary staff⁴ and a little under 90 per cent share a common base. Further, a half of team managers can directly line manage all core members of their team.

Table 1: Indicators of team integration

	Valid N	Valid %
<i>Staffing</i>		
Multidisciplinary core team	227	60.4
All core staff managed within the team	179	49.9
<i>Referral, assessment, care planning and commissioning</i>		
Single point of access (used for all or most referrals).	321	88.0
Use same structured assessment documentation	263	70.1
Single care coordinator across health and social care (for all or most clients)	219	59.7
Single care plan for both health and social care services	293	80.0
Health staff can commission LA services	57	15.2
<i>Other indicators</i>		
Team can share service user records with the local authority	118	31.6
Team shares the same office base	326	86.9

⁴ consisting of a social worker and at least two health disciplines (excluding consultants) – a formulation similar to that used in Healthcare Commission (2009)

In order to assess the relationship between integration and a number of other team and trust characteristics, a single composite measure of integration was generated using the nine items shown in Table 1. This single score was created by counting the number of the indicators each team possessed and, as such, encompasses measures of both *within-team* integration and joint working across health / social care boundaries. This score could be calculated for 330 teams with complete data on all indicators, with a mean of 5.45⁵. Just 6 teams achieved all 9 indicators of integration, though all teams recorded at least one measure.

Table 2 tests whether a range of key team and Trust characteristics are associated with differences in the integration score. Unsurprisingly, teams that regularly work with just one local authority tend to achieve more integration than those working with multiple authorities. The data also show that teams serving rural communities are, on average, less integrated than those in urban and 'mixed' urban/rural areas, though this is not a statistically significant difference.

The location of the team base is significantly associated with the integration score, with teams in community mental health centres and 'other' venues achieving highest levels of integration on average. Within the 'other' category, teams located in a social service setting achieved the highest mean integration score of 6.0. The professional discipline of the team manager is also significantly (at the 10% level) associated with the level of joint working, with social work, OT and "dual" discipline managers leading CMHTs with greater integration than nurse-managed teams. That nurse-led teams are less integrated holds true even after removing the 'multidisciplinary team' indicator from the integration score⁶ (which is, by definition, linked to the discipline of the team manager). There was no relationship between integration and the length of time the team had existed as a multidisciplinary team (not shown).

⁵ And is approximately Normally distributed: Shapiro-Wilk test (p=0.953)

⁶ p=0.076

There is substantial variation in the average score across Trusts, ranging from 7.17 to just 4.11 (excluding Trusts with fewer than five teams responding to the survey). However there are no significant relationships between mean scores and either Trust performance ratings⁷, or whether the Trust was merged with social services. The data also show that larger teams are significantly more integrated⁸, but that teams with more part-time workers⁹ and more referrals¹⁰ per core team member are significant *less* integrated. The proportion of the team's caseload with a diagnosis of dementia was not associated with integration¹¹.

Table 2: Association between team characteristics and integration score

		Mean score	Freq	P value ¹²
Number of local authorities the team works with	<i>One</i>	5.57	214	0.015**
	<i>Two or more</i>	5.14	86	
Type of community the team serves	<i>Urban</i>	5.56	126	0.207
	<i>Rural</i>	5.10	49	
	<i>Mixed</i>	5.48	155	
Location of team base(s)	<i>General hospital</i>	5.47	57	0.018**
	<i>Psych. hospital</i>	5.28	63	
	<i>Primary care</i>	4.80	10	
	<i>Community MH centre</i>	5.66	110	
	<i>Other</i>	5.72	57	
	<i>Combination</i>	4.70	31	
Professional discipline of team manager	<i>Nurse</i>	5.30	223	0.075*
	<i>Social work</i>	5.71	51	
	<i>OT</i>	5.87	15	
	<i>Dual discipline</i>	6.12	17	
	<i>No manager</i>	4.67	3	
Is team in a combined mental health / social care trust?	<i>Yes</i>	5.30	27	0.289
	<i>No</i>	5.47	303	
Assessment of Trust's 'Quality of Service' ¹³	<i>Trust rated excellent</i>	5.47	210	0.356
	<i>Trust rated good</i>	5.47	79	
	<i>Trust rated fair</i>	5.56	32	
	<i>Trust rated poor</i>	4.56	9	

⁷ The "quality of service" performance measure from the 2007/8 annual health check (Healthcare Commission, 2008)

⁸ $r = 0.118$, $p=0.032$.

⁹ $r = -0.115$, $p=0.040$.

¹⁰ $r = -0.189$, $p=0.001$.

¹¹ $r = -0.069$, $p=0.235$.

¹² Parametric tests: t-test or one way ANOVA

¹³ Note that ratings PCTs will be dominated by the Trust's performance in Primary Care

To investigate these associations in further detail, and in particular to test the extent to which each characteristic has an independent correspondence with integration (beyond being simply correlated with other measures), we performed a simple least squares regression¹⁴ (Table 3).

Table 3: OLS Regression of integrations score against team characteristics

	Coeff.	St. Err	P value
Works with one LA	0.432	0.196	0.028**
Works with one LA <u>and</u> in joint MH / SC Trust	-0.619	0.332	0.063*
Team serves a rural area	-0.431	0.260	0.099*
Team is based in a social service building	0.633	0.388	0.104
Team manager is a nurse	-0.426	0.189	0.025**
Referral per team member per month	-0.387	0.131	0.003***
Referral per squared	0.022	0.012	0.062*
Constant	6.535	0.359	0.000***

Sample=294; adj R² = 0.096, p=0.000***

The results show an expected positive relationship between integration score and whether teams work with just one local authority. However a subset of these teams was found to have particularly *low* scores, specifically those that operated in merged mental health / social care trusts. [NOTE: This is a preliminary finding and subject to confirmation] Since almost all such teams work with a single local authority this relationship was hidden in the simple bivariate test shown in Table 2. CMHTs in rural communities are found to be less well integrated than teams serving urban or ‘mixed’ populations, although this is on the very fringes of significance even at the 10% level. Further investigation shows that rural teams are least likely to have all their staff sharing a single base. Also on the margins of significance was whether a team is based in social service buildings, though due to the size of the coefficient and the strong bivariate association noted above, the absence of significance is likely due to small numbers

¹⁴ The validity of using a least squares approach on a quasi-ordinal variable was tested by estimating the same model using an ordered logistic regression on a condensed score, and found very similar results.

(n=17). As anticipated, teams managed by nurses were less well integrated and referrals per team member were negatively associated with integration score¹⁵.

DISCUSSION

This paper provides a unique and timely investigation of the breadth and depth of integration in community mental health services for older people, and a high response rate (88 per cent) enables confidence in the representativeness of the findings. However the research needs to be interpreted in the context of the survey's design and implementation. Firstly, the study sought the views of team leaders but this will provide just one perspective on the working practices of the team, and in particular may differ from the views of consultants who have previously been the subject of related research of the work of CMHTs (Tucker et al, 2007; Reilly et al, 2003). Secondly, it is possible that some respondents will have been less circumspect in saying they had particular practices in place. For example, whilst nearly a third of respondents said health and social care staff were able to access each other's records, contextual information provided in free-text form often suggested that this was only after formal requests had been made. This contrasts with other teams that said they had direct electronic access from their desktops. A more systematic inspection of qualitative information collected through the questionnaire will shed more light on this, but is beyond the scope of this paper.

It is also important to reflect on how this study has conceptualised 'integration', and its application to the subsequent analysis. Some commentators have located integration at one end of a continuum of interagency collaboration, which extends from the complete separation and autonomy of organisations and functions, through to full integration, where the degree of collaboration is so high that the organisations involved share one identity (Glendinning, 2003). However, it is also possible to characterise integration in relation to the types of organisation between which it takes place (such as

¹⁵ though the positive coefficient on the squared term indicates that this negative relationship weakens as referrals per team member increases

between health and social care, or between primary and secondary care) or at an inter-team or inter-practitioner level (Hudson, 2002; Glendinning, 2003; Reilly et al, 2003; Tucker et al, 2009). This study is primarily concerned with indicators of joint working between practitioners within CMHTsOP, and the teams' relationships with generic social services. These measures are explored individually and then combined into a composite integration score which, in the absence of any robust evidence with which to weight the various components, gives equal weight to each.

One aim of this study was to assess progress in implementing these key indicators of service integration. Some can be compared with findings from earlier studies, including national audits of old age mental health services (Audit Commission, 2000, 2002; National Audit Office, 2007) and surveys of consultants in old age psychiatry (Challis et al., 2002; Reilly et al, 2003; Tucker et al., 2007, 2009). In terms of staffing, successive studies have highlighted access to social work and psychology staff as of particular concern (Audit Commission 2000; National Audit Office, 2007; Tucker et al., 2007). Our survey suggests that some progress is being made. For example, whereas surveys undertaken in 2000 and 2004 reported that approximately half of teams contained core social workers, and about a third had core psychologists (Challis et al., 2002; Tucker et al., 2007, 2009), our data suggest these proportions now stand at a two-thirds and a half respectively. Moreover, the proportions of teams reporting that they have *no access* to psychology services stands at just 10 per cent, down from a reported 18 per cent in 2004 (Tucker et al., 2007, 2009). However, as the National Audit Office note, having access to specific staff groups is not equivalent to having access in sufficient numbers (National Audit Office, 2007). Indeed, the contextual information from our survey suggests that service users often have to wait a long time to see a psychologist, and that there may not be a dedicated old age psychology service.

There is also some suggestion that teams' processes and procedures are more integrated than they were in earlier studies. Eighty-eight per cent of teams now have a single point of access (as recommended by Royal College of Psychiatry, 2006), up from sixty per cent in 2004, and seventy per cent now use the same assessment

documentation (as advocated in the *National Service Framework for Older People*, DH, 2001) compared to a little over a third previously (Tucker et al., 2007, 2009). The proportion of teams reporting that service users have a single care plan has also risen. However some standards of integration are proving more elusive, especially those that require cooperation and trust between health and social services at the agency, as opposed to practitioner, level. Indeed, in just 32 per cent of teams are health and social care staff able to access each other's records. Furthermore, health staff were able to commission local authority services directly in only 15 per cent of teams. This chimes with a recent study of six mental health trusts, which found only one example of a community team able to directly commission packages of social care (Healthcare Commission, 2009). This is disappointing given the Government repeated efforts to encourage inter-agency commissioning through measures such as pooled budgets and other partnership arrangements (Goodwin, 2007).

Whilst progress is being made on many fronts, it is important to consider why some teams are still less integrated. Our findings suggest that it is often factors beyond the control of CMHT managers that are influential. For example teams working with just one local authority tend to be more integrated, perhaps reflecting that it is easier to make joint working arrangements with one LA than multiple arrangements with several. The finding that working in a combined mental health / social care trust is associated with *lower* levels of integration is more surprising, for one would expect such organisational structures to make integration easier. However it may be that the decision to form an integrated care trust was informed by previous difficulties in joint working. If so, these results would support previous suggestions that organisational restructuring will not necessarily overcome barriers to integration (Glendinning, 2003; Reilly et al, 2003).

Other features that seem to be important include the location of the team base and the discipline of the team manager, although, interestingly, no previous work seems to have considered these. Our study found that teams based in community mental health centres or in social service settings tended to be more integrated than those based on hospital or primary care sites. Teams led by an occupational therapist or social worker

also tended to have higher integration scores when compared with those led by nurses, perhaps reflecting a movement away from the narrower doctor plus nurses health model.

The association between a high level of referrals per core team member and lower levels of integration is harder to explain. It may be that these teams are especially busy and/or understaffed, and so have less time to devote to collaborative work. Indeed, it is interesting to note that such teams had a particularly high level of vacancies. An alternative explanation is that more integrated teams have clearer operational policies and eligibility criteria, so limiting referral numbers.

An important contextual finding from this survey is that over 60 per cent of teams have undergone, or been affected by, major organisational changes in the last year, and that many respondents anticipate further change. Whether these changes have had an impact on integration, and, if so, in what direction, is still not clear. Perhaps more fundamentally, we do not yet know what particular features, or combinations of features of integration, lead to the best outcomes for older people with mental health problems. It is our intention to address this gap in the knowledge base in our next phase of work.

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