

Integrating Older People's Mental Health Services

Community Mental Health Teams for Older People

A commentary and resource document

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Integrating Older People's Mental Health Services: Community Mental Health Teams for Older People

A commentary and resource document

Aim

To provide a resource for senior managers and Community Mental Health Teams seeking to achieve integration in assessment and care management processes as part of the implementation of the NSF for Older People Standard Seven.

Methods

Review of policy, published materials, web resources and local practice to identify and promulgate elements that contribute to effective commissioning and provision of integrated community mental health teams for older people which will have:

- interagency, multidisciplinary staff involving health and social services;
- integrated assessment, care planning and care co-ordination;
- joint recording systems and IT systems supporting both CPA and SAP; and
- single point of entry or 'access' to specialist mental health assessment.

Audience

Primary Care Trusts commissioning services with their Local Authority partners, and organisations that provide services for older people with mental health needs. The report will be especially useful for:

- commissioners and managers in PCTs and their Local Authority partners; and
- manager, clinicians and other staff seeking to develop integrated teams and influence commissioners across local health and social care systems.

Scope

This report guides implementation of part of the NSF for Older People Standard Seven: Mental health services for older people.

It distils lessons from published materials and local practices.

It identifies the partnership agenda that lies behind the imperative to have or develop integrated CMHT.

It considers the whole systems location of the CMHT(OP), its function, structures, processes and issues of evaluation

Introducing the Authors

Jayne Lingard is an independent service development consultant. Her career has included mental health and learning disability services management; team management of joint approaches to health and social care assessment & care management and also practice as an approved social worker. As a contractor to the Audit Commission she led two cross-cutting 'Forget me not' local audits. Recently she looked at progress on NHS plan priorities with three mental health trusts and their partners including protocols across health and social care systems. As programme development consultant to the Mental Health Foundation from 2000-2003, Jayne developed their website content on older people's mental health (currently at www.mhilli.org) and worked on projects on early intervention in dementia and medicines management.

Alisoun Milne is a Senior Lecturer in Social Gerontology at the Tizard Centre, University of Kent. Her key research interests are: older people with mental health problems, older carers, preventive services and social inequalities and later life. Prior to working at the Tizard Centre she was a Research Fellow at the Personal Social Services Research Unit: she has a background in social work and social work management. Alisoun sat on the Advisory Group for the 'Forget me not national study' and is a member of the National Patients Safety Agency Mental Health Reference Group. Between 2000 & 2003 she was seconded part time to the Mental Health Foundation's Mental Health in Later Life programme where she developed a portfolio of research and policy related projects including the Inquiry into Older People's Mental Health with Age Concern.

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1 Introduction

What are the aims of the document?

1. This document aims to contribute to the development of integration of health and social care processes in the assessment and care management of older people whose mental ill health poses moderate to high levels of risk to themselves or others.
2. The document is intended to support achievement of the first milestone of Standard Seven of the National Service Framework (NSF) for Older People ¹

“...the development of an integrated mental health service for older people...”

3. It focuses on issues of operational integration of service delivery in Community Mental Health Teams for older people (CMHT(OP)). It draws on information from current services about the function and role of CMHT(OP) and is informed by a review of relevant research, current policy developments and 32 responses from across England to a questionnaire on the nature of integration in local services.² See Appendix 1 for the basis of the questionnaire

Who is the document about?

4. Chapter One of the NSF for Older People sets out the increase in demand that is presented to health and social care services by a population that is steadily growing older.
5. The majority of service users of CMHT(OP)s are older people with dementia and depression. They do also provide services for older people with lifelong mental health problems or older people with learning disabilities although the numbers are few.³
6. Planning for the care and management of older people with mental health problems must take account of their carers.⁴ About 75% of people with dementia live with a close relative or spouse. Carers of people with dementia often develop physical and mental health problems due to stress, chronic fatigue, loneliness and financial worries.⁵ The majority of carers of people with dementia are older themselves.⁶

Why is a document on this subject needed?

7. The Department of Health policy team responsible for the implementation of the NSF for Older People undertook a broad consultation exercise, which revealed that integration in the Community Mental Health Team was regarded as a key indicator of service quality.
8. If health and social care workers across England were asked to describe a CMHT(OP) a range of descriptions would be obtained. Integration is similarly a word that lacks a shared understanding. This document tries to pin down what is meant by integration

in CHMT(OP)s. It identifies some of the building blocks of the integrated CMHT and set it in its policy context and place in a whole system.

9. The work of a CMHT(OP) relies on the provision of a range of care settings with staff appropriately trained in the mental health needs of older people: acute physical and mental health inpatient care, rehabilitation services, day services, respite facilities, and a range of care home provision for people no longer able to be supported at home. Another NSF for Older People Standard Seven milestone is for ***“health and social care systems to have agreed protocols in place for the care and management of older people with mental health problems.”*** As an integrated health and social care team would be at the heart of such protocols, consideration of what level of integration has been achieved in any locality needs to play a central part in protocol development.

Who should read it?

10. Those responsible for commissioning services for older people with mental health problems should find this document informative. It will also be of interest to people responsible for providing such services. Service providers that contribute to other parts of the care and management system may also find it helpful in developing an understanding of the nature of the CMHT. Contact details are given of people in areas with integrated CMHT(OP)s who are prepared to be contacted to share their learning.
11. It is not intended that this document would be of direct interest to older people with mental health problems or their carers. Local services may find the document useful when developing information for service users and their families.

What is meant by “integration”?

12. Integration means that the health and social care elements of the CMHT(OP) have no apparent joins to service users, referrers, other professionals or team members and do not pose barriers in the planning and arranging of care packages.
13. Although an important feature of a CMHT, being ‘multi-disciplinary’ does not equate to integration: this only means that the workers are qualified in different professions. ‘Inter-agency’ can also be misleading. Although workers from more than one agency are working together with a targeted group of service users, it could mean that people are running their services alongside each other and still not communicating well.
14. Through integration, all health and social care processes to provide assessment, diagnosis, treatment and care for older people with mental health problems are delivered by a carefully planned, monitored and reviewed single service system.

Why should services be integrated?

15. Older mentally ill people often have physical health as well as social care needs and benefit from medical and psychiatric assessment, intervention and treatment to alleviate mental ill health - as well as physical conditions – to ensure a better quality of life and prolong independence.⁷
16. Separate assessment and care management processes provided by health from those provided by social care organisations entail duplication of effort and cost by public sector services. More importantly, they entail the service user and their family having to engage with many different professionals – an unwarranted invasion of privacy and an unnecessary cause of confusion.
17. Integrated CMHT(OP)s have the potential to be more than the sum of their parts. This document looks at what those parts are, and how the effect of the sum is created.

2 Policy Context and History

1. In recent years there has been a positive approach to developing and promoting health and social care services for older people. There is a clear policy intention that the care of older people must be holistic and responsive to their complex needs.
2. The aim of Standard Two of the NSF for Older People states the imperative to “ensure that older people...receive appropriate and timely packages of care...regardless of health and social services boundaries”.⁸ The standard makes it clear that this should be made possible through “integrated provision of services”.⁹
3. Although there was controversy about the location of services for older people with mental health needs in the NSF for Older People rather than the NSF for Mental Health, the main policy aim is to ensure that services for older people with mental health problems are integrated and co-ordinated with other health and social care provision for older people across and within agencies and care sectors.
4. In the UK – much like the rest of Europe – the care of older people with long term mental ill health is increasingly provided in the community rather than in institutional care.¹⁰ Recent policy developments are driven by increased life expectancy, growing knowledge of late onset mental disorders and the reduction of long stay hospital beds.¹¹ They focus on promoting and maintaining independence, provision of care at home, improving access to services and the need for greater consistency¹², dignity and improved quality of life. Integrated provision and service configurations across health and social care are assumed to result in improved service to patients.¹³
5. This reflects the policy direction for older people generally, although for ‘general’ care services there is also a particular emphasis on reducing dependency, improved access to rehabilitation and the provision of care closer to home.
6. It is widely noted that the most innovative and imaginative ways of meeting the needs of older people with mental health problems are achieved by specialist services.¹⁴ These tend to be reserved for those conditions and patients where diagnosis and management is complex or challenging and are focused primarily on older people with depression and/or dementia.¹⁵
7. Recent policy initiatives include Health of the Nation strategy launched by former Conservative Government. This saw the development of Key Area Handbooks. The Handbook on the Mental Health of Older People¹⁶ identified the health and social care services necessary to meet the mental health needs of older people. Most developments in the last quarter of the 20th century aimed to offer services that are comprehensive, accessible, responsive, individualised and systematic.¹⁷
8. Historically, the configuration and design of specialist services have developed pragmatically, based on the need to secure funding and facilities rather than a scientifically evaluated service model.¹⁸ Common features include

- a community - oriented approach to the delivery of clinical services;
 - domiciliary multi-disciplinary assessments;
 - outreach activities;¹⁹
 - links with community based services such as care homes; and
 - joint work between health and social care professionals and agencies.²⁰
9. Reflecting recognition of differences in service mix and context, no ‘blueprint’ for the development of old age psychiatry services has been developed. As a strategic document, the NSF for Older People sets out in broad terms the sort of service models that are to be encouraged, with broad intentions that need to be locally interpreted.²¹
10. Broad principles have also been issued by the Royal College of Psychiatrists.²² As the needs of older people with mental health problems tend to require responses from a range of agencies, are multi-faceted and often complex, collaboration and integration are identified as key elements of effective community-based care.²³

Partnership Frameworks for Public Services

11. In October 2003, The Secretary of State for Health, John Reid advocated better partnership working between health and social care:

“Fantastic work has been done across the country between local government and NHS organisations in working together to improve services... you may not necessarily agree on local priorities for spending, on how to structure your teams, on how to implement your core professional values... these differences can get in the way of providing a coherent service to users ... The challenge for managers is ...to work through these differences to find the agreement on values in the interests of the people using those services so that they receive seamless and joined up care.”²⁴

12. The central purpose of the NHS and Community Care Act 1990 was to allow disabled individuals – frequently older people – to live independently in their own homes by enabling flexible packages of care to support them and their carers.²⁵ The Act introduced the idea of seamless care and for the first time placed emphasis on health and social care professionals working together to meet the needs of vulnerable adults.²⁶
13. The NHS Plan, launched in July 2000 re-emphasised this service design principle:

“ The NHS will work together with others to ensure a seamless service for patients: The health and social care system must be shaped around the needs of the patient, not the other way round. The NHS will develop partnerships and co-operation at all levels of care... to ensure a patient-centred service.”

14. The NHS Plan enhanced the potential to achieve this by introducing the concept of Care Trusts²⁷, delivery vehicles for integrated health and social care services.

“By placing both NHS responsibilities and local authority health responsibilities under a single management, care trusts can offer a more efficient and better integrated service.”²⁸

However, integration of service delivery can be achieved without such major organisational change.

Partnership in Action

15. In September 1998, a discussion document entitled “Partnership in Action” was produced by the Department of Health.²⁹ It clearly set out the proposed partnership agenda that would be enabled through new legislation.

“For the right services to be delivered to local people at the time they need them, health, social services and other parts of local government must work together in partnership. Our proposals will... make working together much easier...Major structural change is not the answer....”

“We must address the frustrations and distress people experience in trying to organise the kind of care they want, or the kind of support they need as a carer. This often requires contact with several different agencies, perhaps each carrying out its own assessment, and leaving the user or their carer unclear as to who is providing what, and how the bits link together.”

“The proposals ...represent(s) a challenging agenda for management and staff delivering the services but there are gains to be made in terms of streamlining resources between agencies, avoiding duplication and eliminating gaps and improving outcomes for users and their carers.”

The Health Act 1999³⁰ and Health Act Flexibilities

16. The introduction of Health Act Flexibilities³¹ was intended to address the legal barriers standing in the way of integrating health and social care service elements. Where previously certain arrangements between the NHS and local authorities were not legal, the Health Act introduced three new permissive structures.

“The aim is to enable partners to join together to design and deliver services around the needs of users rather than worrying about the boundaries of their organisations. These arrangements should help eliminate unnecessary gaps and duplications between services.”³²

17. Each of the three ‘flexibilities’ have the potential to contribute towards the integrated CMHT(OP)
- **Lead commissioning** - the partners can agree to delegate commissioning of a service to one lead organisation
 - **Pooled funds** - the ability for partners each to contribute agreed funds to a single pot, to be spent on agreed projects for designated services (See Resources section)
 - **Integrated provision** - the partners can join together their staff, resources, and management structures to integrate the provision of a service from managerial level to the front line

The National Service Framework for Older People

18. The Older People's NSF is underpinned by two overarching aims:

- To drive up the quality of healthcare
- To reduce variation in practice

19. All of the standards of the NSF are applicable and important in delivering services to older people with mental health problems. Standard Seven addresses the particular nature of certain aspects of older people's mental health and mental illness services.

20. Standard Seven states that:

*“patients with complex mental health needs can and should be treated and supported in the community and wherever practicable at home.”*³³

21. It sets out the core elements of a high quality mental health service, which are:

- early detection and comprehensive assessment;
- health promotion and prevention;
- access to specialist services, advice and skills, treatment and rehabilitation;
- **integrated care management, including the requirements of CPA for older people with severe and enduring mental illness;**
- organisation of specialist services and teams with emphasis on provision at home and support for carers; and
- continuous development from sharing good practice and learning from experience.

22. Implementation of Standard Seven should ensure that:

*“Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support for them and their carers.”*³⁴

23. Standard Seven does not refer to the CMHT(OP), describing *“the specialist mental health service”* which is *“community orientated...comprehensive, multi-disciplinary, accessible, responsive, individualised, accountable and systematic”*, with robust links with primary care, social services and housing, delivering an integrated service.

24. Two of the three Standard Seven milestones are directly relevant to the development of integration in CMHT(OP)s:

- *“HImPs and other relevant local plans developed with local authority and independent sector partners, should have included the development of an **integrated mental health service** for older people, including mental health promotion*
- *Health and social care systems should have agreed protocols in place for the care and management of older people with mental health problems”*

The NSF for Older People and Carers

25. Although no particular section addresses carers needs, it contains this statement:
“carers’ needs should be considered as an integral part of the way in which services are provided for older people.”
26. The Carers & Disabled Children Act 2000 came into force in April 2001; it extends carers’ rights to an assessment of need, already provided for in the Carers (Recognition and Services) Act 1995.³⁵
27. The new Act has responded to some of the earlier criticism of policy deficits: carers can now receive services and an assessment of their own needs even if the cared for person refuses an assessment for, or the provision of, community care services.
28. Councils have also been given discretion to meet carers’ needs with any service that will genuinely help them continue to care and maintain their health and well-being. This gives much greater scope to be flexible and innovative in the way that support is provided to carers.
29. The Act also empowers local authorities to make direct payments to carers to meet their own needs and to provide short-term breaks voucher schemes to allow carers the flexibility to manage their own package of support. In CMHT(OP)s where there is no Section 31 partnership agreement this duty tends to fall either to the social work member or another social worker linked to the team.

Intermediate Care and Mental Illness

30. The ability of CMHT(OP)s to work with service users in their own home distinguishes them from ‘traditional’ psychiatric services and makes their service meaningful and acceptable for many users and carers.³⁶
31. The model of service of the CMHT is aligned with the shift of policy emphasis towards supporting older people in their own homes or in supported housing and has the potential to prevent or reduce the length of hospital stays.
32. “Intermediate Care: Moving forward”³⁷ addressed the common misconception that older people with mental health problems cannot benefit from rehabilitation and intermediate care services:

‘Services for older people should take account of the mental health needs of those they cater for, for instance by making arrangement within a ‘general’ intermediate care service or by developing services specifically tailored to the needs of a particular client group e.g. people with dementia.’ (p12)
33. Rehabilitation services offered to people with dementia following a hip fracture can result in the maintenance of or improvement in activities of daily living skills and in fewer admissions to residential care.³⁸

34. The work of some psychologists has raised the need to take a rehabilitative approach to dementia. Dr Linda Clare, talking about people with early dementia explains that:
- “Rehabilitation is an approach that tries to help people who are experiencing an illness or disability to function as best they possibly can, and to enjoy as much well-being as they possibly can. It may not be possible to cure the illness or remove the cause of the difficulty, but a lot can be done to help people make the most of life as they live with that difficulty. This is true for people with dementia too.”*³⁹
35. To address the problem of the widespread under-detection of depression in older people and to improve the support provided for people with dementia, intermediate care teams are developing closer links with mental health services.
36. In Portsmouth and East Hants, the community rehabilitation teams include mental health nurses, whose role is to identify and treat people as well as to provide support on mental health issues to other professionals in the team.⁴⁰
37. Dementia Voice has worked with an inter-agency group to develop a statement of principles for developing intermediate care services for people with dementia.⁴¹

NSF for Mental Health⁴²

38. Addressing the needs of people with severe mental illness due to a psychotic illness, Standard Seven of the NSF for Older People states that *“they will require the packages of care set out in the NSF for Mental Health and the same standards should apply for working age adults”*. Thus the integrated CMHT(OP) will need to be part of the care system to meet such needs
39. The policy and service development agenda for mental health services for people of working age (16-64) has benefited from the early introduction of the NSF for Mental Health. The Mental Health Policy Guidance includes a clear document about the nature of the Community Mental Health Team for adults of working age.⁴³ It states that a CMHT has *“Three distinct functions....*
- i) Giving advice on the management of mental health problems by other professionals – in particular advice to primary care and a triage function enabling appropriate referral.*
 - ii) Providing treatment and care for those with time-limited disorders who can benefit from specialist interventions*
 - iii) Providing treatment and care for those with more complex and enduring needs”*
40. Although the guidance is not directly transferable to services for older people, much of the content of the guidance could be of help in developing the operational detail of local services.
41. Professor Susan Benbow, Fellow in Mental Health and Ageing with the National Institute for Mental Health England (NIMHe) was asked her view of the implications of the current policy agenda, and the need to address issues of ageism in all approaches to older people’s mental health, and what this means for CHMT(OP)s. Professor Benbow’s views are set out in Box 1.

**A Personal View:
Professor Susan Benbow, Fellow in Mental Health and Ageing**

“Older people’s mental health is embedded in the National Service Framework for Older People. The Mental Health NSF, published some 3 years previously, was specifically concerned with the needs of adults aged 16-64. Younger adults’ mental health services have seen considerable investment, including crisis intervention teams, home treatment teams and early intervention services. However, older people and their families have crises too. They often prefer home treatment and would benefit from early intervention. Due to this differential policy development and implementation, older people’s services have not seen the same level of development. How is this to be addressed?”

“Older populations have special needs. As people age they accumulate the physical concomitants of ageing, and these are, not infrequently, complicated by physical illnesses. Cognitive impairment also becomes more common in later life and social disadvantages may accrue. When an older person’s mental health becomes an issue, they need a special service, which gives access to knowledge and experience relevant to their needs, which may be complex. If the special needs associated with increasing age are ignored, then services will be ageist and will perpetuate disadvantage. It cannot be assumed that what works for working aged adults will work for older people too, and to bolt on to older people’s mental health services models which have been developed with younger adults is inappropriate and may reinforce ageism.

“Mental health services for older people need to be comprehensive, and to address the range of problems, which may present in late life (not just the dementias). They need to fulfil the same aims as those addressed in working aged adult mental health services, but to do so in a way which takes account of the special needs of older people presenting with mental health problems and which tailors the service to those needs. For example, early intervention in older people’s services may involve developing memory clinics to assess and, where appropriate, treat early Alzheimer’s disease. Another example might involve addressing home treatment for older adults, not by setting up separate older persons’ home treatment teams or by allocating a small proportion of working aged adult teams’ caseloads to older people, but by making additional resource available in order to provide more intensive home treatment by expanding existing community mental health teams for older adults.

“The integration of health and social services at the level of the consumer of health services is critically important. It will not necessarily be brought about by wholesale system changes: indeed organisational changes may consume so much energy that they prevent integration from being taken forward at the level of practitioners. What integration should mean in practice is that one referral to an older people’s mental health service gives access to a multi-disciplinary team of health and social care professionals as set out in Standard Seven of the Older People’s NSF.”

Read about NIMHe’s work on Older People’s Mental Health at <http://www.nimhe.org.uk>

3 Commissioning Integrated Mental Health Services

1. The most comprehensive overview of the current challenges and opportunities in the delivery of mental health services for older people across England and Wales was the Audit Commission's report, entitled "Forget me not: Mental health services for older people".⁴⁴
2. Two principal areas were raised as concerns. These were the of levels of variation in
 - availability, accessibility and outcomes of mental health services, particularly in the prevention and management of dementia and depression; and
 - organisational arrangements at strategic and operational level for delivering these services: where services sit, and the level and quality of joint working.
3. The key recommendation was that a comprehensive strategy for older people's mental health should be developed

*"Commissioners in health and local authorities should take the lead in setting out strategic goals and priorities ... While jointly commissioned services with shared budgets may be the ideal, they should aim for a co-ordinated service, while minimising organisational change as far as possible."*⁴⁵

4. This report was followed by a two-year audit programme around England and Wales. Analysis at national level of the data from these audits showed that there was a correlation between good co-ordination and strategic planning and good services.⁴⁶
5. The national priority was identified as the need to improve commissioners' understanding and expertise about mental health services for older people and how they may be delivered to achieve the best outcomes

"Agencies should develop joint plans for commissioning and delivering integrated services, based on good information and involving key partners"

Straddling the mental health and older people commissioning agenda

6. The NSF for Mental Health and then later the NSF for Older People led to setting up of Local Implementation Teams (LITs) for each NSF and in some PCTs and Social Services Departments the appointment of commissioning managers specifically in relation to each set of milestones. This created the risk of a lack of focus on the older people's mental health agenda as it was not firmly located in either area.

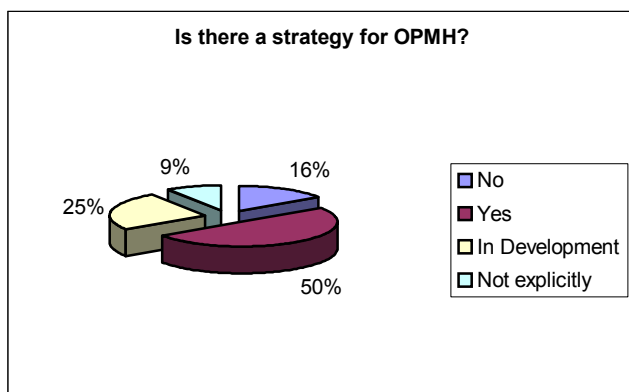
- The Older People’s Mental Health Sub-Group of the National Mental Health Partnership¹ commented on the difficulty of older people’s mental health services (OPMHS) sitting across two commissioning and providing agendas:

“That the development and integration of OPMHS involves both specialist mental health focus and the wider Older People’s focus complicates the issue. In the DoH, in the ADSS, in StHAs and PCTs, policy, enabling strategies and commissioning tend to be split into an Older People’s ‘stream’ and a Mental Health ‘stream’. Building an integrated middle ground, so that development of OPMHS can sit firmly within the wider system of older people’s mental health and social care services, whilst benefiting from specialist mental health drivers is difficult and essential. Local OPMHS strategies (commissioning and/or providing) need to reflect the standards required by both the NSF for Mental Health and that for Older People.”⁴⁷

Local mental health strategies for older people’s mental health

- In England the cost of caring for older people with dementia is estimated to be £6.1bn and the cost of caring for older people with depression at £6.6bn.⁴⁸ About half of this sum is borne by unpaid carers.⁴⁹
- A service planning population of 250,000 will include 37,500 people aged 65 and over. Among these will be approximately 2000 with dementia, 5600 with depression (750 severe), 750 with psychoses and 750 with other conditions.
- A typical general practice of list size 10,000 will include 1500 people aged 65 and over. These are likely to include around 75 people with dementia, 225 people with depression (including 30 with severe depression), 30 with psychoses and others with various less common conditions.⁵⁰

Graphic 1



- The 32 responses from areas around England to questions about older people’s mental health services gave the picture represented in graphic 1 of the current state of development of their Older People’s Mental Health Strategies.⁵¹ However, of those areas that reported having strategies, few were jointly developed between health and social services.

- Different approaches can be taken in developing local strategies. One respondent to the questionnaire provided an example of the provider to some extent taking the lead: *“We have a strategy within the Partnership NHS Trust and in turn we are developing local strategies with each PCT through our PCT linked NSF groups...”⁵²*

¹ The Partnership consists of 62 mental health provider organisations. Open access to their website is by registration at <http://www.nmhp.co.uk>. The OPMHS sub-group briefing paper is on the website.

13. Ensuring the CMHT(OP) is linked into local strategic service planning systems is important as members are often well placed to note deficits in community services, breaks in the care pathway and issues that need to be addressed from the perspectives of users and carers.⁵³
14. Work is being done by Dr Susan Bedford², NIMHe Eastern regional lead for older people's mental health, to learn more about what services are available across the region. This will provide crucial information to assist the local commissioning task. Dr Bedford's work is set out in Box 2.

Box 2

A Survey of CMHT(OP)s in East Anglia

Dr Susan Bedford, NIMHe Eastern Older People's Mental Health Fellow, is surveying current CMHT(OP) service delivery in the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority area. She was part of a previous research study that developed joint assessments for older people between health and social services.

The survey was prompted by local stakeholders including Dementia Focus,⁵⁴ wanting a scoping survey of the local SHA community teams. Dr Bedford is developing a list of teams and their locations, population information, staff numbers, information about the nature of their integrated working with social services, whether they have access to psychology and details of any local difficulties.

The methodology is a semi-structured face-to-face interview with the team leader, allowing them to comment on their service and to identify their local good practice in moving towards integration.

The planned outcomes of the work are information on local services, the ability to identify gaps in provision, a report on perceived unmet needs and apparent good practice.

Dissemination will be via final reports to teams and commissioners, meetings with managers and with Dementia Focus. The audience will be community teams, managers, the SHA, NIMHE and all other stakeholders.

Although in the early stages at present, Dr Bedford would be pleased to be contacted about her work and can be contacted at Dm214@aol.com

Service mapping

15. Service mapping of older people's mental health services can assist local commissioners in developing a clear understanding of where there are gaps or duplications in local services.
16. Durham University have developed a comprehensive range of service definitions team in partnership with a wide range of stakeholders. Each health community is able

² not to be confused with Professor Susan Benbow

to use the Durham mapping website⁵⁵ in order to collate detailed information about all services designated as being available for older people with mental health problems.

17. When reporting on integration in Older Person's Community Mental Health Team, the section on 'Special Attributes'⁵⁶ will list the features of integration. The person completing the data return is asked to:

"Indicate the degree to which Community Mental Health Teams have integrated health and social care staff providing assessment and care management by indicating which criteria are met."

18. During the piloting phase, the website has four criteria, which are options that can be selected. Some areas will not be able to record that they have any of the options and others will be in a position to record that they have all four options.

The options are:

- Interagency multidisciplinary staff involving health and social services
- Integrated assessment, care planning and care co-ordination
- Joint recording systems and IT systems supporting both CPA and SAP
- Single point of entry or "access" to specialist mental health assessment

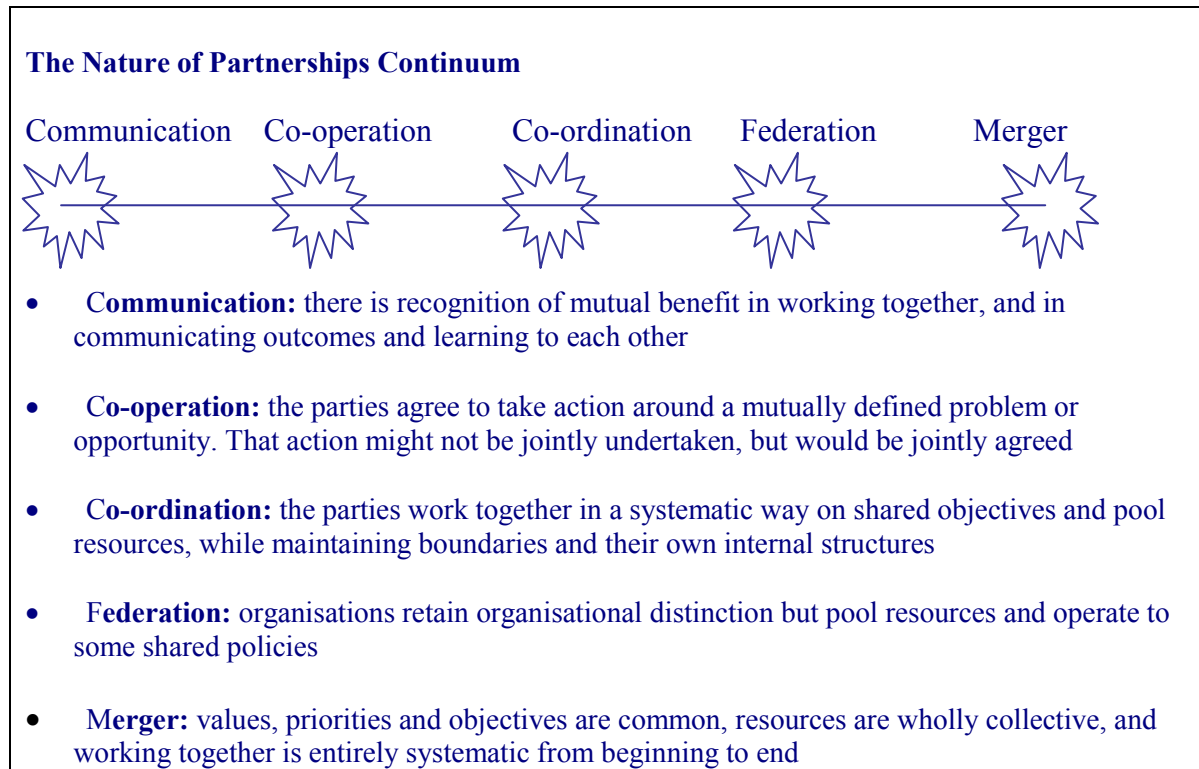
Service specification

19. An Audit Commission report entitled "Developing Productive Partnerships"⁵⁷ identifies a number of critical factors for fruitful partnerships:
 - Shared purpose - this may include unambiguous mission statements and clear terms of reference
 - Resources - partnership performance is dependent on the resources it can draw upon. To help make the best use of resources be clear about the resources that are within the control of the partnership, establish clear criteria for the allocation of resources and consider the resources required to avoid over commitment
 - Clear indicators for measuring success - as well as developing a strategy, partnerships need to develop baseline indicators, milestones, targets and performance monitoring. These need to be specific and relevant to the work of the partnership
20. Where more than one agency is either commissioning or providing a service, a team service specification clarifies the purpose of the team. In addition to assisting commissioning, this enables both immediate operational efficiency through the development of clarity of purpose within the team and service evaluation and review.

Partnership as a continuum

21. A lot of work has been done on the nature of partnership. Any area considering integration might find it useful to analyse the stage of integration that have been reached in its commissioning and services. Box 3, from a document exploring a particular partnership issue,⁵⁸ summarises staging posts of partnership.

Box 3



Lead commissioning

Whilst older people's mental health services commissioning needs to be well informed by a good understanding of mental health, it must be enmeshed in a system of commissioning for older people's health and social care.

22. A recent learning point on lead commissioning for mental health services is to be found in a 2004 SSI report on adult mental health services, where the lead is often taken by a PCT on behalf of local authorities and other PCTs:

“In early 2003, councils and primary care trusts had a shared responsibility to produce Local Delivery Plans, setting out their intended investment in mental health 2003-06. The large majority of councils have since reported they were fully involved in this process, but 39 per cent reported that resulting plans did not reflect key social care priorities, with investment being focused on a small number of new services prescribed by the NSF, and on meeting cost pressures in the NHS.

“Councils need to ensure that those services for which they have traditionally led development – for example, accommodation, advocacy, flexible day services, funding to voluntary organisations - retain a clear, valued place in local planning priorities.”⁵⁹

Sought outcomes from integration

23. NIMHE and the ADSS jointly produced a briefing for directors of Social Services Departments on the integration of mental health services entitled “*Positive Approaches to the Integration of Health and Social Care in Mental Health Services*”.⁶⁰
24. The document identifies the outcomes that should be achieved from integration as shown in Table 1

Table 1

<ul style="list-style-type: none"> • An organisation which achieves effective outcomes for its stakeholders in a way which maximises participation and partnership • Service users and carers at the heart of the service • Service models which focus on the whole person in the context in which they live, and which can bring an effective ‘whole systems’ approach to bear • A value-driven organisation which has all staff and partner agencies working to common values and goals • A recognition of a valuing of diversity, something in which Social Services has until now been ahead of the health service • Sound governance arrangements which value openness, learning and innovation and links to the wider community governance • A workforce which has the right skill-mix to achieve its objectives, is supported, developed and empowered • Combining service effectiveness with cost effectiveness • Proper attention to dual diagnosis e.g. cover for people with learning disabilities and a mental health need, and effective integration with drug and alcohol services • Integration of Mental Health and Public Health so that the service is not simply a ‘mental illness’ service
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25. All local health and social care communities need to develop a clear and shared local vision about integration based on the current configuration of services. They will need to decide on outcome indicators to check progress against which to see if they have achieved improvements through integration.
26. The following list is a suggestion of sought outcomes to be prioritised at a local level depending upon current performance across the health and social care service pathways
 - Improved access to specialist services
 - Less complicated care journeys
 - Improved service user experience
 - Reduced carer pressure
 - Reduced number of professionals involved
 - Reduced risk of duplication
 - Reduced risk of oversight

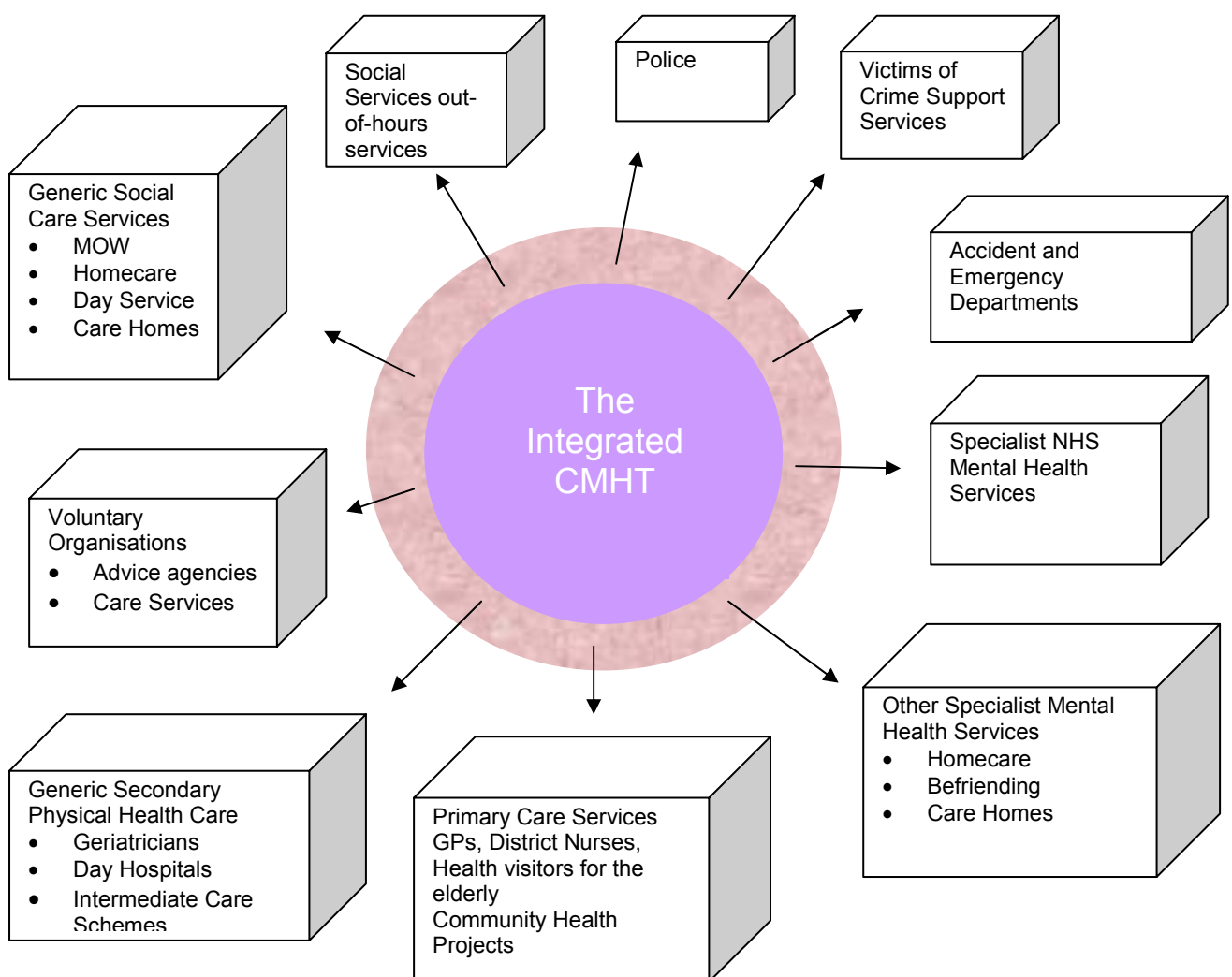
4 Care Pathways – Integrating Health and Social Care

1. In February 2004, in a speech to a conference concerned with the independence of older people⁶¹, the Social Care Minister Stephen Ladyman was clear about how services should be designed

“Services need to be shaped around the needs, wishes, and aspirations of the people using them not the organisations providing them.”

2. Community Mental Health Teams for Older People are regarded as pivotal to the delivery of an integrated service; A recent review described them as ‘the cornerstone’ of a comprehensive local community-based service and as a means of assuring the co-ordination of provision that spans health and social care.⁶² Figure 1 demonstrates the key services in the care pathways of older people with mental health problems.

Figure 1: The CMHT(OP) in a health and social care system



Source: Jayne Lingard

3. One of the three Standard Seven milestones sets out the need for health and social care systems to develop protocols for the care and management of older people with mental health problems. The guidance on the minimum contents for protocols states:

“Key to improving the experience of the user and carer is to make the patient pathway through any transition between services as seamless as possible, and for the main principle to be interests of the user and carer rather than of the service.”⁶³

The service users of CMHTs for Older People

4. No national data is currently collected specifically about the service users of CMHT. Although Social Services have information on numbers of service users with mental illness and service users who are older people, they do not collate information on older people who have mental health problems. Health care statistics are available about the age and gender of people using mental illness inpatient beds⁶⁴ and it is known that the majority users of old age psychiatry services are over 80 years of age.⁶⁵
5. Many CMHT(OP)s provide an important consultation to other professionals working with people with less severe or high risk mental health problems. Whilst not primary service users, it is important that this group of people are recognised when considering the system impact of the service.

Age

6. Mental health service providers should be operating according to locally developed transition protocols. These are designed to ensure that services respond according to the person’s lifestyle and needs and not simply their age.⁶⁶
7. Community mental health services for older people can also provide services for people who have experienced long-lasting serious mental illness that started when they were much younger. These people often have not had the opportunity to develop independent living skills and may not have developed a range of mutually supportive relationships. Their needs are therefore quite different from older people who develop mental health problems later in life. NIMHE has funded Dementia Plus West Midlands to carry out a study of care for people who enter old age with enduring or relapsing mental illness.⁶⁷ The Royal College of Psychiatrists have produced a paper considering their needs.⁶⁸

Gender

8. As the number of very old people is set to rise, so is the number of people living alone and due to the different life expectancies of men and women, this will mean an increase in widowhood.⁶⁹ Significant differences between both the lifelong and age related experiences of men and women have implications for their mental health.

9. Older women experience high levels of poverty, live alone for many years and experience chronic disabilities - risk factors for developing depression. Rates of depression in women are double those for men.⁷⁰
10. Men aged 80 years and over appear to be at particular risk of suicide.⁷¹ Although this is not fully understood, loss of role, widowhood, limited social support, and fragmentation of the family all play a part.⁷²

Ethnicity

11. It is now acknowledged that older people from black and ethnic minorities do not use mental health services to the extent that they should given the prevalence of dementia and other mental health problems in these ageing populations.⁷³
12. In 1998, the Social Services Inspectorate published a report entitled “They look after their own, don’t they?” which challenged the myth that ethnic minority families universally support dependent members and highlighted a number of service deficits.⁷⁴ The report concluded that:

...the variety of services available offering choice to Black elders was limited and the Eurocentric nature of service provision meant many Black elders had difficulty in having their needs met.”⁷⁵

13. The “Forget me not” audits also highlighted a dearth of specialist services for ethnic minorities⁷⁶ and the National Service Framework’s Standard Seven states:

“Older people from black and ethnic minority communities need accessible and appropriate mental health services. Unfortunately, for a number of reasons, services may be neither readily accessible nor fully appropriate.”⁷⁷

14. Although some work has been done to develop culturally appropriate mental health day, respite and residential care services, particularly for people with dementia, there is no such evidence in the public domain about CMHTs.⁷⁸

Living alone

15. Between 1991 and 2011 the percentage of people with dementia living alone is estimated to increase by 59% from one quarter to one third of the total number of those with dementia in the UK. These individuals make significant demands on services both in the community and in hospital.⁷⁹ Special attention needs to be paid to identifying and supporting older people with dementia or depression living alone, to their safety and to the co-ordination of services.
16. In 1997, Diana Barnes produced a DH/SSI³ report called “Older People with Mental Health Problems Living Alone”⁸⁰ which stated that
“For older people with mental health problems who live alone, a ‘seamless’ service within their home is essential with service providers cooperating to meet needs in the most satisfactory way.”

³ Department of Health/Social Services Inspectorate

People reliant on carers

17. About three quarters of people with long-term mental health needs living in the community receive support from carers.⁸¹ Most are older and the majority are spouses. Most care for sustained periods without input from services. Entry to a care home of the cared for person is often triggered by the collapse of the carer. Identification of the need for support before a crisis is reached can delay - or even prevent - such admissions.
18. Older carers, particularly those providing intensive care, are at considerable risk of developing mental ill health themselves due to the effects of physical stress associated with lifting and handling, emotional strain related to caring for a person with dementia, lack of sleep and fatigue, isolation and the loneliness of being a 24hour carer.⁸² In such situations, the CMHT(OP)s have two people as direct service users
19. Over the last 20 years considerable investments in supporting family members and prolonging community-based care have been made. These include:
 - Admiral nurses⁴
 - Early intervention services⁸³
 - Memory clinics
 - Befriending schemes
 - Carers support groups run by the Alzheimer's Society and by carers agencies such as Carers UK
20. There is some evidence that innovative sitting and home-based support services are being developed through the Carers Grant, enhancing the quality of life of the carer.⁸⁴
21. As with services for older people with mental health problems services for carers vary in availability, eligibility and quality.⁸⁵

People living in care homes

22. The NSF for Older People alerts us to the under-diagnosis of depression in non-specialist care home residents.⁸⁶ The CMHT(OP) is well-placed to provide treatment to this population as well as support care home staff.
23. The CHMT(OP) is also well placed to work with specialist care homes for people with long-term mental health problems. Advising about the management of challenging behaviour has been identified as a particularly useful role.⁸⁷
24. Specific work has been done on the medication of people with dementia living in specialist residential care and the need for frequent expert review to ensure an appropriate drug regime.⁸⁸

⁴ Admiral nurses are specially trained nurses who support carers of people with dementia. The service was developed by the charity 'For Dementia' <http://www.fordementia.org.uk/admiral.htm>

Whole system thinking

25. A CMHT(OP) by its nature does not operate in a vacuum; integration within the team cannot be achieved unless the wider service setting is committed to establishing systems and structures that support and facilitate integration on wider basis.⁸⁹
26. Friends of the Elderly, a charitable organisation commissioned a study from Oxford Brookes University to provide information on the needs of older people with mental health needs.⁹⁰ They studied 26 health communities. Of these, 20 said that

“services...remained somewhat fragmented but ...were more joined together in areas that had multidisciplinary teams (CMHTs).”

27. Of the 20 authorities, 17 had set up specialist community-based teams but these were not available in all districts. Most service plans included further team development in order that coverage was comprehensive across authorities.
28. Specifying the objectives of the CMHT in relationship to the wider health and social care system, supporting the development of team policies and procedures in relation to this, and clarifying the organisational parameters of the team’s work are core elements of defining the team’s role and purpose.⁹¹
29. This clarity can assist in the implementation of protocols, which, guidance states

“should indicate when and how people with mental illness should be referred between different services across different agencies, with mechanisms to optimise appropriate information sharing.”⁹²

30. The Health & Social Care Change Agent Team (CAT) was established in January 2002 to tackle delayed transfers of care (or delayed hospital discharges) and associated arrangements. Box 4 sets out their definition of a whole systems approach.

Box 4

Defining a Whole Systems Approach: Health and Social Care Change Agent Team

“A Whole System values the contribution of all organisations/agencies/partners to the provision of the service. Services are planned and integrated across organisations and the impact of the contribution of each on the others is essential if there is to be successful planning across organisational boundaries. Whole Systems Working is not just about working across organisations but about working across professions within organisations, so that services are not constrained by professional barriers and demarcations.”

For the whole document, go to

<http://www.dh.gov.uk/assetRoot/04/07/29/53/04072953.pdf>

31. A CMHT(OP) needs to have a range of formal and informal liaison arrangements with all health and social care services which are used by older people with mental health needs or where detection of mental health needs is possible. General medical services provided in primary care and geriatric medicine are important, as are links with day centres and support groups for carers.
32. Locating the CMHT in the 'system' and adopting a clear set of policies and procedures are key factors in facilitating greater integration of health and social care services.⁹³ A part of this relates to identifying the CMHT's position within the user and carer care pathway and its links with other services and professionals.⁹⁴ These include: primary care; inpatient psychiatric care; day, respite and residential care; social services; geriatric medicine; community services; and carers support services.⁹⁵
33. Work done in three areas of England to locate the CMHT(OP) in their local whole system of care for older people can be found at Appendix 2.

Promoting access in a whole system

34. It is important that the 'way in' to the CMHT(OP) is understood across all health and social care systems and that clear access criteria are made available. The "Forget me not audits in Wales noted that referral routes to CMHTs varied and arrangements were not always understood by those professionals and services who needed to know; this included GPs and geriatric services.
35. In some areas all referrals were received and filtered through a single access point; this helped to ensure that referrals were channelled to the right practitioner or service. In other areas, referrals could arrive at one of several points and require health and social care practitioners to refer on as necessary; this often led to duplication of effort and/or assessment and did not offer a reliable mechanism for ensuring a specialist service was in place quickly.⁹⁶
36. The 32 respondents to a questionnaire⁹⁷ reported having various arrangements for creating a single point of entry. Not untypical was one who indicated a gradual move towards this:

"There is an integrated duty system and one allocation meeting for the service. Plan to have single point of entry in the future."
37. The Audit Commission audits in Wales noted wide variation of access criteria to CMHT(OP)s.
38. Criteria included:
 - if people had dementia and were 65 or over;
 - if people had dementia or a functional mental illness and were 65 or over;
 - if people had dementia (at any age) or if they had a functional illness and were 75 or over and were considered frail; and
 - if people had moderate or severe dementia and were 70 or over, or if they had a functional illness and were 70 or over and were considered frail⁹⁸

39. In one third of Welsh localities the access criteria were neither well understood nor fully agreed. There were not always protocols in place to ensure consistency and timeliness. Clear referral mechanisms between hospital and the community team are particularly important as this transition - if badly dealt with - can hasten the admission of frail older people to long term care.⁹⁹ Agreed protocols on the boundaries with primary care are also important to enable the team to retain its focus on those with long term and/or complex mental health problems.¹⁰⁰

Working to achieve integration

40. In 2001, an interagency project supported by the Modernisation Agency¹⁰¹ run by East Kent Authority, Ashford Primary Care Group, East Kent Community Trust, Kent County Council Social Services Department was part of the National Patient Action Team Mental Health pilot. Box 5 gives details of the project.

Box 5

Integration Agenda 2001

Two project managers were appointed for two days per week – a Clinical Nurse Manager (Health) and a Senior Practitioner (Social Services).

The project was prompted by

- Confusion within primary care about referral route and role of CMHT(OP) specialist services
- Need for agreement on referral pathways between Acute Medical Services, Accident and Emergency and OPMHN services
- Lack of agreed protocols between Health and Social Services for CPA/Care Management responsibility of Care Managers

The project used the following techniques

- Process mapping
- Plan, Do, Study, Act cycles
- Service redesign
- Area-wide workshop to share learning

The outcomes were that

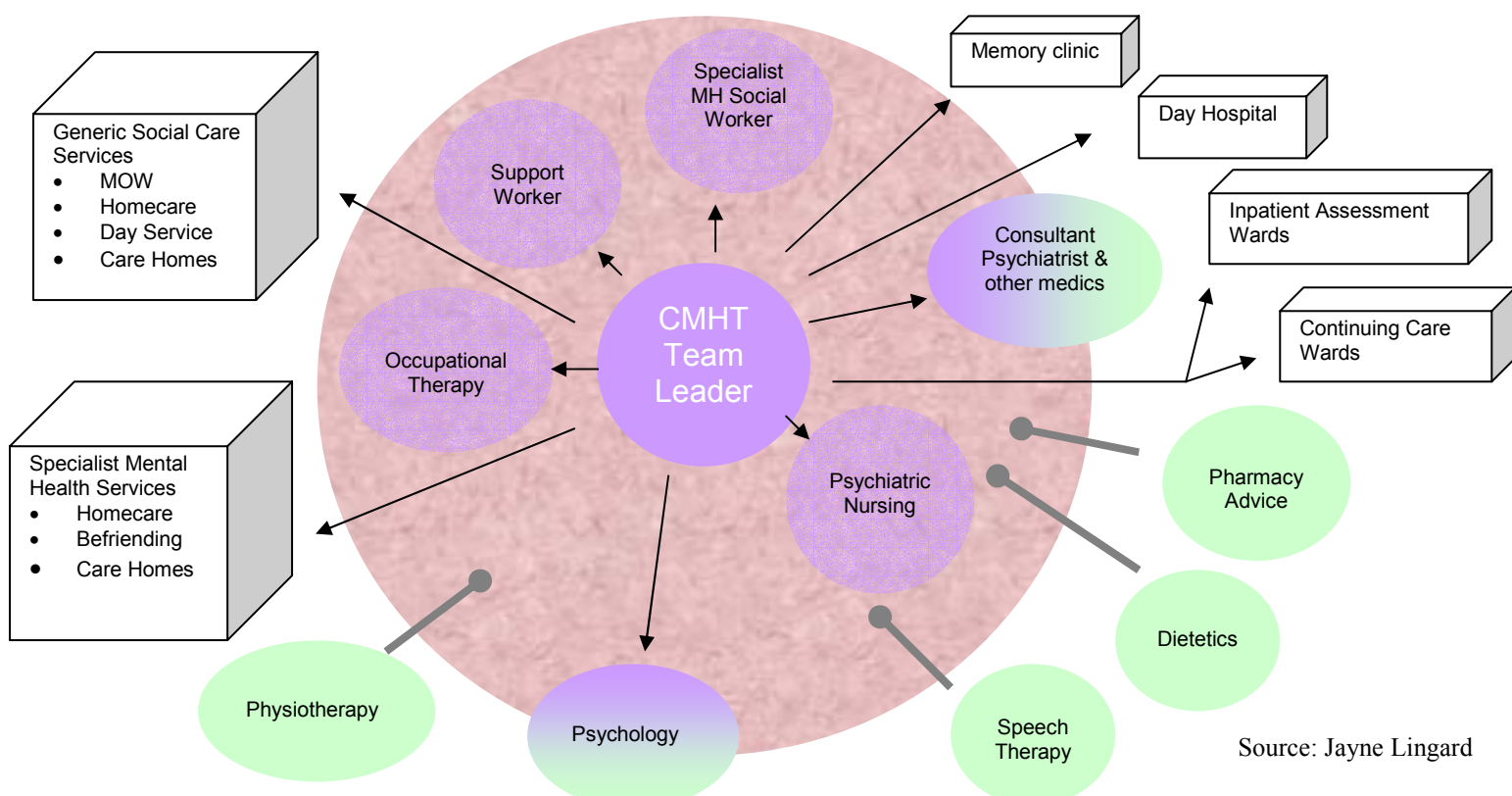
- Waiting list for screening and assessment cleared following short-term appointment of dedicated CPN
- Ongoing screening service implemented – identifying pathways for inappropriate referrals and advice to referrers
- Professional CPN and OT time refocused to ensure higher priority to initial assessment rather than ongoing support
- Revised name for team with linked publicity agreed to reflect focus of work more accurately
- Revisions to operational policy discussed and agreement made on further changes required to policy, which will clarify Social Services contribution to the team
- Mapping to look at access to services and protocols with acute services completed

Source: Effective Interagency Working¹⁰²

5 Purpose and Function of the Integrated CMHT (OP)

1. The NSF for Older People envisages specialist mental health services as treating and supporting older people with more severe levels of mental ill health, predominantly dementia and/or depression; people with complex needs e.g. multiple physical problems alongside a mental illness and those at risk of suicide, where first line treatments have been inadequate and/or where psychotic symptoms such as delusions may be present.
2. For older people with dementia, specialist services will treat those who wander or are at risk of abuse or self harm, have challenging behavioural and/or psychological symptoms, may be suitable for anti-cholinesterase drugs and have complex or multiple needs, e.g. where communication is severely impaired. The specialist team can also manage those with a dementia and depression.
3. Integrated or not, in relative terms the CMHT(OP) is new. The development of such teams can be traced through four key studies:
 - Studies of teams that work directly to support older people with mental health problems in 1997¹⁰³
 - Work on community teams for people with dementia in 1998¹⁰⁴
 - The “Forget me not” audits undertaken by the Audit Commission in England and Wales in 2000 and 2002¹⁰⁵
 - Reviews of mental health services for older people that encompass community mental health teams in 2002¹⁰⁶
4. Figure 2 gives one view of the key roles within and interfaces of the CMHT(OP)

Figure 2: The Integrated CMHT: An interagency multi-disciplinary service



Function of a CMHT for Older People

5. In 1997, the World Health Organisation (WHO) identified that *“the multi-disciplinary specialist service in old age psychiatry can include a range of professionals including psychiatrists, nurses, psychologists, occupational therapists, physiotherapists, social workers and secretarial staff who should meet regularly to co-ordinate and discuss new referrals and current caseload.”*¹⁰⁷
6. WHO further regards the team as needing an ‘identified leader’ and that initial assessments should take place in the patient’s own home and should include family members and where helpful the GP/primary care team. The assessment should result in the formulation of a care plan and follow-up arrangements, which have clear objectives, defined responsibilities for community team members and usually the designation of a key worker.¹⁰⁸ These should include the provision of support, information and advice to carers.
7. CMHT(OP)s aim to improve access and responsiveness to service users and carers as well as ensure care co-ordination, both within and without the team.¹⁰⁹ The following key functions of a CMHT for older people, have been identified:¹¹⁰
 - Acting as the focus for referrals from primary care, secondary services, social services and users and carers
 - Conducting home-based multi-disciplinary specialist assessments
 - Monitoring and reviewing care and care packages
 - Providing on-going care, support and treatment for older people with more complex mental health problems, and their carers
 - Providing outreach support to users of other services with mental health problems e.g. residents in care homes
 - Ensuring access to a range of services for users and carers
 - Providing support, advice and training to staff in agencies which provide care to older people with mental health problems e.g. care homes, voluntary agencies, carers organisations
8. Particular knowledge and skills that an CMHT(OP) can offer include¹¹¹
 - In-depth understanding and expertise of mental illness in later life, its treatment and prognosis
 - A pace of working which is appropriate for this user group
 - A familiarity with specialist services in the area
 - Expertise in working with families and carers, particularly of people with dementia
9. Although there are some differences in these descriptions, it is clear that there is broad agreement that the team’s role is to assess, treat and support older adults with complex and/or long-term mental health problems and their carers in the community.¹¹²

10. The 'Durham' Service Mapping exercise¹¹³ to capture information about older people's mental health services currently gives the following definition of the purpose of a CMHT(OP)

"A Community Mental Health Team for older people is a multidisciplinary team offering specialist assessment, treatment and care specifically to older adults with mental health problems in their own homes and the community. They may provide a whole range of community-based services themselves, or be complemented by one or more teams providing specific functions"

11. Newham CMHT(OP)'s information leaflet for service users and carers found at Appendix 3 gives a good summary of the service's role and function.

Unique contribution of CMHT(OP)s

12. A number of reviews highlight the importance of CHMT(OP)s being underpinned by a set of principles, particularly for working with people with dementia. These include:
 - An approach to dementia as an impairment which can be supported by maximising remaining strengths and abilities, supporting family and social networks, maintaining roles, relationships, responsibilities and interests, living ordinary lives in the community¹¹⁴
 - Recognition of the need for specialist help and services as and when required from knowledgeable and skilled professionals and support staff who have a positive approach to dementia¹¹⁵
13. In their recent review of mental health services for older people Challis et al¹¹⁶ looked at CMHT(OP) support to residential and nursing homes. Although the level of support varies, the majority of teams provide individual treatment to care home residents with complex mental health needs and more general support and advice to care home staff. The Audit Commission noted that this type of support can help to reduce admissions to hospital or transfers to other nursing homes and can help staff to provide a better environment for those in their care.¹¹⁷
14. A standard component of CMHT provision is domiciliary assessments.¹¹⁸ This makes more efficient use of staff resources and better management of caseload.¹¹⁹ Certainly, outreach care has been very recently identified as a key component of 'integration' of health and social care services.¹²⁰ Most older people wish to remain at home for as long as possible as do their carers. There is evidence that intensive support of older people with long-term mental health problems can be effectively achieved building on the work of a CMHT.¹²¹
15. At present, there are an insufficient number of home care workers trained to understand mental health problems amongst older people, specialist day care places, respite care beds available on a flexible basis and support for carers of people with dementia.¹²² The CMHT(OP) has an important part to play in the development and continuing support of such services, part of which will contribute to intermediate care provision.

6 The Structures of the Integrated CMHT (OP)

1. *“Values are a deep-rooted phenomena; they cannot be changed at the drop of a hat, and we know very little about how they form, and how and why they change. Therefore, the values that pervade an organisation would tend to be a stabilising force, keeping the [organisation] doing what it has done in the past, and is doing now. Problems arise if these values do not support the preferred strategy.”¹²³*
2. Chief Executives in the NHS and local authorities need to ensure that the cultures of their organisations recognise and reward behaviour that promotes integration by staff at all levels of the organisation. This is the opposite of what they have historically been expected to do: to protect the interests of the organisation and create a strong single organisational culture - an ethos promoted by business-based management courses. They must be supported by boards and elected members in this shift of organisational culture.

Figure 3: Leadership Qualities Framework



3. The NSF for Older People says *“Strong leadership within all relevant organisations will be essential – every chief officer will need to demonstrate their personal support.”¹²⁴*
4. The NHS Modernisation Leadership Qualities Framework supports this agenda: *“It is imperative that leaders in the health service work collaboratively in order to be effective – and such partnerships must exist with their own staff, with patients and their carers, as well as with other statutory and voluntary agencies. It is a key means of Delivering the Service in a joined up and integrated way, thereby ensuring the best possible health provision within the realities of limited resource.”¹²⁵*

Source: NHS Modernisation Agency

5. The Local Government Association and Association of Directors of Social Service’s joint discussion document on the future of services for older people is clear on the role of senior managers:

“A whole systems workforce plan will be required for older people’s services, to focus on the local community, while linking into regional plans... Modernising the workforce and implementing the changes will require managers to possess high levels of leadership, business and finance skills. Leadership programmes to develop these skills will need to be established.”¹²⁶

6. Issues identified in 1997 by the Social Services Inspectorate¹²⁷ as representative of joint commitment to CMHT activities included
 - Shared management by health and social services
 - Pooled budgets
 - Dedicated resources from both SSD and health authority for CMHT activities
7. The SSI also regarded joint working as greatly helped and encouraged by:
 - Proximity, particularly a shared office/base
 - Monthly meetings
 - Routine training of health and social care professionals on multidisciplinary working
8. Barnes' work in 1997¹²⁸ was advised by a representative stakeholder group in the care and management of older people with mental health problems. They identified the following features of successful joint working between health and social care services
 - It need not necessarily be in a team
 - It is greatly helped by proximity and professionals knowing one another
 - It has developed strongly from joint working over major projects such as the closing of long stay hospitals
 - Liaison with a department of Old Age Psychiatry, e.g. monthly meetings in the care management office
 - Routine training across health and social services teams
 - Access to each other by health and social care professionals
9. In their review of CMHTs for older people, Sheard and Cox¹²⁹ note that teams that work collaboratively share a number of key characteristics. These included having
 - A dedicated team base
 - A team co-ordinator/manager who is skilled at developing joint working methods
 - A commitment to joint working
 - Shared case records
 - Regular team meetings
 - Joint training
 - Being able to refer to health/social services resources regardless of discipline¹³⁰
10. Other facilitating structures Sheard & Cox noted are
 - Devolved budgets
 - Team policies and procedures
 - User/carer involvement in service planning and delivery
 - A clear link for the team into the wider service system
11. In 2000 and 2002, the Audit Commission also noted that joint training proved to be an effective way to promote joint work as well as to develop appropriate skills.¹³¹
12. Sheard and Cox (1998) also identify a number of factors that limit the degree to which teams can achieve collaboration. These include: practitioners working as isolated professionals; separate referral procedures and work priorities; health and social services managers maintaining separate control over health/social care practitioners; and a lack of team objectives. Members working as part-time members of the team with other work responsibilities external to the CMHT is also a barrier.¹³²

13. In “Treated As People: An overview of mental health services from a social care perspective, 2002-04”, the SSI notes:

“The complexity of the organisational environment demands a clear focus for and authoritative leadership of mental health social care services. We have found that better performance and prospects for improvement are associated with:

- *effective joint management and corporate governance of services*
- *unified management of multi-disciplinary teams, within which individual professions feel equally valued*
- *commitment of senior managers to the service development agenda*
- *focused planning and implementation structures, often associated with project management approaches*”¹³³

Organisational Context

14. As recently as 2000 the Audit Commission noted that joint working at the field level is undermined by ‘half hearted’ agency commitment despite its capacity to greatly enhance the quality and effectiveness of services for older people with mental health problems.¹³⁴ Whilst some adaptation to specific area or service related circumstances may be appropriate, the Commission consider that the resources of mainstream agencies need to be brought together in an efficient and coherent way for collaboration to be assured:

*“Agencies need to consider how best to organise specialist teams, and make consistent arrangements that support joint working”*¹³⁵

15. The organisational context for a CMHT(OP) can be determined according to the best fit within existing local arrangements. Department of Health Joint Unit guidance on pooled budgets proposes:

NHS Trusts [can take on] ... 'operational commissioning' in the activities of care managers within the context of care management and assessment. Thus Community Mental Health Team, and other multi-disciplinary teams can be sited in NHS Trusts as well as in local authorities.”¹³⁶

16. A 2004 report on strategic partnering¹³⁷ from the Office of the Deputy Prime Minister makes the following helpful points about creating pooled budgets

“Some organisations are cautious about moving quickly to this new approach, so they are setting up parallel accounts on a transparent basis to develop trust. This helps subsequent rapid change, so that when comfort through this arrangement is achieved the budgets can be physically pooled and run as one.

“However, the current guidance does not make any provision for a trial pooling period and we believe this should be encouraged...In addition, central government, through the regulators, currently asks for all aggregated budgets to be disaggregated at the year-end. This should be replaced by a standard estimate on shares.

“The DH has provided much assistance on the Value Added Tax (VAT) procedures to be adopted when budgets are pooled and a lead provider nominated.”

A Pooled Approach

17. Wiltshire County Council and the Avon and Wiltshire Partnership NHS Trust have worked to integrate their CMHT(OP). Services for older people with risks associated with their mental health have been integrated in shadow form since 2000, and formally since 2001.
18. Pooled care purchasing budgets are managed by the mental health trust, which is the partnership provider. Appendix 4 gives an example of the views of two of the key partners in the process – a social care commissioner and a mental health provider trust operational senior manager.

Bringing together agencies and professions in CMHT(OP)s

19. Table 2 highlights some of the comments made about the challenges of marrying professional and organisational cultures by the 32 respondents to a questionnaire¹³⁸

Table 2

Ambiguity over CMHT role and responsibilities	Concerns over perceived 'take-overs' and feelings of being 'externalised'	Harder to marry cultures the higher up the organisation you get
Defining and understanding of professional roles and responsibilities essential	HR and Operational issues problematic	Improves information exchange
Time intensive	Needs training and support, for example review meetings and reflective practice	Co-location increases joint- working and mutual respect
How change is managed is crucial, should have a 'bottom up approach' ensuring staff feel ownership of the process	Recognising professional differences and acknowledging overlap of skills essential	Reluctance to embrace change

Source: 32 respondents to a questionnaire

20. One respondent to the questionnaire had quite a lot to say about this matter. Gaynor Abbott-Simpson, Assistant Director, Mental Health Services for Older People, South Essex Partnership NHS Trust was appointed as a joint manager under the terms of a formal partnership agreement with Southend Borough Council. She has been involved in the creation of three CMHT(OP)s. Her views can be found at Appendix 5, a case study of the integration of organisations and professions.

Composition of the CMHT(OP)

21. The multi-disciplinary nature of the team means that it is important that both the distinct contribution of each discipline is spelled out, as well as the roles that might be shared. Any team needs to be planned according to the locally agreed service model with set numbers of staff with specified hours.
22. In a 1997 review of people with dementia living at home, the Department of Health found that the ‘most effective care’ was delivered by a CMHT that included health and social work professionals.¹³⁹ In the same year a Social Services Inspectorate report of older people with mental health problems living alone, suggested that:

*“A community mental health team for older people includes a specialist in old age psychiatry who co-works with a community psychiatric nurse, a social worker and occupational therapy colleagues on assessments, is willing to follow up patients at home and provides medical support/advice to local day and residential services”*¹⁴⁰

23. In its 2000 review of mental health services for older people¹⁴¹, the Audit Commission defines a CMHT as a team that includes at least two professions working together and meeting at least once per week to discuss referrals and current cases. It noted that

*“Multi-disciplinary CMHTs are the most commonly used approach to joint working between agencies, although the composition of the teams varies.”*¹⁴²

24. “Losing Time”, which summarised the Audit Commission’s findings from its audits of mental health services for older people in Wales, reported finding at least five different configurations of team working, as shown in Table 3.¹⁴³

Table 3

1. Dedicated health practitioners and specialist social workers, integrated meetings and joint documentation
2. Specialist social workers with variable degrees of integration with health colleagues
3. Generic social workers drawn from adult care teams with variable degrees of integration
4. Health practitioners and social workers from integrated adult community mental health teams
5. Specialist health practitioners from adult mental health team, generic social workers from adult social care teams

Source: Audit Commission

25. In at least one third of the Welsh audit areas, joint working was based on long-standing working relationships between individual practitioners. Whilst positive in the short term these are vulnerable to staff changes and communication failures.¹⁴⁴ Ovretveit¹⁴⁵ notes that relying on informal arrangements between team members can be problematic; more formal structures are needed to embed joint working within daily practice and longer term operations of the team.

CMHT(OP) Team Structures

26. CMHTOPs do not adopt a universal structure or pattern; it is widely acknowledged that there is no 'model' team.¹⁴⁶ Despite the significance of professional views on shaping policy direction, professional groups and Royal Colleges do not speak with one voice about the 'best' model of service delivery for older people with mental health problems.
27. There is agreement however on the principles that should underpin care delivery, the need for strategy development and targeted investment and the importance of adequately funded research into the effective management of dementia and depression. Many of these statements emphasise the importance of teamwork particularly multi-professional teamwork.
28. Arie and Jolley¹⁴⁷ note the challenge of defining the concept of teamwork in old age psychiatry, given the need for working across professional boundaries, overlapping roles and user-led services. Finlay puts it well:
*"... a group of individuals, with varying backgrounds, perspectives, skills and training, who work together towards the common goal of delivering a health or social care service. Ideally team members collaborate and value one another's different contribution."*¹⁴⁸

And in 1997 Barnes found:

*"care being taken to ensure that boundaries between health and social care were not acting to the detriment of service users. However, this often depended on goodwill, and sometimes required a blurring of the definitions of tasks in the interests of flexibility."*¹⁴⁹

29. Further, the fact that teams develop 'organically' taking account of local conditions, population need, geography and resources makes the development of a single model unhelpful. Representation of disciplines within the CMHT varies in each health community and even within health communities due to historic variations in mental health service development and investment patterns. All areas have been subject to the limited availability of specialist professional staff.
30. Both the English and Welsh Forget me not¹⁵⁰ audits found that the number of specialist health and social care practitioners per team and per area varied widely and did not bear any clear relationship to need. In one site, no social work posts were committed to the CMHT. One small project paid for half a social work post to be seconded to a team. In another area, different team configurations were operating, leading to much confusion about care arrangements.¹⁵¹ Some users experienced delays receiving multi-disciplinary assessments, largely attributable to a shortage of suitably qualified practitioners.¹⁵²
31. The management of multi-disciplinary teams is widely noted as requiring careful planning, especially where different agencies are involved. Decisions need to be made about the roles of the different professionals, identifying which tasks can be carried out by all members and which require the unique skills of a particular discipline.¹⁵³

32. The SSI regards preparedness to blur traditional and professional boundaries in the interests of flexibility as a key element of effective care.¹⁵⁴ Other commentators on inter-disciplinary working have observed that it requires particular values, knowledge and skills, including:

“A willingness to adapt, innovate and participate in change; coping well with uncertainty; adopting a problem solving approach; reflecting on practice; effective communication; respect for users, carers and other professionals, and understanding the particular needs of older people with mental health needs from different ethnic backgrounds.”¹⁵⁵

“A preparedness to be flexible, to merge roles and to pool team skills and resources to achieve a care outcome, subscription to a working culture that encourages innovation.”¹⁵⁶

Which disciplines?

33. Such an approach will benefit from clarity about the basis of the individual contribution of each team member. In integrated teams, workers are offered uni-professional supervision and support with personal development to ensure that their unique contribution is not eroded.
34. One respondent to the questionnaire said that in their team: *“Some CPNs will deal with medication issues, Approved Social Workers provide assessment under the MHA, Psychologists and OTs provide particular specialist assessments... All appropriately qualified staff - RMNs CQSWs, ASWs, OTs , Psychologists - act as care co coordinators. The manager position is open to anyone with any of these qualifications.”*
35. Teams need to be clear about the distinction between clinical leadership and organisational management of the team, whether combined in one person or carried out by different people with their responsibilities made clear. The clinical leadership role carries responsibility for ensuring and supporting a robust clinical risk management regime. The organisational management role ensures that there are sound policies, procedures and systems for managing all staffing matters, finances, information systems and crucial housekeeping issues to ensure that service has suitable venues for all activities.¹⁵⁷
36. Fairbairn¹⁵⁸ defines the ‘typical’ CMHT as including a Consultant Old Age Psychiatrist, one or more junior doctors, hospital nursing staff, community psychiatric nurses, occupational therapists, attached social workers and a psychologist. Members of the team meet regularly to discuss cases and co-ordinate their activities. Typically this will take place during case conferences and reviews as well as formal team meetings. Noting that the Old Age Psychiatrist is ‘most often’ leading the team, he further observes:

“On the one hand the particular specialist skills of each clinician needs to be respected but on the other hand recognition needs to be given to the fact that there may be considerable overlap of skills in areas such as assessment and support of carers”¹⁵⁹

37. The Audit Commission report on mental health services for older people in 2000 included a review of CMHT membership¹⁶⁰. It found that this varied considerably. Six of the 12 areas had teams incorporating a consultant psychiatrist who shared cases with colleagues, attended a weekly meeting and made themselves available for consultation. In other sites, consultants regarded themselves as ‘team leaders’, who made managerial decisions about team activities and directed members to contribute to specified elements of the care and treatment of patients. Community psychiatric nurses were employed in all 12 sites, social workers and occupational therapists were team members in six, and Physiotherapists and psychologists in four.
38. Workers associated with a CMHT(OP) might be categorised as
- Core members: Workload is fully in the CMHT, including the team manager
 - Part-time members: Total workload is partly generated by the CMHT and partly in other areas of the care system
 - Associate members: Work closely with the CMHT but whose workload is generated from a variety of sources

The Team Leader/Manager

39. The team leader/manager has an important role in coordinating the work of team members and ensuring the necessary systems and communications are in place. The role can be performed by a worker with leadership skills, experience of working in mental health services for older people and a good understanding of the roles and responsibilities of all staff. Questionnaire respondents¹⁶¹ were asked whether the team manager role was open to any profession. In 17 of the 22 areas that had some degree of integrated provision the role was open to any discipline. In the other five, it was only open to nurses.
40. Providing ongoing support to the team leader/manager is also identified as crucial, particularly in ensuring that the team is enabled to ‘stick to its brief’. As the service system, strategic and policy objectives, personnel and user and carer influences are subject to constant change,¹⁶² it is easy for teams with cross-agency and multi-professional roles to lose their original brief and/or to be forced to deviate from the essential role they were set up to perform.
41. Staff working within the team are governed by different professional codes and may have different contractual obligations and/or statutory duties. In addition to a range of core team skills that any member would offer, they also have unique professional contributions to make. It is also important to establish both line management and professional support systems for team members; these may be located in different agencies particularly for social workers.¹⁶³
42. Nearly all respondents to the questionnaire¹⁶⁴ in areas where there was some integration said that professional staff were offered clinical supervision by someone of their own professional background. One area said they had a system of both multi-professional reflective practice and single-discipline reflective practice. Another area spoke of peer group supervision

The Social Worker / Care Manager

43. The social worker working in a CMHT(OP) brings a social care perspective to the care, treatment and management of the older person and their carers.¹⁶⁵
44. Under the NHS and Community Care Act 1990¹⁶⁶, social workers or care managers have a statutory duty to assess the needs of ‘any person in need’ of care or support and their carers. Under the Carers Recognition and Services Act¹⁶⁷ and the Carers and Disabled Children’s Act 2001¹⁶⁸ it is their specific responsibility to assess the needs of carers.
45. Use of the Health Act flexibilities can broaden out these duties in order for them to be shared by the whole team, avoiding the need for duplication of caseloads, breach of the therapeutic relationship and the increased intrusion on the life of the service user.

Approved Social Workers: Core Team Members or External Partners?

46. A social worker who is ‘approved’ under the Mental Health Act (1983)¹⁶⁹ is called an Approved Social Worker (ASW). This Act gives social workers a central function¹⁷⁰ in the care and protection of mentally disordered people.¹⁷¹ An ASW has a duty to assess the needs of any person considered to require compulsory detention in psychiatric hospital for assessment and/or treatment under one of three ‘Sections’ (Section 2, 3 or 4) of the Mental Health Act¹⁷². The ASW may also apply for a Guardianship Order under Section 7 of the MHA; this applies to people who may not require admission to hospital yet still need a measure of compulsion to ensure their safety and general welfare.¹⁷³
47. The status and relationship of the ASW in CMHT(OP)s needs to be carefully considered. In order to fulfil the spirit of the current ASW role, the social worker needs to have some degree of independence. However, the impact on the quality of the service to the older person by the Approved Social Worker sitting outside of an integrated team needs to be considered.
48. The first implication of the ASW role for team integration is the scarcity of ASWs. In order to provide sufficient cover, local authorities usually need ASWs to participate in a non-specialist ASW rota. Requests for assessment and follow-up takes them away from their base team, potentially causing imbalance in a well-managed team approach.
49. The second is that the local authority duty to appoint approved social workers⁵ was created at a time when social workers fulfilling statutory duties generally only worked as employees of local authorities. With the advent of Partnership Trusts and Care Trusts and the integration agenda, social workers may become the employee of an NHS organisation. Interpreting the ‘duty to appoint’ as meaning social workers cannot be employed by the integrated service provider has the potential to undermine the integrated nature of the CMHT(OP).

⁵ Section 114. - (1) A local social services authority shall appoint a sufficient number of approved social workers for the purpose of discharging the functions conferred on them by this Act (Mental Health Act 1983)

50. Does the ASW remain the employee of the local authority? Or are they seconded to the Trust, remaining a local authority employee but managed by the Trust? Or do both employment and management transfer to the Trust, thus bringing the ASW fully within the CMHT(OP)?
51. The disadvantages of ASWs standing outside the team are
 - ASWs might be on different terms and conditions from social workers in the team, and more so now ‘Agenda for Change’⁶ is coming into force
 - A social worker employed by a Trust cannot subsequently become an ASW without changing employer, and terms and conditions
 - If ASWs are also team managers at the time of integration, they have to choose between becoming an integrated team manager or remaining an ASW
 - Trust planning processes would not take into account the need to create additional ASW posts, so the planning of social care becomes disjointed
52. One respondent to the questionnaire,¹⁷⁴ Surrey Oaklands, were concerned about the need to have ASW expertise and knowledge at the centre of the CMHT(OP). When they audited all mental health act assessments within the Trust, it was found that 25% were of older people over the age of 65. *“We need to be sure that follow-up care for older people complies with the Section 117 duties of aftercare, and the role of an ASW in that is valuable.”*
53. One Trust employs social workers that are then ‘placed at the disposal’ of the local authority for Mental Health Act Assessments.¹⁷⁵
54. Legal advice may be helpful in resolving some of these issues, although they stand to be clarified by the publication of the new Mental Health Act in the current draft of the bill, references are made not to the “approved social worker” but social worker/mental health professional.

The Community Psychiatric Nurse

55. The community psychiatric nurse brings experience from working on inpatient wards with older people in both an assessment and continuing care environment. In this setting, useful skills will have been acquired for planning and implementing care in a person’s own home or in a care home.
56. They will have developed skills of communicating with people who are experiencing mental health problems knowledge about medication regimes and the ability to plan and deliver care for people whose behaviour has been severely compromised by their mental illness.
57. The developing role of the nurse in prescribing¹⁷⁶ and therefore medication review has great potential to strengthen the team’s ability to treat and support people in the community.

⁶ Agenda for Change is a new system of job evaluation and grading that will grade all jobs within a service in relation to each other. It is an NHS initiative. See http://www.modern.nhs.uk/scripts/default.asp?site_id=48

58. An interesting exploration of the issues arising for nurses from the integration agenda, can be found on the Mental Health Nursing Association web-pages at <http://www.amicus-mhna.org/guideintegratedtrusts.htm>
59. *“MHNA views the closer working partnerships between health and social care workers and organisations to be encouraged, with the better understanding of each other's roles and the consequent improvement in service and care to service users and their carers and families.”*
60. Although the association's fundamental position is as above, the piece looks at the reasonableness or otherwise of expectations that nurses take on what were previously roles performed by social care staff.

The Occupational Therapist

61. An occupational therapist can promote a team focus on rehabilitation for the older person with mental health problems: enabling individuals to retaining or recover skills that an older person will need to live as independently as possible.
62. In *“Interface to Integration”*,¹⁷⁷ a consultation document on the modernisation of Occupational Therapy Services in local health and social care communities, the College of Occupation Therapists reports an increasing demand for occupational therapists *“and the Government's recently announced commitment to achieving a significant growth in the numbers of student education and training places in England between now and 2004... [is a] recognition of the contribution occupational therapists can make ... to develop services that promote independence, particularly for older people...one of the core objectives of occupational therapy...”*
63. The document goes on to state that

“Occupational therapists welcome the move to integration. It is a concept that fits with the profession's holistic philosophy and practitioners see the opportunity to offer something better to their service users. The profession now has the opportunity to step beyond the historical interface issue and modernise its contribution to health and social care services.”
64. According to the college website in April 2004, a consultancy report was shortly due to report on ways forward for the profession.

The Psychiatrist

65. The relationship of the psychiatrist to the CMHT(OP) varies: some psychiatrists regard the team as a support service to draw from whilst others regard themselves as core members of the team. In their website glossary definition of the CMHT, The Royal College of Psychiatry website lists psychiatrists amongst the membership:

*“CMHT members include community psychiatric nurses (CPNs), social workers, psychologists, occupational therapists, psychiatrists and support workers. Team members are often based in the same mental health centre.”*¹⁷⁸

66. In 1998, the Royal College of Psychiatrists¹⁷⁹ and the Royal College of Physicians specified a mix of staff for an CMHT(OP) serving a population of 37,500 people aged 65 and over as shown in Table 4

Table 4

Medical Team: 4 Consultants	8 Community Mental Health Nurses	Clinical Psychologists
1 Specialist registrar (if able to offer training)	4 Social Workers	Occupational Therapists
4 Trainee Doctors for careers in psychiatry, medicine, GP or other speciality	Secretary for each consultant plus administrative and information staff	Physiotherapists Dietician
Chiropodists	Speech therapists	Pharmacist

Source: Royal College of Psychiatrists

67. Some GPs are said to prefer the convention of referring directly to a consultant psychiatrist. Some teams find that investing in liaison time with GP practices by other members of the CMHT(OP) can lead to the level of trust and respect needed to encourage team-based referrals. Others respond on a case-by-case basis:

“In rare situations where for example the patient is known and has a diagnosis we may double check with the GP that they will only accept a consultant home visit. It may also be that the consultant at this point will take a member of the CMHT and do a joint home visit. Our overriding principles are putting the patient first, maximising resources and delivering care in a timely manner.”¹⁸⁰

68. One belief is that all referrals should be assessed by medical staff; the counter argument is that all members of the multi-disciplinary team can conduct an initial assessment resulting in quicker, more flexible and cost-effective services, better use of available skills and improved staff morale.¹⁸¹ Further, it is not associated with any significant misdiagnosis of psychiatric disorder¹⁸² although it may result in under-use or inappropriate use of psychiatric interventions.¹⁸³
69. A recent review of older people’s mental health services suggests that the majority of CMHT members perform relatively few multi-disciplinary initial assessments – with psychiatrists doing the majority - although there is evidence that ongoing assessments and review work is more widely shared.¹⁸⁴
70. Another difference between psychiatry staff and other members of the team is that in previous terms and conditions, consultants charged an additional fee if the GP requested a home visit. Sometimes a fee might be claimed if a person needed a home visit but one was not requested. The budget for the visits was held by the Trust employing the psychiatrist and was not recharged to the PCT transparently.
71. With the new consultant contract, some NHS Trusts assume that such visits are within contracted hours so no fees are paid. Others have incorporated a fee level into base salaries or invite consultants to claim for home visits up to a certain number per quarter.

The Support Worker

72. Support worker posts may have originated as either healthcare/nursing assistant posts within the NHS or senior care assistants within the Local Authority. They therefore can be subject to different salaries, hours and travel expenses.
73. In the implementation of the NSF for the mental health needs of working age adults, a post called “support, time and recovery workers was created by the Workforce Action Team.¹⁸⁵ They proposed the following common understanding for use in mental health services:

“STR workers are people who come from different walks of life with different backgrounds including volunteers and existing and former service users who have the ability to listen to people without judging them... STR workers are able to help service users to have an ordinary life assisting them with their everyday, practical needs in whatever setting they find themselves to facilitate recovery.

“When the workforce action team were looking at those not currently working in a role affiliated to an existing professional group, it became clear that there was little or no consistency in expectations of these workers; they were not always fully integrated into the team to deliver care by way of a holistic team approach; and their training and supervision, if any, was patchy; their status was low; and they were often not highly valued.”

74. According to the service-mapping database,¹⁸⁶ 204 STR workers have been introduced into community mental health services for adults of working age services across England.

Care Brokers

75. Some CMHT(OP)s have developed a role which can be called Care Brokers or Care Administrators. In addition to taking care of much of the paperwork involved in setting up care packages, these staff are well-trained and experienced in negotiating the financial aspects of care provision from local providers. The aim is to reduce the time spent by mental health professionals in the non-specialist practical arrangements of care packages, without requiring the service user to interface with another professional.¹⁸⁷

New Roles, New Ways of Working

John Reid summed up the nature of the need for change in a report on NHS Workforce Statistics in 2003¹⁸⁸

“It is not just about [staff] numbers, it is also about what people do. I want to commend the widespread development of new roles and new ways of working across the NHS, the diversity and flexibility of our staff and the move away from professional demarcations to team working based on patient needs.”

7 The Processes of the Integrated CMHT (OP)

1. A key component of the delivery of high quality care is integrated multi-disciplinary assessment and care management.¹⁸⁹ Most CMHT(OP) users have complex, multi-faceted needs and require support from both health and social care services.¹⁹⁰

Integrated Care Management and the Care Programme Approach

2. Both care management and the Care Programme Approach (CPA) for people with mental health problems were designed to provide more co-ordinated care to vulnerable adults.¹⁹¹ Although not primarily associated with older people, the CPA is of relevance since the criteria for inclusion within it include a history of self-neglect, which is often a feature of older people with severe mental health problems.¹⁹²
3. Two recent reviews of services for older people with dementia observe that implementation of CPA for this population was ‘patchy’.¹⁹³ Limited investment and a lack of clarity about the link between CPA and care management were noted as difficulties as were differences between local authority and health trust boundaries.
4. These findings are echoed in a very recent study of CPA/CM arrangements for older people with mental health problems.¹⁹⁴ This found that the application of CPA is not uniform and that where it is applied there is often a duplication of approach with care management. This undermines team working and contributes to separation of activity. Overall, the study concludes that there is considerable scope for the greater integration of care management and CPA for older people with mental health problems and

“there is little evidence to suggest that care systems to facilitate integrated CMHT working are well developed.”¹⁹⁵

CPA and Older People

5. Recent policy guidance¹⁹⁶ addresses the integration of the Care Programme Approach with care management for adults of working age in contact with secondary mental health services and stresses that the same principles are relevant to the care of older people with mental health problems:
 - Assessing the range of needs
 - Treatment and care at home -including providing talking therapy where there is another care manager
 - Supporting carers of people with significant risks
 - Inpatient care -planning for admission, expediting discharge
6. Only half of the respondents to a questionnaire¹⁹⁷ who had integrated teams reported that older people were routinely included in the CPA.

Integrated Assessment and the Single Assessment Process

7. The key operational responsibility for CMHT(OP)s is that they...

“Ensure that where it is appropriate for older people to move from CPA to SAP (or vice versa), such transitions are effectively managed with minimum or no disruption to the services that are provided.”

8. Guidance on the Single Assessment Process¹⁹⁸ clarifies the relationship between CPA and SAP

- *“The Care Programme Approach (CPA) should be applied to older people with severe mental illness due to schizophrenia or other psychoses. The assessment of their needs should be based on the Single Assessment Process (SAP) for older people*
- *SAP, plus critical aspects of CPA, should be applied to other older people with severe functional or organic mental health problems, who were they younger would be provided for under CPA*
- *When individuals subject to CPA reach old age, switches to SAP are not inevitable, and should only be made in the best interests of individuals and the continuity of their care”*

9. The guidance goes on to say

“For older people with severe mental illness, such as schizophrenia, localities should apply CPA. When doing so, the assessment of care needs should be based on the four types of assessment set out in SAP...”

Apart from cases [as] above, both the assessment and care management aspects of SAP should be applied to all other older people with mental health problems including depression and dementia. If, because of their needs, such older people would have been placed under CPA had they been younger, localities should consider applying critical aspects of CPA to their care...”

10. Full guidance on the relationship between CPA and SAP can be found at

<http://www.dh.gov.uk/assetRoot/04/07/32/80/04073280.pdf>

11. One respondent to the questionnaire gave the following explanation of how assessment tools for SAP and CPA are being developed in their locality:

“We are currently involved in the local steering group for SAP in developing local processes. The tool chosen locally for the Contact and Overview assessments is FACE.¹⁹⁹ The domains of the FACE documentation provide the same framework as in CPA, therefore the Mental Health Team input will provide a Comprehensive model of assessment rather than an Overview.”²⁰⁰

Integrated Assessment

12. Integrated multi-disciplinary assessment is a key element of integrated care management. The University of Bath is working with a partnership trust to looking at how to improve on inter-professional integrated working. The research will include CMHT(OP)s and a report will be delivered to the trust at the end of 2004 and a paper submitted for publication early in 2005. See Appendix 6 for full details of the research.

13. The “Forget me not” report noted that joint assessments can result in a better, shared understanding of the user’s needs and situation. They can...

“avoid the user having to provide the same information several time,s and help them to feel that their care is consistent and co-ordinated.”²⁰¹

14. The Audit Commission advises that CMHTs should have clear protocols for assessment and that users with complex needs should receive “

“at least one multi-disciplinary assessment at an early stage after referral to the service and joint reviews at intervals afterwards.”²⁰²

15. The Audit Commission found that commitment to multi-disciplinary assessment varied considerably across teams and areas from almost none to almost all.²⁰³ In only four of the twelve sites reviewed, over half of service users whose files were examined had received at least one multi-disciplinary assessment.
16. Joint Trusts appeared to ‘do better’ in terms of conducting joint assessments and those authorities who had procedures in place to integrate CPA and care management arrangements were more likely to conduct shared assessments and keep joint records.²⁰⁴
17. In order to integrate provision of health and social care assessment, Section 31²⁰⁵ partnership agreements can be used to facilitate delegation of the duty of assessment for services that resides with both health and local authorities.

Managing Risk

18. Accurate and balanced risk management for older people with mental health problems and their families is at the heart of the assessment role of the CMHT.²⁰⁶ Safety and security need to be balanced against the needs for autonomy, opportunity and choice.
19. There may be different approaches as well as different registration and policy guidance between health and social care agencies. Effective integrated working requires risk management policy that is acceptable to all. CMHT(OP)s need to provide members with a framework for sharing risk management and a decision-making process. The leadership of this need to be clearly accepted either by a senior nominated clinician or the team manager.

20. 80% of respondents to the questionnaire²⁰⁷ who had integrated teams said they had risk management protocols in place. One respondent described their local practice:

“A risk screen is an essential part of the initial assessment process. If areas of concern are highlighted at that point a more in-depth assessment is required – which may involve the input of other professionals within the team.

Issues of intervention against the patients wishes would be discussed with Consultant Psychiatrist, ASW (within the Team) and Team Leaders or Service Manager.”

21. Another respondent gave this description of local practice:

“We have an OPMH specific brief risk screen and full risk assessment depending on the client’s needs. Team members can discuss or raise concerns in their weekly multi-disciplinary meeting with the CMHT manager, professional supervisor or the client’s consultant. This will depend on urgency and nature of risks identified. Dependent on their capacity to consent, risks may be discussed with their carers as well.”

Access to Health and Social Care Services

22. Working across traditional health and social care boundaries, having the capacity to access services promptly and flexibly and the use of pooled budgets have consistently been associated with better care for older people with mental health problems.²⁰⁸
23. The “Forget me not” audits found a mixed picture with some teams having significantly greater levels of flexibility and capacity to act ‘jointly’ than others.²⁰⁹ In one study site, any member of the team was able to arrange for home care, day care, residential or nursing home care, which meant that services could be put in place quickly. The Commission concluded that

“Community based professionals need to have ready access to a range of flexible services including the practical and therapeutic resources of both [health and social services] agencies in order to help users and carers appropriately.”²¹⁰

24. Barriers to flexible access were also identified. In one site, the social worker attended all CMHT meetings but could not take referrals directly from community psychiatric nurses. Day care could be agreed but care home placements had to be agreed with a Social Services team manager.²¹¹ The report of the Welsh audits noted similar findings even in sites where team members shared an office base (Audit Commission in Wales, 2002).
25. The Audit Commission recommends a single point for all referrals into the team to ensure a co-ordinated and prompt multi-disciplinary response.²¹²

Designing Effective Care Management Systems

26. Evidence from research studies and audit reviews suggests that the development of effective care management depends on the following elements being in place:
 - An assessment and care management procedure which is agreed and ‘signed up’ to by all team members
 - Breaking down territorial boundaries between health and social services agencies and between health and social care professionals
 - Devolution of decision-making to CMHTs, including devolved budgets
 - Conducting joint multi-disciplinary assessments and maintaining shared records
 - A single point of entry for referrals

Joint Recording Systems and IT Systems supporting both CPA and SAP

27. Advances in information and computer technology offer the potential to improve information exchange and to help managers review and monitor performance. The Audit Commission could find nowhere in Wales with IT systems fully compatible between health and social services. Management information predominantly consisted of aggregating ‘input’ measures such as attendances at clinics and visits made by practitioners, rather than addressing outcomes such as user well-being or carer satisfaction/reduction of stress.
28. The use of single multi-agency case files can also improve the management and co-ordination of care. Despite this, the Welsh “Forget me not” audit found that few teams used integrated documentation and under one half recorded information in a standard shared format.²¹³

Charging for Care

29. Despite their observation that inter-agency working results in shared commitment to CMHT goals, the Social Services Inspectorate noted that: “... *good collaborative arrangements between SSD and NHS staff ... were sometimes placed at risk because of external pressures to define boundaries more clearly and to determine the costs of health and social care*”.²¹⁴ The advent of pooled care purchasing budgets may relieve this pressure.
30. Despite pooled budgets and service provision, it remains necessary to charge for some social care services. At present, whilst professional support by CMHT(OP) members and all health care is not charged for, most services provided by, or via, social services such as homecare or respite care are charged for. Councils have had the power to charge for social services since the introduction of the 1948 National Assistance Act, which recognised the principle that, while health services should be delivered free, charges for social services were acceptable. In particular, it laid out a national framework for charging for residential care.⁷

⁷ The framework for charging for non-residential care grew in a more ad hoc way, until the position was consolidated in 1983 with the Health and Social Services and Social Security Adjudications (HASSASSA)

31. Local authorities can now delegate specified charging functions for care services to NHS trusts where they are delivering services under partnership agreements. Councils need to ensure that NHS-based staff employed on charging duties are fully trained and able to advise in all aspects of charging, including assessment of a person's ability to pay charges, their entitlement to state benefits and when and how to exercise discretion and that each team employs staff with appropriate financial expertise.
32. *“The NHS Bodies and Local Authorities Partnership Arrangements (Amendment) (England) Regulations 2003 [S.I.2003/629] came into force 1st April 2003. The regulations permit councils with social services responsibilities (hereafter referred to as “councils”) to delegate to NHS bodies specified charging functions for care services, where those services are delivered by the NHS bodies under partnership agreements. Any arrangements to delegate charging functions will be made on a purely voluntary basis between partners.”*²¹⁵
33. The guidance stresses that
- “It is of the utmost importance that service users understand which services are provided free of charge by the NHS. Actions to help reinforce this message such as each partner's logo appearing on official correspondence will help with this perception.”*
34. Full guidance on the delegation of charging functions by local authorities to NHS partners under joint arrangements can be found at
- http://www.integratedcarenetwork.gov.uk/downloads/guidance_on_charging.doc
35. However, the importance of being clear what elements of assessed need are healthcare needs and which social care is not diminished. Charging for social care services whilst delivering health services free at the point of delivery requires that this distinction be maintained.

Continuing Care

36. An important responsibility of local commissioners is the application of an effective continuing care policy to support the CMHT(OP) in arranging for the care of their service users. Although the continuing care criteria are established at Strategic Health Authority (SHA) level, each SHA was charged with taking...

“such steps as it considers reasonable to obtain the agreement to the proposed criteria of each Primary Care Trust situated in the Authority's area and each local authority.....within the Authority's area”

Act, which sets out the framework within which councils can exercise discretion. Councils' legal powers to charge for non-residential services come from Section 17 of the 1983 HASSASSA Act

37. One SHA that has recently agreed its policy is Avon Gloucestershire and Wiltshire. Box 6 gives the details of how this was achieved and why it is relevant to the subject of CMHT(OP)s.

Box 6

Continuing Care Policies: Removing barriers to integrated care planning

The Avon Gloucestershire and Wiltshire Strategic Health Authority (SHA) completed a revision of its policy, obtaining the agreement of twelve PCTs and seven local authorities.

Fundamental to the agreed process for the review was an agreement between the respective legal advisers that informed the small review group, which had representatives from PCTs, local authorities and the SHA. The revised policy and implementation guidance was issued on April 1st 2004.

So why are continuing care criteria needed for pooled care purchasing budgets?

Stephen Thorpe, Head of Partnerships, Avon Gloucestershire and Wiltshire Strategic Health Authority explained:

“If health and social care communities are interested in developing pooled budgets it is important that there is agreement between them regarding the NHS CHC policy. Agreement removes a potential source of inter-agency dispute as to new funding responsibilities. The community is able to focus firstly on ensuring comprehensive assessment to ensure the service user’s needs are best met and then how a joint or pooled budget can be utilised to achieve maximum commissioning effectiveness for those organisations.

Expenditure on continuing health care, as a proportion of funds used by health and social care to purchase care services, is surprisingly small compared to the profile it has sometimes been given by PCTs and local authorities. Agreement on continuing health care policy is only a starting point and a great deal depends on the nature of the pooling agreement, the budget’s construction and auditing requirements.”

Avon, Gloucestershire and Wiltshire Strategic Health Authority’s policy can be found at the following website give below. It includes:

- useful case studies showing who is entitled to health care by exploring different situations based on their experience over the last few years;
- an operational principles guide which gives more details about eligibility for social and health care for types of conditions and client groups;
- training material which backs up and reinforces understanding;
- common screening and assessment tools to help staff to apply the conditions fairly, and help patients and their families to contribute to the outcomes; and
- evaluations and reviews to tell how things are working in practice.

<http://www.agwsha.nhs.uk/agw/agw19.html>

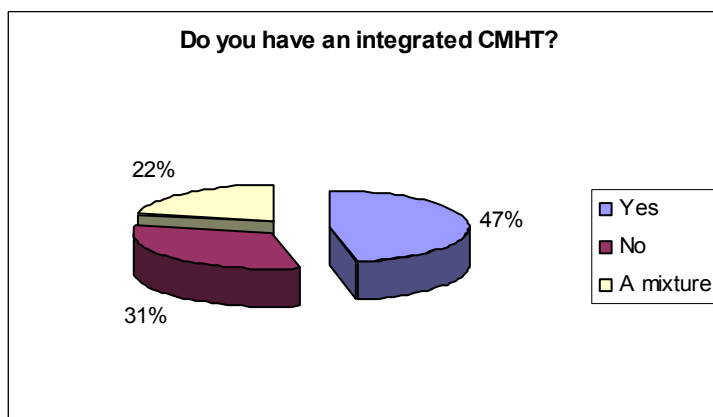
8 The Integrated CMHT (OP)

Integration of two agencies

1. The team developing the NSF for Older People review on behalf of CHI, SSI and the Audit Commission conducted five stakeholder conferences held in London, Leeds and Bristol during June and July 2003. The summary of views²¹⁶ expressed in the Standard Seven workshop at each of these included the view that:

“Joint appointments between health and social care have made a real difference to effectively delivering services”²¹⁷

Graphic 2



2. 15 of the 32 respondents to the questionnaire²¹⁸ about current services for older people with mental health problems said they had integrated CMHT(OP)s. Seven said they had a mixture of integrated and non-integrated working and ten had no integration (see Graphic 2).

3. However, all respondents were all keen on the idea of integration. Table 5 shows the potential benefits they identified as flowing from the integrated CMHT(OP):

Table 5

Positive Aspects of Integration, ranked by the number of times mentioned	
Community-Based Care	Enhances the opportunity to maintain people at home for as long as possible and minimizes hospital admissions
One-Stop Shop	Provision of specialist and comprehensive assessment, intervention and care for users and carers at a “one-stop shop”
Networking	Advantages of a multi-disciplinary team, including sharing of skills, resources and knowledge and opportunity for networking
Inter-Agency Working	Establishes good links within disciplines and with other organisations / sectors
Speed of Service	Ensures a quick response for users/carers
Value-for-Money	Financially beneficial as increases economies of scale and is more cost-effective compared to wards
Co-ordinated Care	Ensures continuity of care between the home and hospital
Efficient	Reduces duplication through joint assessment, documentation and identification of health needs
Normalising	Provides a less institutionalised form of care thereby reducing the associated stigma and prejudices
Galvanising	Leads to a shared vision of the future direction of mental health services for older people

Source: 32 responses to a questionnaire

4. One area said that they were just developing an integrated CMHT(OP) and that the process of development itself was improving matters:

“We are currently in the process of integration, which we are looking to achieve by October 2004. Staff are currently meeting on a monthly basis to discuss issues of concern and how the service can be developed to ensure best service delivery. This is already having an impact of improving service efficiency. A joint training programme is also in place.”

5. Mental Health Services for adults of working age are further along the path to integrated CMHTs. The SSI reports the following concerns about the operation of integrated adults of working age services in a report looking across 2002-2004:

“The main areas of [anticipated] risk to plans identified in spring 2003... included:

- *various aspects of partnership working (including management capacity to handle the complexities of the shared change agenda)*
- *consolidation and maintenance of integrated management structures and strength of commitment to partnership achieving consensus and equity of service access across a number of PCTs; and*
- *lack of integrated or compatible IT systems, including the capacity to deliver effective management information.²¹⁹”*

6. Several of the 32 respondents²²⁰ reported the view that the low priority of older people’s mental health was leading to lack of resources, training, time and development. A lack of commitment at senior level was a common issue said to be standing in the way of integration.
7. No relationship was found between the level of integration and the numbers of organisations involved. The most frequently cited issues standing in the way of integration were
 - No compatibility between all systems of SAP and CPA
 - Terms and conditions of employment
 - Budget management
 - Electronic and paper information keeping
8. Only seven of the 22 respondents where there was some degree of integration had used Health Act flexibilities to create their interagency working arrangements.
9. Both health and social care professionals were commissioning social care services in only eight of the teams.

Integration consolidated by Health Act flexibilities

10. The integrated CMHT in the Royal Borough of Kingston, set up nine years ago, was highlighted as an example of good practice by Sheard and Cox in 1998.²²¹ There is now a section 31 partnership agreement between the local authority and the mental health trust for the management of mental health services. There is a joint strategy for older people between the acute trust, primary care trust, local authority and the mental health trust. The borough is home to 20,000 older people and is served by 30 GP practices.
11. The line manager of the team's core staff is Rita Seewooruttun, a qualified occupational therapist. Rita is a keen exponent of the integrated team. In Box 7 she explains the nature of the local integrated CMHT.
12. Rita's description of the team includes many of the features reported by those respondents to the questionnaire²²² where there was an integrated CMHT(OP) and as such is a useful exemplar of the nature of such a service.

Box 7

The Integrated CMHT in the Royal Borough of Kingston

"We are developing dementia and depression protocols in a group with representatives of the trust, local authority, primary care services and the primary care trust. In relation to the CMHT, there is a joint health and social services statement of intent explaining the responsibilities of both organisations and a service specification detailing the team.

"The team is made up of 5.5 CPNs, 2.0 Admiral Nurses, 4.6 social workers (including an ASW) with 1.2 support workers, a part-time occupational therapist and psychologist. The CPNs, social workers, mental health workers and Admiral Nurses share office space and are supported by 2.0 administrative staff. Two consultant psychiatrists work as clinical team leaders but not as integrated core team members.

"We have not found having different professional cultures within the team to be a problem: recognising professional differences whilst acknowledging the overlap of skills is essential. Roles in the team are prescribed according to discipline, but with flexibility, dependant on what is being asked for and the details on the referral or initial assessment.

"The core functions of the team are

- *Assessment, identification of the individuals health and social care needs*
- *Implementation of the combined health and social care plan to meet those identified needs*
- *Commissioning of services required, both in terms of health and social care*
- *Implementation of the plan, monitoring*
- *Reviewing the health and social care plan.*

“Along with my full-time deputy, I am the line manager of the staff, both health and social services. The employment contracts of the social worker, team manager, deputy team manager, administrative staff and 0.6 of the mental health support worker employment contracts are with the local authority. These staff are seconded to the trust for day- to-day management. All other staff have a contract with the trust. We all have access to training from both health and social services. Although I line-manage all staff in the team, arrangements for uni-professional supervision are separate.

“There is one ‘way in’ to all of the workers – one referral point, one database of referrals and one decision-making process for referrals being accepted. Core team members share the duty rota. There is a weekly allocation meeting at which all referrals are discussed.

“Referrals are from virtually anybody, but have to have the GP’s involvement and agreement. Service users or carers tend to self refer where they have used our service previously. All referrals go to the duty officer of the day and are seen the same day or the next day unless the user/carer wishes to have a different appointment date.

“We have a combined CPA/Care Management policy which brings together the procedures of both the trust and the local authority: a care co-ordinator is the same as a care manager. Care-coordinators and key staff involved in the care of the user do risk assessments. Concerns can be discussed either with the team manager, colleagues, and clinical team leader or at the team meeting with other team members present. If it is a difficult case the team manager can chair a risk assessment meeting.

“All professional core team staff conduct financial assessments and commission social care services directly from the provider. High-cost packages may have to go to panel. If service users need inpatient care, care coordinators discuss with consultants and liaise with the inpatient units and their family and arrange the admission to the ward.

“We use documentation from both organisations. There is no need for referral from health to social care staff and no repetition of the assessment process in order to commission services to meet assessed needs. We have jointly agreed assessment documentation. Our files have the same layout as those in the generic older people’s teams, which is helpful when receiving files or transferring to those services on discharge.

“The team is subject to audit and inspection by both health and social services. There are tensions especially if the objectives of both organisations are not recognised as being met. Issues around changes and systems can lead to tensions if not discussed between all parties to ensure that there are no negative effects of the proposed changes.

“We need to develop better systems for producing the performance indicators required by both the trust and the local authority: they each have their own data requirements. We need to ‘marry’ the separate electronic systems in order not to increase the administrative time of clinical staff. There is one combined paper file for each service user within the CMHT but we have not yet moved to establishing a one file per user across all our services...”

Rita Seewooruttun would be pleased to discuss integrated assessment and care management for older people with mental health needs, and the associated organisational issues. She can be contacted at rita.seewooruttun@rbk.kingston.gov.uk

13. Tony McDonald Borough Manager, Croydon Integrated Mental Health of Older Adults Services responded to the questionnaire.²²³ He is very clear about their local learning from integration so far. Box 8 shows an analysis of their local experience.

Box 8

Learning from Croydon Integrated Mental Health of Older Adults Services

“Our experience through the integration has enabled us to begin to:

- *Offer a continuity and continuum of care to clients and carers*
- *Reduce duplication and be more seamless for clients and carers*
- *Improve communication and understanding*
- *Breakdown professional boundaries and silos*
- *Work with others more closely, i.e. primary care, voluntary sector and community*

“Crucial to being able to do this and making it work are:

- *All team members being co-located together*
- *A single management and reporting structure*
- *Clear professional supervision structure*
- *Commitment and buy-in from senior management and commissioners*
- *Clear communication and consultation*
- *Motivation and commitment of front-line staff and managers*
- *Good relationships locally*
- *Involvement of users, carers, voluntary and community organisations*

“What would help us to develop this further is:

- *An integrated performance management framework*
- *Pooled budgets*
- *Specific key performance indicators/targets*
- *Ringfenced grants/development/growth funding from the centre*
- *Joint commissioning with a single lead commissioner*
- *Clarity on health commissioning i.e. either mental health or older people”*

Tony would be please to speak to anyone interested in learning from Croydon’s experience and can be contacted at Tony.McDonald@slam.nhs.uk

Checklist of features of integration

14. A checklist of the features of integration can be found at Appendix 7. This is based on the responses of respondents to the DoH’s consultation on performance indicators and the 32 respondents to the questionnaire. Each area will need to decide which of these features are needed, and to what extent, in order to deliver an improved service and not simply lead to disruptive organisational change.

9 The Outcomes of the Integrated CMHT (OP)

1. A crucial element of developing a new service or evidencing the value of an existing service is evaluating its outcomes. In this final section a review of issues relevant to evaluating the outcomes of CMHT(OP)s will be offered.

Evaluation of Services

2. Service evaluation brings together elements of performance monitoring, audit and research. It involves:

“the systematic collection of information about the activities, characteristics and outcomes of a service or team to.... improve effectiveness and make decisions with regard to what those services are doing or affecting.”²²⁴

3. Service evaluations tend to be ‘impact evaluations’: they determine the outcomes and effectiveness of a service for individuals or groups of individuals. Table 6 sets out the different levels and shows that service evaluations are located at Level 2 of the hierarchy of evaluation.²²⁵

Table 6

Level 1	Evaluation of a specific treatment, e.g. CBT for phobias
Level 2	evaluation of care for particular user groups, e.g. assertive outreach for people with severe mental health problems
Level 3	Evaluation of organisations, e.g. mental health services in Area A
Level 4	Evaluation of health systems, e.g. the NHS

Source: Coulter

Design and Methodology

4. At the outset of an evaluation process it is crucial to be clear about what is being evaluated and why. For CMHT(OP) integration: how well professionals work together, how far they jointly achieve the team’s aims usage of the CMHT and throughput impact and outcomes and, difficulties encountered and achievements, would all be aspects of an overarching evaluation. Appendix 7 gives features of integration that could be used as a checklist in an evaluation
5. Who the evaluation is for - local management systems, a regional/national review, to inform research and/or policy - will significantly influence direction, emphasis, breadth and depth and will also influence the methods employed.
6. In terms of design, service evaluations tend to: either collect new material or use existing data from case and other records, analyse that data and offer commentary about the following:

“... usage of the service/team, profile of users - and carers if relevant - how effective it is, whether it is achieving its stated aims, what its impact is on users and carers (and sometimes other services) and its strengths and weaknesses. Costs data is also often collected”²²⁶

7. Service evaluations typically employ a combination of qualitative and quantitative methods. These will include:
 - Focus groups and/or structured interviews with users, carers and staff
 - Interrogation of case files and records
 - Throughput and destination data, i.e. who used service; where did they go to
 - Services used - in addition to those of the CMHT itself
 - Services not used, e.g. delay or prevention of use of long-term care
 - Reduced carer burden and/or improved quality of life
 - Management and activity data, e.g. workload documentation
 - Costs data
8. In depth interviews gather more detailed material about users and carers for case studies or illustrate the use of a care pathway. Measures of health and well-being may be used to offer evidence of impact on users and/or carers.
9. The group of service users and carers using the services of one CMHT may be compared with those of another to evaluate differences, teasing out what intervention, care package or approach results in a more integrated outcome.²²⁷
10. Templates or evaluation frameworks contain the dimensions to be evaluated, how success is to be measured and how each will contribute to the overall evaluation. This ensures consistency of approach amongst a group of evaluators.²²⁸
11. Perspectives that evaluations usually capture are those of service users, carers, staff and operational managers. Senior managers, commissioners and clinicians with links with the team may be included in larger systems evaluations.

User and Carer Contributions to Service Evaluations

12. The ‘real test’ of whether or not integrated care is working is whether outcomes for users and carers are improved.²²⁹ Gathering the views of users of CMHT(OP), particularly those who are disempowered or who are dependent on the service for their survival, is difficult. People with dementia have long been regarded as ‘unreliable’ sources of information.²³⁰
13. It is possible to monitor user views of increased accessibility, greater choice and range of services and prevention of institutionalisation.
14. It is more problematic to measure improvements in quality of life or ‘improved integration’ as most instruments are insufficiently sensitive to people with dementia.²³¹

15. Researchers working for a University must submit an application to a local or multiple research ethics committee. Those working within a health setting are subject to clinical governance policies that expect full consideration of ethical issues. This is challenging when researching the views of people who have impaired communication or cognition such as people with dementia.²³²
16. Although carers are increasingly involved in service evaluations including CMHT(OP)s,²³³ it is important to give consideration to their level of dependency on the service when seeking an ‘honest’ view of its role and impact.²³⁴ It is also important not to rely on carers as ‘proxy’ representatives for users but to make every effort to obtain an independent assessment of both perspectives.
17. Evidence about what service users and carers want from CMHT(OP)s is limited. Box 9 lists what was established by Sheard and Cox in 1998.

Box 9

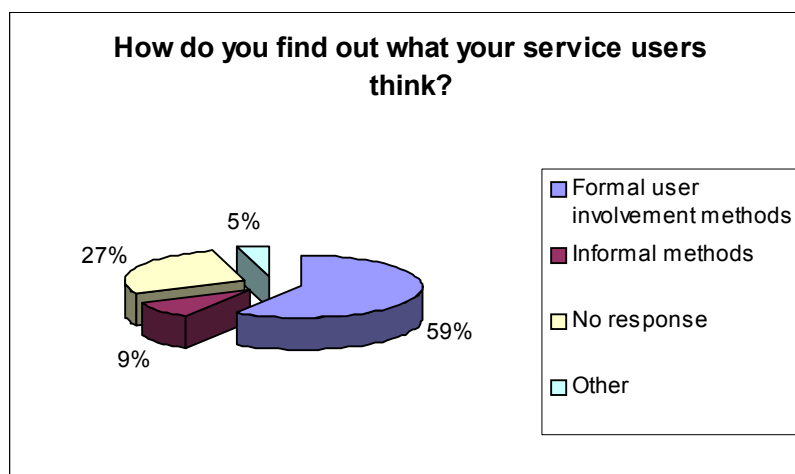
What service users and carers want from CMHT (OP)s

- A broad skill mix
- Teams to cover functional as well as organic mental health problems
- Improved co-ordination of health and social care elements
- A 24 hour service
- Ongoing support, or if withdrawing an explanation as to why
- Information regarding medications
- A person to answer the telephone at the team base, not an answer-phone
- Provision at weekends, particularly to relieve isolation amongst carers
- Provision of guidance on legal and financial matters

Source: Sheard and Cox 1998

18. Respondents to the questionnaire on CMHT(OP)s²³⁵ gave the picture, illustrated by Graphic 3, of their consultation with service users and carers.

Graphic 3



19. Reported methods included consultations, informal anecdotes, complaints and letters of thanks.

20. One area had a comprehensive range of involvement:

“We have a user and carer involvement group, local user and carer events, feedback and questionnaires, compliments and complaints, user and carer representation on steering groups, planning group.”

Approaches to Evaluating Service Outcomes

21. There are broadly three linked - but separate - approaches to evaluating service outcomes. Elements of all three are relevant to evaluating a CMHT(OP):
 - Performance assessment
 - Service evaluation
 - Research.

Performance Assessment

22. This usually relies on the collection of information generated through the record-keeping or management information systems that monitor the functioning and costs of running a particular service.
23. In 1997 the Department of Health Handbook on the Mental Health of Older People emphasised the need for effective monitoring and evaluation of performance, outcomes and quality by commissioners of services.²³⁶
24. The performance measure proposed for the milestones in Standard Seven was a new measure, which was not specified, that the Regional Office and Social Care regions were to use jointly.
25. Since publication of the NSF for Older People and “Shifting the Balance of Power”²³⁷, the Strategic Health Authorities have taken on former Regional Office responsibilities and the former Social Care Region tasks now fall to the Commission for Social Care Inspection. More is being devolved to local performance management arrangements.
26. The NSF for Older People addresses the need for joint-working when measuring performance.²³⁸

*“Where service delivery requires the joint participation of both health and social care services, information from the two frameworks is drawn together as interface information”*²³⁹
27. Older people’s mental health services stand to benefit through integration from this marriage of performance frameworks. When measured in health service terms alone, few current NHS performance indicators have the right focus for this service area. Where Social Services investment is made alongside health monies, reporting is also required on the performance indicators of the Personal Social Services Performance Assessment Framework.
28. The performance indicators relevant to older people’s mental health that are required by Mental Health Trust can be found along with a commentary on their usefulness at Appendix 8 Those required by Social Services local authorities can be found at Appendix 9 along with a further commentary on their application.

29. Box 10 gives details of how one area is pulling together performance information at the Strategic Health Authority level and the benefit of this.

Box 10

Pulling it all together: Collaborative performance management

Towards the end of 2003, Dr Wendy Kaiser, Head of Older People's Programme, Northumberland, Tyne and Wear Strategic Health Authority (SHA) was looking for a collaborative solution to the performance management of the older peoples programme for 2003-4 and 2004-5, including the NSF for Older People. Performance management was spread across primary Care organisations, local authorities, the social services inspectorate (soon to become part of CSCI) and the SHA.

This meant there was no overview of delivery of the whole programme for Northumberland, Tyne and Wear across agencies, other than of the NSF in each of the six localities through their local implementation teams (LITs).

There also did not seem to be much consistency between localities in how and when the LITs were accountable to their communities for delivery of the older people's programme. Most LITs were collecting information on the performance for their locality, but were not all formally reporting to their communities, nor reporting the whole picture to the SSI or the SHA.

Dr Kaiser proposed a collaborative approach to performance management to the accountable officers for each LIT. She identified the benefits and opportunities of a collective performance framework:

- Clarified accountability for delivering currently disparate parts of the programme in order to enhance joint working
- Identification of best practice across the SHA and where more support is needed
- An overview of performance for Chief Officers, Local Strategic Partnerships and elected members
- Information to enable the SHA to performance manage the NSF

Dr Kaiser adapted a tool developed by Northumberland, which identified the NSF targets and the Improvement, Expansion and Reform targets between 2001 and 2006, and the already existing flows of information that could be used to report on progress.

All six health communities signed up to this collaborative approach. They agreed to report to the local body to which they are accountable at the end of March 2004. They will then copy their statement of progress to SSI (by then CSCI) and the SHA. The SHA will bring together the six sets of data to share across Northumberland, Tyne and Wear, to facilitate sharing and benchmarking of progress.

Dr Wendy Kaiser will be pleased to discuss this approach and to share the integrated reporting pro forma that has been developed to support it.

She can be contacted at wendy.kaiser@nhs.net

Service Evaluation

30. In their 2004 series of reports on services for older people, the Audit Commission exhorts evaluation of services as an important but by no means simple task:

“Evaluation needs to be planned from the start. Any evaluation will need a number of components and to look at three dimensions – process, outputs and outcomes:

- *Evaluating processes is important in order to check that things are working as intended*
 - *Evaluating outputs checks whether new arrangements are actually delivering change. Do new partnerships and other ways of working actually result in new kinds of services or new ways of delivering existing services?*
 - *Evaluating outcomes is the most difficult – but most important – to measure. Do the new ways of working lead to better health, quality of life or well-being for the people who use them?”²⁴⁰*
31. Service evaluations can be internally or externally conducted. The externally conducted review is usually multi-dimensional, measurable and can be applied to a range of services to generate benchmarking information. The Audit Commission’s “Forget me not” audits²⁴¹ employed such an approach.
32. Box 11 summarises the Audit Commission’s national work on mental health and older people, which was part of a programme of work entitled “Better Services for Vulnerable Older People”, the design of which pre-dated the publication of NSF for Older People in 2000.

Box 11

Audit Commission’s work on Older People’s Mental Health

Forget Me Not, published in January 2000, set out the Audit Commission’s analysis of mental health services for older people in England and Wales. During 2000 and 2001 auditors appointed by the Commission carried out local audits of these services.

Forget Me Not 2002, published in February 2002, summarised the main findings in England. The audits found very wide variations in practice and provision of mental health services for older people across England.

Many GPs expressed a wish to receive more support, but specialist support and training for them could be limited. Specialist services needed strengthening in some areas, with more day and respite care being available. Teamwork and overall strategy often needed further attention.

Losing Time, published in June 2002, provided a snapshot of these services in Wales, based on the findings from the audits in Wales.

Reviewing the NSF for Older People

33. The new Healthcare Commission is responsible for commenting on the implementation of the NSF for Older People. The methodology for the review has been developed by a team from the former organisations, CHI and SSI, and the Audit Commission. Their work included extensive consultation across England.
34. In their work plan for 2004/5²⁴² the Healthcare Commission say that they will be:

“...undertaking joint reviews with the Commission for Social Care Inspection and the Audit Commission to assess progress regarding the National Service Framework for Older People, involving work in 12 to 15 local health communities, to support organisations in improving services to and promoting the rights of older people in healthcare, community care and social care.”
35. A series of questions have been formulated to guide the reviews. The ‘Issues and Investigations’ list for Standard Seven could be useful in designing local self-assessment. The most pertinent questions are shown in Box 12.

Box 12

Healthcare Commission review of the implementation of the NSF for Older People

Commissioning of the integrated CMHT:

- *Is the planning of older people mental health services done jointly involving health, social care, independent sector and voluntary agencies?*
- *Are care standards monitored jointly? What mechanisms are there for joint monitoring?*
- *Are commissioners of services considering where joint working service delivery could take place?*
- *Have Health Act flexibilities been used to coordinate commissioning?*
- *Are there service level agreements between agencies that monitor service delivery and regularly check what services are doing? e.g. performance assessment of quality of services.*

Provision of the integrated CMHT:

- *Are there joint leadership and management arrangements across agency and organisations for teams?*
- *Is there a multi- agency workforce plan?*
- *Is the information of clients’ care available to other members of the team and shared across agencies?*
- *Are multi-professional team meetings held?*
- *Are multi-agency team meetings and case conferences held?*
- *How are care plans and assessments communicated across teams and how are multi agencies involved?*

See www.healthcarecommission.org.uk for future updating of this list

Research

36. Research tends to be conducted by external researchers working in a University setting or by clinicians with training in research methods. These aim to evaluate the overall functioning of a service or a particular aspect of a service using validated measures or research tools. They may compare the group receiving the intervention with a similar group not receiving it over a specified time period.
37. A number of research studies have evaluated the outcomes and/or effectiveness of psychogeriatric teams. They focused either on one or more teams in an area, or on a specific team activity.
38. Most studies of team effectiveness either employ a randomised controlled trial (users of the team are compared with users of the routine service), or evaluate the impact of the intervention on users and carers in terms of levels of dependency, use of services and carer burden.²⁴³
39. Methodological weaknesses have been identified as
 - Non-representative samples
 - Incomplete datasets
 - Lack of comparison data
 - Limited confidence about outcomes being linked to the intervention of the team.
40. In 1995, Banerjee et al²⁴⁴ conducted a randomised controlled trial of the effect of intervention by a psychogeriatric team on depression in frail elderly people living at home. The study evidenced that the group that received the intervention were significantly more likely to be depression-free six months later (58%), later compared with the control group (25%). Psychiatric treatment was substantially more effective than GP care alone.
41. In 1999, Bedford et al²⁴⁵ and Melzer et al²⁴⁶ reviewed the outcomes of four community psycho-geriatric teams on users and carers over a six-month period. The studies found that the teams work with highly dependent people with dementia, that carers tend to be highly stressed and that there is widespread unmet need for residential and respite care.
42. Evaluations focusing on activities such as the diagnostic²⁴⁷ and treatment abilities²⁴⁸ of team members suggested that first assessments of patients can be made safely and effectively by a range of professionals other than doctors.
43. Other studies have reviewed the organisation and membership of psychogeriatric or similar teams.²⁴⁹ A particularly well-designed piece of evaluation work is outlined in Box 13

Service Evaluation

The Lewisham Care Management Scheme - Intensive Care Management Model

In the late 1990s Challis and colleagues did pioneering work in evaluating an intensive care management scheme for older people with mental health problems in Lewisham, South London.²⁵⁰

The service combined specialist domiciliary care for people with dementia, specialist mental health care and intensive case management. Intensive care management combines the co-ordination role with a supportive social work role for a small number of service users who have complex and frequently changing needs.

The case managers were located in a based in a mental health team for older people, had caseloads of 20-25 cases and control over a devolved budget to enable them to provide individually tailored services.²⁵¹

Methods

The evaluation employed a quasi-experimental approach: it compared a group of users of the LCMS with those in a similar community mental health team for older people not receiving intensive care management.

Standardised measures were used to assess outcomes: service usage and destination; quality of life for users; quality of care for users and carers; and a set of more general health related issues.²⁵²

Outcomes

The findings of the evaluation suggest that LCMS had a positive impact upon older people and their carers. Both showed significant improvements in levels of social contact, carers experienced reduced stress levels and there were significant improvements in levels of overall need and risk, and fewer admissions to care homes.

Overall, these findings suggest that there are gains to be made from a targeted intensive case management approach to this highly vulnerable group of individuals which less intensive interventions have not been able to achieve.

The role of the case manager in linking specialist mental health support together with home-focused social care was at the heart of LCMS's success.²⁵³

Integration in Older People's Community Mental Health Teams
QUESTIONS FOR MENTAL HEALTH SERVICE PROVIDERS

[A] Service Context

1. Do you have a lead commissioner for OPMH?
2. If yes, 5, who employs them?
3. Do they have a mandate to commit resources on behalf of all local health and social care purchasers?
4. Is there a strategy for OPMH?
5. If 'yes' – to what extent is it joint (jointly developed, owned, implemented and funded)?
6. If 'no', is there one in the making or planned? - If not, why not?
7. Do you have protocols for the care and management of OPMH problems across the health and social care system?
8. Where are CMHTs in the care pathway? Have care pathways been mapped?
9. Where do memory clinics fit with CMHT operations?
10. Do you have an integrated CMHT? Does this include both health and social care workers?

[B] Interagency multidisciplinary staff involving health and social services

1. What is the purpose of the team? Do you have a team service specification? Can we see it please?
2. What is/are the core role(s)/functions? For whom?
3. How long has the current configuration of service been in place?
4. Have Health Act flexibilities been used to set it up?
5. Who is employed (FTEs) and by whom?
6. Do you have any long-term vacancies?
7. Who is the team leader?
8. Is the team leader post open to any discipline?
9. What are the workload management arrangements? What is the frequency of management supervision
10. Who agrees leave?
11. To whom do workers report sickness?
12. Who is responsible for disciplinary issues?
13. Who is responsible for recording the issuing of verbal or written warning?
14. Are workers offered and do they have uni-discipline clinical/professional supervision and professional development mentorship/guidance?
15. Do you have any comments about marrying organisational cultures?
16. Do you have any comments about marrying professional cultures within the team?
17. Are workers co-located? Which ones?
18. In the same building, same corridor or same room?
19. Do they share administrative staff?
20. Do new members of staff routinely spend time learning about other members' roles and priorities?

[C] Joint recording systems and IT systems supporting both CPA and SAP

1. In what ways do workers share information?
2. Is there a Joint Electronic Database?
3. If not, who enters data into each of the systems?
4. What files are maintained for each person accepted by the team? Electronic record only, paper record only or electronic and paper records?
5. Is there a single service user record?
6. If not, do staff have access to each other's records?
7. Do service users sign anything giving consent for sharing of information?

[D] Single point of entry or “access” to specialist mental health assessment

1. How do people access the team?
2. Does the team have eligibility criteria?
3. Does the team operate standards for response times?
4. Who can refer to the team?
5. Is there a single point of entry? What are the referral methods and duty systems?
6. Are there any internal referral systems?
7. Is there a single allocation system?
8. Are roles prescribed in the team according to discipline?

[E] Integrated assessment, care planning and care co-ordination

1. Which team members conduct holistic care needs assessments? Are these SAP or CPA?
2. Is there a Section 31 agreement in place regarding delegation of the statutory duty of assessment?
3. Does the team use common assessment tools?
4. Are these tools linked into SAP?
5. Are these tools linked into CPA?
6. Do service users go on the CPA register?
7. In risk assessment, how are issues of risk decided? With whom does a worker discuss their assessment if they have concerns that the person may be possibly in need of intervention (possibly against their wishes)?
8. If service users need home care (non-specialist):
 - a. What process is followed?
 - b. What communication takes place?
 - c. What administration is needed, including which forms?
 - d. What recording is done?
9. Which staff commission social care services?
10. Which staff do not commission social care services?
11. Do staff have training on accessing social care services?
12. Who in the team can authorise accessing to mental health care services (day/inpatient/ nursing home care)?
13. If service users are in need of inpatient care
 - a. What process is followed?
 - b. What communication takes place?
 - c. What administration is needed, including forms?
 - d. What case-file recording is done?
14. Which team members act as key workers, care-coordinators or team leaders / managers?

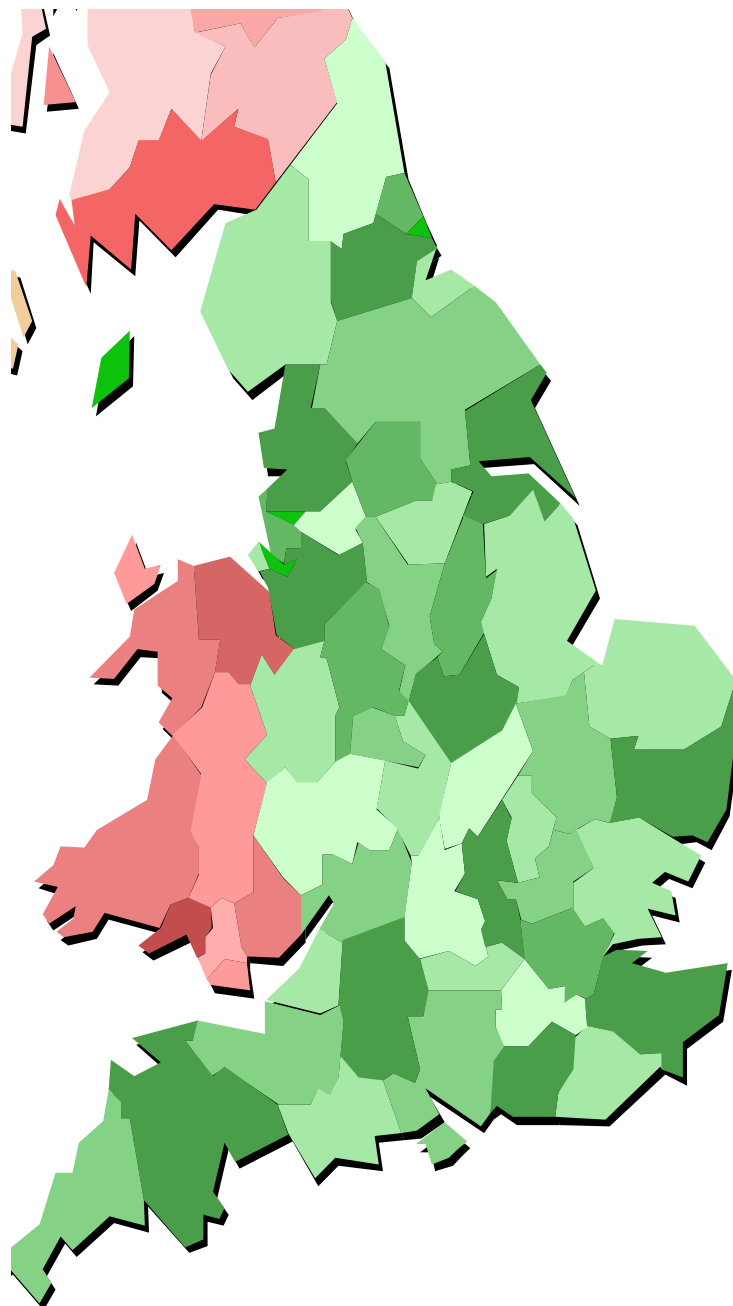
[F] Evaluating the Service

1. Has the team been evaluated? If so, can we see the evaluation, please?
2. Do you have the way of working wholly or partly written down in any operational policies or procedures?
3. How do you find out what your service users think?
4. Are your service users included in Trust patient / CPA surveys?

[G] Areas not covered by a CMHT

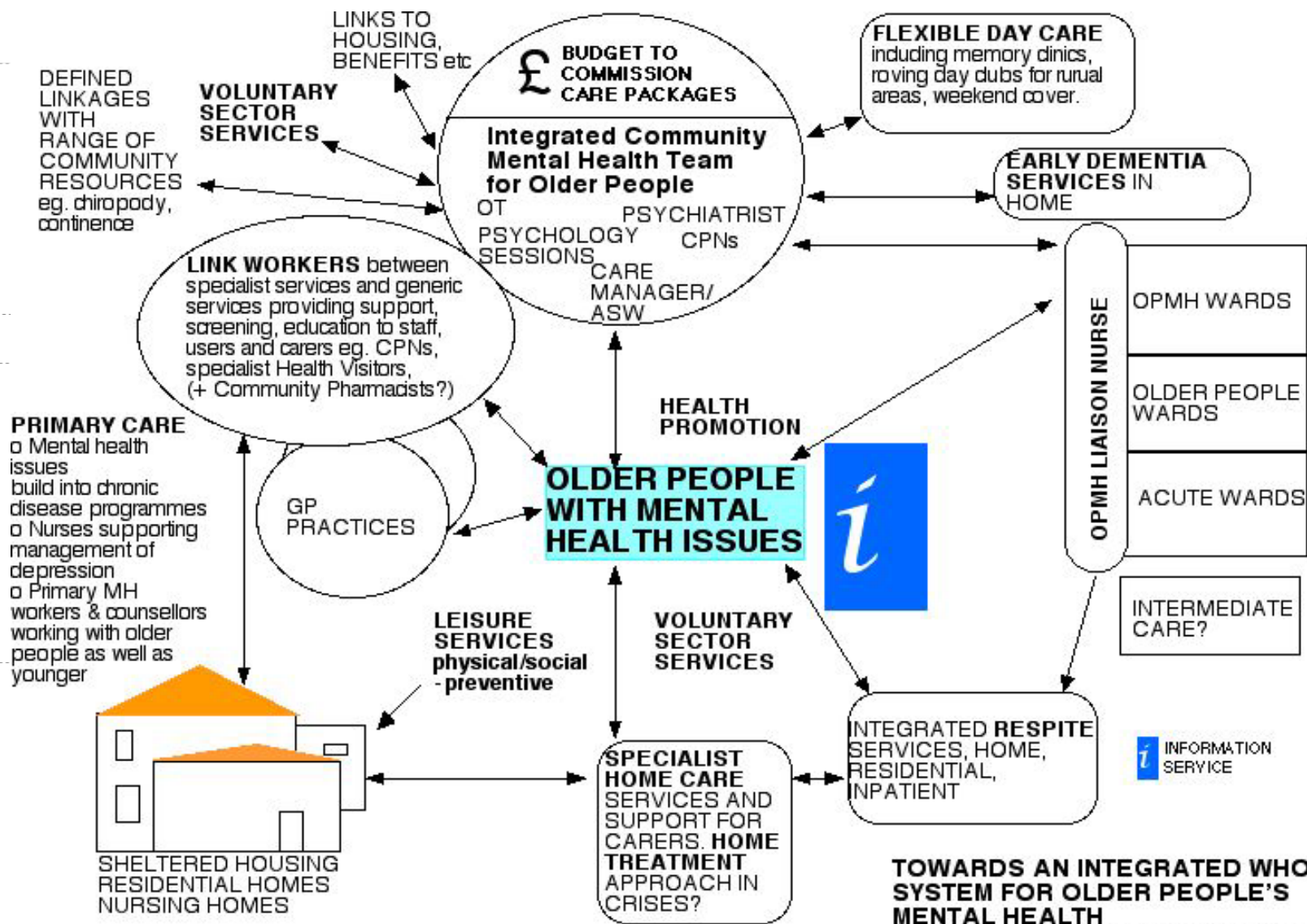
1. Are there identified health staff for OPMH working in localities?
2. Are there identified social care staff for OPMH working in the same localities?
3. How do people get referred to either service?
4. Are there eligibility criteria for specialist services?
5. Are referrals cross-referenced to each agency?
6. Do the staff meet up?
7. Do staff access each other’s resources?
8. What ASW cover is there for OP with MH needs?

Respondents to questionnaire-based request to ‘the field’ for information about CMHT(OP)s March 2004



- Barnsley
- Brentwood, Basildon, Thurrock
- Calderdale
- Cambridge
- Croydon
- Devon Partnership
- Gloucestershire
- Hammersmith & Fulham
- Herefordshire
- Hounslow
- Kingston
- Lambeth
- Leicester
- Lewisham
- Lincolnshire
- Merton
- Newham
- Norfolk
- Northants
- Plymouth
- Rotherham
- Selby
- Southend & Castlepoint
- Southwark
- Sunderland
- Surrey
- Sutton
- Swindon
- Tower Hamlets
- Wakefield
- Walsall
- Wandsworth

Older People's Programme



TOWARDS AN INTEGRATED WHOLE SYSTEM FOR OLDER PEOPLE'S MENTAL HEALTH
 OLDER PEOPLE PROGRAMME MARCH 2004

WHAT CAN YOU EXPECT FROM US?

- *A comprehensive assessment of your needs.*
- *Specialist support for service users and carers*
- *A response within 2 working days*
- *Access to services such as home care and respite care if you fall within the critical substantial bands of the Fair Access to Care Services criteria.*
- *If you are not eligible for services from this team we would give you advice and information on alternative support.*

GPs, Carers, other professional agencies or self-referral. If we are unable to assist we can advise you about the most appropriate service.

EAST LONDON & THE CITY MENTAL HEALTH TRUST

COMMUNITY MENTAL HEALTH TEAM FOR OLDER PEOPLE

4TH Floor, Francis House, 760-762 Barking Road, Plaistow, London E13 9PJ
Telephone No: 020 8271 1318
Fax No: 020 8271 1363
Office Hours: 9.00am – 5.00pm Monday – Friday
After Hours: Emergency Duty Team – Tel 020 8552 9587

REFERRALS

We have a Duty Officer available Monday to Friday between 9.00am and 5.00pm.

The Duty Officer will deal with all referrals and respond to them in order of priority and need. The telephone number is:
020 8271 1318

WHO CAN REFER?

What IS THE CMHT FOR OLDER PEOPLE?

The Community Mental Health Team offers assessment and provides or arranges appropriate care for older people.

Where appropriate, a member of the team will visit the service user in their own home or in a convenient setting i.e. hospital ward to discuss present problems. We aim to offer help and support and to provide a high level of care. Emphasis is also placed on assisting carers.

WHO IS IT FOR?

- Newham residents
- People over 65 years old
- People with mental health needs such as schizophrenia, depression, severe anxiety, dementia with complex needs
- People at risk of mental health deterioration.
- People who are already known to the Adult Mental Services will be transferred by the Psychiatrist at the appropriate time.

THE TEAM CONSISTS OF

- ***Community Psychiatric Nurses***
- ***Social Workers***
- ***Occupational Therapists***
- ***Psychiatrists***
- ***Psychologists***
- ***Support Worker***
- ***Administration Staff***
- ***Support WorkersAdmin Staff***

HOW DOES IT WORK?

The purpose of the team is to provide help and support to older people with mental health needs in close liaison with Health and Social Services, voluntary and non-statutory groups.

- ***To provide mental health assessments***
- ***To provide advice, information, counselling and support for service users and carers as appropriate***
- ***To facilitate admission to hospital for assessment and treatment if necessary.***
- ***To facilitate respite care and other community services e.g. day care.***

Views on integration: Wiltshire County Council and the Avon and Wiltshire Partnership NHS Trust

“Integration has led to a widening out of assessment to take in the family and carer picture. I believe this has led to fewer admissions to hospital and the resulting reduction in independence skills of being in a non-acute ward for months. But if we were starting afresh, we should consider integrating services across the whole range of older people’s needs, not just their mental health needs. There is little interface between the mental health services for adults of working age and older people, unlike the need for high levels of cooperation between physical and mental health care of older people. CMHTs have a crucial contribution to make to the service system”

Chris Chorley, Assistant Director of Mental Health and Learning Disabilities, Wiltshire Social Services, sees the following older people’s system roles for CMHTs:

- With CMHT training and support, voluntary organisations can be enabled to maintain people with lower risk mental health needs in their own homes
- The CMHT can work with mainstream home care providers to develop their services so they are able to provide person-centred dementia care.
- Through early CMHT involvement, breakdown of family care can be avoided. This would be further enhanced through integration with older people’s services
- Supporting residential care homes to care for people with mental health needs reduces moves to higher dependency care. More providers can develop the confidence needed to provide a range of care including intermediate, step-down and respite care for people with some degree of mental health need

Integrating within a mental health trust – an integrated provider manager view

“As an RMN/RGN I considered myself to be well informed. I was confident that integration would lead to better results for the service user. Despite this, it has taken me 2½ years to understand both the complexities and opportunities of social care. You can’t underestimate the preparation needed for integration.”

Peter Wilson, Assistant Director of Mental Health Services for Avon & Wiltshire Partnership NHS Trust, recommends the following recipe for success

- Don’t presume health and social care staff understand each other’s roles
- Ensure health staff understand the nature of social care assessments and the range of potential social care options in order to access care homes, respite care or domiciliary care
- Decide whether this role will be shared by all or just undertaken by some staff
- Consider systems and mindsets when asking staff to produce performance information on both social and health care
- Prepare managers for managing people from different agencies particularly health staff about the roles and responsibilities of social workers
- Have a social care representative on the Trust Board

Peter Wilson and Chris Chorley would be pleased to discuss the issues of integrating care, and can be contacted by email: Peter.Wilson@awp.nhs.uk and chrischorley@wiltshire.gov.uk

Integration of Organisations and Professions in South Essex

Gaynor Abbott-Simpson, Assistant Director, Mental Health Services for Older People, South Essex Partnership NHS Trust was appointed as a joint manager under the terms of a formal partnership agreement with Southend Borough Council. She has been involved in the creation of three CMHT(OP)s:

“Marrying professional and organisational cultures within the team was far more difficult than the physical aspects of coming together...eventually, workers see that it is not about losing professional identity but retaining it and enhancing their roles. It takes time though!”

“Change inevitably brings tensions, and the organisational cultures of the NHS and SSD are different. The team quickly embraced change and a positive working culture within the team developed. By keeping the focus on improving service delivery and staff from both agencies showing a willingness to trust professional judgements and decisions, the differences have been overshadowed by the similarities.”

Gaynor outlined the benefits that she associates with CMHTs:

“CMHTs streamline services, which not only increases efficiencies by maximising resources, but also improves access for the Service Users by providing ‘one port of call’ to Mental Health Services in terms of both planning and delivery.

They enable us to identify and address the diverse needs of people from within an integrated team, thereby minimising duplication, which in turn has the potential to lead to more effective and person-centred service delivery.

They also help to highlight the profile of mental health in older people, which can become lost.

Finally, CMHTs have the potential to provide support, consultation and education to the community”

In Gaynor’s experience, the keys to integration are:

- Health and social care budgets should be pooled
- Management posts should be across both health and social care
- Adequate resources are needed, particularly support to the purchasing of services for individuals and general administration of the social care management role

The issues standing in the way of integration are

- Outdated policies that do not reflect integrated working and approaches
- Managing staff from several organisations with different terms and conditions

Gaynor would be pleased to give more information about her role in South Essex and can be contacted at Gaynor.Abbott-Simpson@southessex-trust.nhs.uk.

Services Research and Integrated Community Mental Health Teams

“There have been legislative, policy, organisational and training initiatives to encourage full integration but problems persist, with strong adherence to uni-professional cultures and mistrust of managerial solutions⁸. What has not been explored is an approach that enables professionals, through collaboration within several integrated teams and with service users and carers, to develop their own practical strategies for working together successfully.

“Better inter-professional integrated working is a major goal for Avon & Wiltshire Partnership NHS Trust and for government policy in health and social care, and should include service users and carers as partners. This research will investigate how this might be done”

Dr Willm Mistral and Dr Mark Baldwin of University of Bath have agreed a research protocol with Malcolm Sinclair, Director of Mental Health (Wiltshire), and Ruth Webb, Head of Social Work (Wiltshire) for Avon & Wiltshire Partnership Mental Health Trust.

The principal research question concerns practical solutions to the difficulties of inter-professional practice within integrated Community Mental Health Teams. They aim to identify changes to working practice that could facilitate integrated health and social care teamwork, across professional boundaries and with service to users and carers and to describe factors which facilitate or hinder inter-professional working;

They will do this by establishing criteria for effective inter-professional practice from the literature, and from focused interviews/discussions with CMH Teams, AWP Managers, Service Users and Carers. They will explore opportunities and threats to integrated practice and identify and describe changes to working practice based upon opportunities and the avoidance of threats.

The research team plan to draw conclusions about how CMH Teams could capitalise on opportunities and negate threats to integrated service delivery.

Methodology

- Interviews with four key managers within Wiltshire mental health services to establish integrated service delivery aims and objectives
- Focus group with service users and focus group with carers to ascertain views on effective integrated working
- Three focus groups with members of integrated health & social care teams to discuss opportunities and barriers to effective integrated practice, and to establish practical changes to working practices which could be evaluated over time
- Feedback focus group findings to senior managers; interviews managers as to feasibility of any suggested changes to working practice
- Feedback to all participants via half-day conference and reports

Outcome Measures.

Important outcomes of this study will be an assessment of the degree of congruence of criteria for effectiveness put forward by the four participant groups (Users / Carers / Clinicians / Managers), and conclusions as to the feasibility of modifying working practices to improve the effectiveness of integrated working

⁸ Norman, I. & Peck, E. (1999) Working together in adult community mental health services: an interprofessional dialogue. *Journal of Mental Health*, 8, 217-230

Features of Integration that could be used as a Checklist in Evaluation

A health or partnership trust wanting to assess its current state of operational integration in the care and support of older people with mental health problems could apply this checklist of features and consider whether they are achieving the desired outcomes.

Some represent greater integration than others. The numbers of squares next to a feature roughly reflect⁹ the significance of that feature to service – rather than organisational – integration. The squares could be used to create a score to set a baseline for service development.

1. Team Functions

- 1.1. Multi-disciplinary community care assessments
All members of the CMHT conduct SAP/CPA assessments of health and social care need, singly or jointly, including a separate formal assessment of carer needs
- 1.2. Social care commissioning¹⁰ arrangements are integrated
All team members providing assessment and care management are trained in arranging and authorised to arrange social care services
- or
- Social care commissioning arrangements within team¹¹
At least one team member is available during team operating hours who is trained and authorised to arrange social care services
- or
- Social care commissioning arrangements via external social care colleagues
Team members are clear about how to access social care services through social care colleagues in the area and these arrangements work efficiently
- 1.3. Financial information recorded by all team members
All members trained in gathering information for purposes of financial assessment if required for accessing services where a charge is levied at the point of delivery
- or
- Support to multi-disciplinary care managers in administering care packages
All team members' care management role supported by team member trained in financial and business aspects of care brokerage

⁹ Based on the views of 32 respondents to the survey carried out for this commentary document

¹⁰ Social care commissioning: The term “commissioning” is used here to mean the process of matching services to identified individual needs and then arranging for access to the services. It does not refer to the activity of commissioning for whole populations at a strategic level. It is used in preference to the term “purchasing”, which is more often used to mean agreeing price or spot/block contracting. There is currently a lack of consensus about these terms, which tend to be used interchangeably.

¹¹ Social care commissioning within team: Social care services (e.g. generic homecare, MOW, day care, residential care) can be arranged by the assessor within the team (health or social care professional using SAP or CPA), without an additional layer of assessment or internal or external referral (neither within the team nor to another agency). There may be some form of resource-allocation authorisation (as in the case of access to residential care, high value social care packages, inpatient beds or day hospital places) but no additional assessment. The assessors in the team should be trained in the assessment of needs in relation to the health and social care services being accessed, and also be able to collect the necessary financial information for a financial assessment to be conducted by the social care organisation responsible for charging. The aim of this is to reduce delay in the provision of services, reduce bureaucracy and reduce intrusion into the life and privacy of the person concerned.

2. Team Structures

- 2.1. Core membership of team
At least the following disciplines are represented in the team, the majority of whose workload arises from the single point of service entry: psychiatry, community mental health nursing, social work/care management, and occupational therapy
- 2.2. Agreed set of team policies
Policies have been developed by the team in partnership with joint management. They guide and underpin team activities and include clarification of the team's role, aims, function, membership and links with other parts of the health/social services system
- 2.3. Single line management regardless of employing agency
All team members are accountable to the team manager on workload, organisational and team issues. A peer or more senior colleague of the same profession may provide supervision concerning professional practice development
- 2.4. Shared formal training sessions on both health and social care related issues
All team members access the same range of training options as appropriate to their role

3. Team Processes

- 3.1. Single point of entry for referrals
Single system of receiving referrals with a single plan for 24-hour cover. All team members can receive referrals (including social care professionals)
- 3.2. Single allocation system
Referrals for specialist assessment from a range of sources are entered into one referral tracking process whether paper or electronic. Decision about accepting the referrals and allocation to which worker is made on that record. There is a method of reviewing the initial assessment as a team to see if the right discipline is working with the person
- 3.3. No internal referrals
No additional assessment required in order to access health or social care resources beyond usual resource gatekeeping processes such as residential care panels or discussion about use of inpatient beds or day hospital with a consultant
- 3.4. Weekly team meetings are held with health and social care personnel
Weekly team meetings including senior mental health personnel are held to consider referrals and discuss mental health needs of older people either being worked with by the team or about which team members are being consulted
- 3.5. Shared assessment tools and documentation
One set of tools and documentation support both SAP and CPA

4. Team Administration

- 4.1.** Joint electronic service user database
Assessment and care management activities (SAP or CPA) as well as other team functions are tracked on one computer system that all team members have access to, contribute to and are trained to use.
- 4.2.** Co-location of administrative base
Workers share the same working area including refreshment facilities and toilets
- 4.3.** Shared administrative staff
Telephone contact point staffed by one person or team. Service user record filing system and data entry administered by same person or team
- 4.4.** Single patient record
Only one case file is kept for each service user and is used by all team members for all recording
- or**
- Shared access to health and social care records
Staff have physical access to one another's case files and databases, overseen by an administrative team member

Please note: This checklist has been developed by Jayne Lingard based on the literature and research in this document and on the views of the 32 respondents to the questionnaire and some other service providers. Its design would benefit from trial and subsequent discussion before it can be regarded as a reliable tool.

Performance indicators relevant to older people's mental health that are required by health service commissioners

Performance ratings for NHS trusts in England, covering the year ending March 2003 were the first to be produced and published by CHI, the Commission for Health Improvement.

This year was also the first in which primary care trusts and mental health trusts received full star ratings. In April 2004, this duty passed to the Healthcare Commission¹² who will need to take account of integration between health and social care commissioning and provision and the older people's mental health service development agenda.

The following performance indicators are currently included in mental health NHS trust reporting schedules. Their usefulness in the direct performance management of older people's mental health services is limited:

Key target	Relevance to mental health services for older people
CMHT integration	This has been relevant only to Adults of Working Age services so far
Mental Health Minimum Dataset implementation	This dataset will be useful for developing trend data, but was developed initially with adult of working age services in mind
Number of outpatients waiting longer than the standard	Useful where services for older people are entirely reliant upon referrals from GPs to consultants. Information about waiting when referred to a CMHT single point of entry is not collated within this indicator
Capacity and capability	
Missed outpatient appointments	Only measures one aspect of the service: follow-up by psychiatrists. With CMHTs, home visits are often first point of contact
Clinical focus	
CPA systems implementation	Relevant only when older people are included in Care Programme Approach systems
Psychiatric readmissions (older people)	This indicates whether people are being properly supported at home following a period of inpatient care or if people are not being discharged too early. With inadequate community support, older people may have to enter a care home following a psychiatric admission. They are less likely to be readmitted from such care. This may not always be the best outcome for an individual; intermediate

¹² <http://www.chai.org.uk/Homepage/fs/en>

	care may have enabled them to return home. This situation may be masked by this indicator
<u>Suicide rate</u>	This information is not separated out by age in national reporting
Patient focus	
<u>Transition of care between adult services and OPMH</u>	The introduction of clear policies about transition of care between services are important. Their implementation needs to be audited locally
<u>Patients with copies of their own Care Plan</u>	This can be usefully cross-referenced with the Social Services performance indicator about being given a statement of needs

Source of commentary: Jayne Lingard

Performance indicators relevant to older people's mental health that are required by social care commissioners

The Commission for Social Care Inspection (CSCI) has responsibility for developing Personal Social Services performance assessment framework (PAF) indicators, subject to agreement by ministers, and responsibility for publishing the performance indicators, as well as the Social Services star ratings.

Grouped indicators can be used to answer the following questions in relation to older people. The numbers in brackets show the reference number of the performance indicators²⁵⁴ that would contribute to answering that particular question:

To what extent is my council...

Caring for people in home settings rather than residential care? (CF/B7, CF/C22-23, AO/B11, AO/C26-32)	Providing people with the services they want? (AO/C51, AO/D37, AO/D52-53)
Investing now to prevent people needing more services later? (CF/E44, AO/C29-32)	Making sure people get the services they need? (CF/C20, AO/D39-40, AO/D42, AO/D53, AO/E49-50)
Helping to promote older people's independence (AO/C26, AO/C28, AO/C32, AO/C33, AO/C51)	Ensuring services are delivered quickly? (AO/D38, AO/D41, AO/D43)
Treating people from ethnic minority groups fairly? (CF/E45, AO/E47-48)	Providing services at a reasonable cost? (CF/B7-10, AO/B11-17)

<http://www.publications.doh.gov.uk/paf/pdfs2003/generalpages2003.pdf>

Some of these performance indicators are reported on by one partnership trust as a condition of the service contract with the local authority social services department. They both enable the purchaser to get a picture of performance by the integrated service provider and contribute to the purchaser's own Social Services star rating

All the indicators have their limitations in being able to say how well a specific adult user group such as older people with mental health problems is being served. However councils should have data that helps them monitor how sub-groups of users are being supported by different services.

PAF Ref Number	Title of performance indicator	Benefit to commissioners and service improvement processes
PAF D42	Number of Carer Assessments	<p>At provider level, can show whether carers are having their needs taken into account in care planning for individuals</p> <p>At national level, this indicator is simply the number of completed formal assessments under Carers' legislation. As it does not distinguish user groups, so it is hard to know without further data if carers in a particular user group</p>

		are getting a fair deal. To assess performance requires data for comparator group councils.
PAF D40	%of clients receiving a review of their needs	Review performance is important as an indicator of what proportion of users are having their needs reviewed and care packages adjusted. Year-on-year improvement should be observed. As above there is no way of knowing which user groups are getting the benefit of reviews unless the SSD has internal data.
PAF D39	% of statements of needs issued	Important indicator of user information/empowerment which should now be routine. Promotes service user involvement in planning their own care
PAF C 28	Households receiving intensive homecare per 1,000 population	Counted as 10 hours or more per week, this PI is usually taken as referring to older people but does not necessarily do so. Government priority for year-on-year improvement. Performance can be measured against national targets and comparator group councils
PAF C26	Admissions of supported residents aged over 65 to care homes per 10,000 population	If performance is at a similar level as in comparator councils, active management will be needed to ensure admissions do not rise or ideally are reduced. Some councils have achieved this. However, a decrease in admissions to care home cannot be assumed to be directly related to an increase in intensive home care activity: it is important to look at the wider picture including NHS services including use of intermediate care beds or rapid response services.
PAF B13	Unit cost of care home care for older people aged 65 and over	Trend over time and in-house/independent provider comparisons are monitored
PAF B11	Intensive homecare as a proportion of total high cost care purchasing	Needs to be taken with C28 to develop the narrative around success in “growing” intensive home care
PSA 8	Number of new direct payment and independent living fund claimants	Direct payments are a government priority and year-on-year growth is expected. Could apply to older people with MH problems if carer/advocate is budget holder
PAF C32	Adults helped to live at home	This PI is an indicator of “spread” of services for older people, and how much preventive services are reaching out. Trends over time and against comparator councils are significant

Source of commentary: Dick Beaver, former SSI inspector

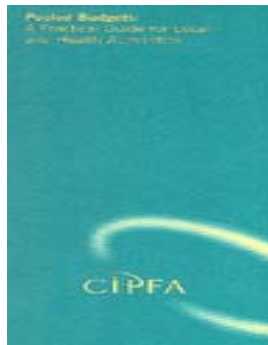
Resources

Checklist for using the Health Act Flexibilities

This document sets out a suggested checklist for local authority and health staff using the flexibilities introduced in The Health Act 1999. The purpose of the flexibilities is to move attention away from structure and process to focus on how organisations can respond effectively to the needs of their customers and patients.

<http://www.publications.doh.gov.uk/jointunit/checklist.pdf>

Pooled Budgets: A Practical Guide for Local and Health Authorities (2001)



“required reading for any practitioner... who has responsibility for implementing pooled budgets ... it will be invaluable...in your mission to make the financial partnership work.”

<http://secure.cipfa.org.uk/cgi-bin/CIPFA.storefront/>

Health Act Flexibilities: Framework and Manual North Yorkshire Health Authority, North Yorkshire County Council and City of York Council, 2001

http://www.integratedcarenetwork.gov.uk/downloads/060703_upload_haf_manual.doc

Integrating health and social care

Margaret Edwards and Clive Miller

This publication examines the practical implications of achieving greater integration between health and social care services. It is a very practical book, illustrated throughout with real life examples, practical tips and 27 'try this' exercises for individuals or groups.

http://www.opm.co.uk/publications/pubs_briefing.asp

Effective Interagency Working in mental health, older people's services and children's services. A Department of Health Publication 2002, highlighting examples of interagency working in mental health, older people and children's services. Each case study has been written by the health and social care team who have been trying to improve services for their clients. A copy is available from pauline.clow@npat.nhs.uk.

Health Act 1999: Guidance on Section 31 Partnership Arrangements

http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/TertiaryCare/HealthAct1999PartnershipArrangements/HealthAct1999PartnershipArticle/fs/en?CONTENT_ID=4000373&chk=P1gzXh

Details of Section 31 Partnership arrangement for Southwark Adult Mental Health Services

<http://www.slam.nhs.uk/news/boardadmin/docs/25mar03/Partnershipdetails.doc>
(when prompted for user name and password, click on 'cancel')

Integrated Working and Governance: A Discussion Paper



"The paper is designed to take consideration of the issues beyond just the care trust model in order to consider the governance of health-social care partnerships more generally. Indeed, it suggests that some of the issues that have arisen around governance in care trusts may lie in the continuing of approaches to corporate governance developed during earlier iterations of partnership in those localities"

For the whole document, go to:

http://www.integratedcarenetwork.gov.uk/downloads/icn_governance_paper_final_version2.doc

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