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Take your partners please

Invited commentary on … Partnership working[†]

David Yeomans

Abstract Partnership working with the voluntary sector is developing across mental health services. Such partnerships have the support of the Royal College of Psychiatrists and the Department of Health. Setting up a partnership requires enthusiastic psychiatrists who are willing to work in new ways. These psychiatrists will face issues of personal and clinical responsibility, confidentiality and fairness. They will also have to deal with continuing changes that could unsettle a new and developing collaboration. Early intervention services may use partnerships more than other adult psychiatry services, but partnerships could be established in any specialty. Psychiatrists should make sure that appropriate evaluation is built into any new partnership.

Most consultant psychiatrists work with voluntary sector agencies. These organisations are responsible for clinical services, housing, information, day care, respite and crisis work. It would be unusual if a consultant psychiatrist were not regularly in contact with these services. However, it is rare for that contact to be in the form of a partnership.

Tait & Shah (2007, this issue) present a useful review of partnership working between the voluntary sector and statutory mental health services. They describe the policy that has been published to support partnership working and portray many of the issues that arise in multi-agency partnerships. They outline several levels of partnership that can exist and give two examples of partnership working in early intervention services. However, early intervention services are new arrangements, and new services allow novel commissioning arrangements from the outset. This can include setting up the relationships between staff in voluntary and statutory organisations, including consultant psychiatrists. This facilitates the exploration of partnership working where the goals are clear and shared by all involved. Introducing partnerships to existing services may be a harder challenge. Setting up a new multi-agency service allows staff to opt in with a clear understanding of the partnerships from the outset, but introducing new relationships into existing services requires everyone to shift their perspectives without a clear opt in. This needs extensive preparation and team building. If we look at this from the perspective of consultant psychiatrists, several themes emerge.

[†]See pp. 261–271, this issue.

Responsibility

For psychiatrists entering into multi-agency collaborations there will be issues about responsibility for other practitioners' work. The practitioners who work for voluntary sector organisations may have different management and disciplinary structures and different terms and conditions of employment to those of the NHS. Clear agreements between employers are needed to facilitate working together. In practice these differences can be successfully managed. Social services and the NHS work together in multidisciplinary teams yet often retain separate management, employment and disciplinary procedures. This is a precedent that can be built on for joint working with the voluntary sector. Many consultants will need the support of their own NHS employer to ascertain the limits of their responsibilities when working with voluntary sector colleagues.

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Confidentiality

Another issue for psychiatrists is confidentiality. Who can see clinical records and how is that responsibility for confidentiality managed? Can staff in voluntary sector organisations have the same access to records as statutory sector staff? Can volunteers work in clinical areas? Can service user workers run interventions and participate in clinical decision-making? All of these issues are likely to arise in a multi-agency partnership. Information-sharing agreements and confidentiality policies can be written to support cross-agency working. However, there will be new questions that arise when services start to interact in new ways and there must be an appetite to successfully deal with these questions when they are asked.

Fairness

Another theme that emerges is fairness. The care programme approach (CPA) is a useful example for examining this. The CPA allocates responsibilities to care coordinators. Care coordination is a statutory role. Voluntary sector staff may feel this role is not appropriate for them. Statutory sector staff may feel that partnerships should shoulder responsibilities evenly and their voluntary sector colleagues should take a share of this statutory responsibility. It is an interesting issue and one that is likely to appear in most partnerships at some point.

The concerns of the voluntary sector

National Health Service (NHS) staff should not forget that voluntary sector workers may have considerable reservations about working with the bigger statutory organisations. Voluntary sector workers may ask themselves whether they will we be overwhelmed by the NHS, whether their values will be trodden on and whether their clients will be harmed by the new partnership. When voluntary sector organisations consult with their members and clients they may find that the people they support are also concerned about working more closely with statutory services. Some service users have deliberately chosen voluntary sector provision instead of statutory services. They could be concerned that the NHS is too ready to detain them in hospital or medicalise their experiences. They may wish to avoid 'treatment' models. Not only will statutory services need to be aware of these concerns, they will have to go to service users and sell the partnership alongside the voluntary sector if it is to get off to a good start.

Evaluation

One of the key elements that partnerships must budget for and incorporate is evaluation. Commissioners need a way to judge the outcome of partnerships against alternative forms of service provision. Partnerships should have a say in how evaluation is carried out and make sure that the method is clear from the outset. For example if the simple measure of client contact is chosen, then organisations that run groups or day centres need to be sure that activity is measured equitably with organisations that run clinics and in-patient units. Partnerships should also consider how their approach might reduce the costs associated with traditional forms of care.

Partnership in practice: CHOICE

Co-locating services in a shared setting can make it easier for service users to use a variety of services. When I moved my out-patient clinic from a quiet primary care clinic to a thriving voluntary sector day centre, I found that it was far easier to introduce service users to the day centre. I simply gave them a tour and introduced them to staff and members of the day centre. This helped people engage with the services on offer. My clinic became a major referral source for the day centre and this led me to consider a more formal partnership with the voluntary sector.

I work in a partnership involving a voluntary sector provider, Leeds Mind. The service, called CHOICE (http://www.leedsmind.org.uk/view.aspx?id=94), was created from existing services, a Mind day centre and a community mental health team (CMHT) that includes NHS and social services staff. Additional components were added, including befriending, counselling for people with severe mental illness, complementary therapies and a range of other projects. The separate teams gradually came together over a year of increasingly 'joined up' training and joint working.

The chief executive of Leeds Mind developed a practical model to balance our joint work and our independent activities. Each of the two original service areas has a component with independence and a component that is joined with the other (Fig. 1). Our referral meeting is an example of joint work. Service users can access all three components, but the contributing organisations need only work across two components. This was very helpful from the outset, since the CMHT engaged in another partnership with a pharmaceutical company early on. Leeds Mind did not want to join in that particular partnership, so we used the independence of the CMHT to work with another partner without forcing

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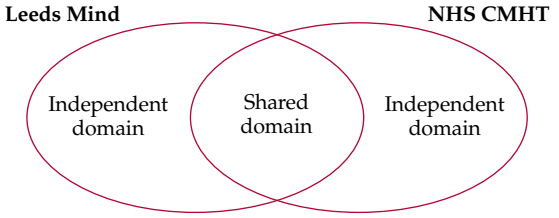

Fig. 1 The CHOICE partnership model.

a conflict of principles on our voluntary sector partner. Similarly, Leeds Mind can do things that are not common practice in the NHS. For example, we set up another independent sector collaboration to provide complementary therapies to our service users.

Challenges

The majority of staff and service users are very positive about the partnership and the wider choice of services on offer. However, NHS managers have presented us with the big challenges. Although our steering group has been supportive, other managers in the NHS trust appear to want to shift resources out of the CMHT and use the voluntary sector service to replace trust staff. We have resisted this. Some NHS managers are pressing for voluntary sector staff to take on statutory responsibilities as care coordinators. This is a clear example of how one agency's values may impose on another agency.

Changes within Leeds Mind have also created uncertainty. Our multi-agency partnership has had to deal with reorganisations within each of the partner organisations. The biggest driver for these changes is central government health and social care policy. It is therefore important to make the partnership adaptable and relevant as new government policies emerge.

Psychiatrists in partnerships

Psychiatrists who want to work in cross-agency partnerships will also want to engage service users in new ways. They will value novelty and learning from others. Tait & Shah give us an extensive set of policy references that should help practitioners wishing to set up partnership services. Psychiatrists may find *New Ways of Working for Psychiatrists* (Department of Health, 2005) helpful. The report emerged from a collaboration between a number of organisations, key among them being the Care Services Improvement Partnership (CSIP), which incorporates the National Institute for Mental Health in England (NIMHE), the Royal College of Psychiatrists and the Changing Workforce Programme (CWP). New Ways of Working aims to enhance effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts. This guide indicates that central government health and social care policy supports multi-agency working and partnerships with the voluntary sector. The important question is will psychiatrists support this way of working?

Declaration of interest

D. Y. works in a partnership between Leeds Mind, Leeds Social Services and Leeds Mental Health Teaching NHS Trust.

Reference

Department of Health (2005) *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services through New Ways of Working in Multidisciplinary and Multi-Agency Contexts. Final Report 'But Not the End of the Story'*. Department of Health.

Tait, L. & Shah, S. (2007) Partnership working: a policy with promise for mental healthcare. *Advances in Psychiatric Treatment*, **13**, 261–271.

MCQs

1 Voluntary sector provision does not include:
a clinical assessment and direct care for mental illness
b information services for service users and carers in hospital and community
c housing support
d Mental Health Act applications for hospital admission
e crisis work.

2 Confidentiality in partnerships can best be maintained by:
a Preventing all voluntary service staff from accessing medical notes
b Gagging clauses in individual employment contracts
c Confidentiality agreements between agencies
d Not communicating across agencies
e Asking permission from service users to share notes.

3 New Ways of Working is:
a an attempt to enhance psychiatric expertise in multi-disciplinary and multi-agency contexts
b a way of cutting down on consultant psychiatrists' numbers and saving money
c published by NICE
d an unimportant policy
e unavailable online at the Department of Health website.

4 Voluntary sector and statutory sector partnerships benefit from:
a shared and independent domains
b strong perceptions of unfairness by staff
c cautious waiting for published evidence of controlled trials

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d constant reorganisations in both sectors
e unenthusiastic psychiatrists.

5 Statutory and voluntary sector partnerships work only:
a in early intervention services
b if consultant psychiatrists are enthusiastic
c if there are no critical incidents
d with complete agreement of all staff
e in a spirit of collaboration.

MCQ answers

1	2	3	4	5
a F	a F	a T	a T	a F
b F	b F	b F	b F	b F
c F	c T	c F	c F	c F
d T	d F	d F	d F	d F
e F	e F	e F	e F	e T

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